

**AMA/Specialty Society RVS Update
Committee**

**Five-Year Review Recommendations
October 2000**

Volume 1

**AMA/Specialty Society RVS Update Committee
Five-Year Review Recommendations
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AMA/Specialty Society RVS Update Committee Five-Year Review Recommendations

CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion	0.81	0.81	2	7
11402	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	1.61	1.61	2	6
11642	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 1.1 to 2.0 cm	2.93	2.93	2	6
11730	Avulsion of nail plate, partial or complete, simple; single	1.13	1.13	2	7
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	1.70	5	7
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.86	1.86	5	7
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.76	1.76	2	6
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	3.92	3.92	2	6
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	3.79	3.79	2	6
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	5.95	5.95	2	6
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children	4.00	4.00	5	7
15001	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	1.00	1.00	5	7
15100	Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.05	9.05	5	7
15101	Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.72	1.72	5	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.83	9.83	5	7
15121	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	2.67	2.67	5	7
15350	Application of allograft, skin; 100 sq cm or less	4.00	4.00	5	7
15351	Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	5	7
15400	Application of xenograft, skin; 100 sq cm or less	4.00	4.00	5	7
15401	each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	5	7
17000	Destruction by any method, including laser, with or without surgical curettment, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion	0.60	0.60	2	7
17003	Destruction by any method, including laser, with or without surgical curettment, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; second through 14 lesions, each (List separately in addition to code for first lesion)	0.15	0.15	2	7
17004	Destruction by any method, including laser, with or without surgical curettment, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia, 15 or more lesions	2.79	2.79	2	7
19000	Puncture aspiration of cyst of breast;	0.84	0.84	2	6
19100	Biopsy of breast; needle core (separate procedure)	1.27	1.27	2	6
19125	Excision of breast lesion identified by preoperative placement of radiological marker; single lesion	6.06	6.06	2	6
19160	Mastectomy, partial;	5.99	5.99	2	6
19162	Mastectomy, partial; with axillary lymphadenectomy	13.53	13.53	2	6
19240	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	16.00	16.00	2	6
20205	Biopsy, muscle; deep	2.35	2.35	5	5

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20245	Biopsy, bone, excisional; deep (eg, humerus, ischium, femur)	3.95	8.50	1	5
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66	0.66	2	7
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	0.68	2	7
21740	Reconstructive repair of pectus excavatum or carinatum	16.50	16.50	5	6
21800	Closed treatment of rib fracture, uncomplicated, each	0.96	0.96	2	5
23076	Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular	7.63	7.63	5	5
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	16.92	21.10	1	5
23485	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	13.43	13.43	2	5
23585	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation	8.96	8.96	2	5
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies);	9.35	9.35	2	5
23630	Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation	7.35	7.35	2	5
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation	10.06	10.06	2	5
24076	Excision, tumor, upper arm or elbow area; deep, subfascial or intramuscular	6.30	6.30	5	5
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	13.17	13.17	2	5
24545	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension	10.46	10.46	2	5
25076	Excision, tumor, forearm and/or wrist area; deep, subfascial or intramuscular	4.92	4.92	5	5
26562	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)	9.68	15.00	1	5
27048	Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular	6.25	6.25	5	5

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27075	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis	17.23	35.00	1	5
27077	Radical resection of tumor or infection; innominate bone, total	23.13	40.00	1	5
27216	Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)	15.19	15.19	2	5
27217	Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami)	14.11	14.11	2	5
27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	20.15	20.15	2	5
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	14.91	14.91	2	5
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (direct fracture exposure)	15.60	15.60	2	5
27280	Arthrodesis, sacroiliac joint (including obtaining graft)	13.39	13.39	2	5
27282	Arthrodesis, symphysis pubis (including obtaining graft)	11.34	11.34	2	5
27284	Arthrodesis, hip joint (including obtaining graft);	16.76	23.45	4	5
27328	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular	5.57	5.57	5	5
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	17.72	17.72	2	5
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation	17.92	17.92	2	5
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	15.65	15.65	2	5
27590	Amputation, thigh, through femur, any level;	12.03	12.03	2	5
27619	Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)	8.40	8.40	5	5
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	14.99	18.20	1	5
27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip	9.20	11.00	1	5
27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip	11.80	13.00	1	5

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27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula	16.23	16.23	2	5
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)	8.88	9.18	4	5
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	8.34	8.34	2	5
28420	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)	16.64	16.64	2	5
28445	Open treatment of talus fracture, with or without internal or external fixation	9.33	15.62	1	5
28705	Arthrodesis; pantalar	15.21	18.80	4	5
29450	Application of clubfoot cast with molding or manipulation, long or short leg	1.02	2.08	1	5
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)	7.76	7.76	2	7
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	9.46	11.05	1	5
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	15.13	16.00	4	5
31600	Tracheostomy, planned (separate procedure);	3.62	7.18	1	3
31622	Bronchoscopy, (rigid or flexible); diagnostic, with or without cell washing (separate procedure)	2.78	2.78	2	3
31625	Bronchoscopy, (rigid or flexible); with biopsy	3.37	3.37	2	3
31645	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)	3.16	3.16	2	3
32000	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	1.54	1.54	2	3
32005	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)	2.19	2.19	2	3
32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)	3.98	3.98	2	3
32035	Thoracostomy; with rib resection for empyema	8.67	8.67	2	3
32095	Thoracotomy, limited, for biopsy of lung or pleura	8.36	8.36	2	7
32100	Thoracotomy, major; with exploration and biopsy	11.84	11.84	6	3

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32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear	13.62	13.62	6	3
32220	Decortication, pulmonary (separate procedure); total	19.27	19.27	6	3
32225	Decortication, pulmonary (separate procedure); partial	13.96	13.96	2	3
32320	Decortication and parietal pleurectomy	20.54	20.54	6	3
32440	Removal of lung, total pneumonectomy;	21.02	25.00	4	3
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	18.32	23.75	4	3
32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)	19.71	19.71	6	3
32491	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure	21.25	21.25	2	7
32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	14.30	14.30	6	3
32520	Resection of lung; with resection of chest wall	21.68	21.68	2	3
32602	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy	5.96	5.96	2	3
32651	Thoracoscopy, surgical; with partial pulmonary decortication	12.91	12.91	2	3
32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis	18.66	18.66	2	3
32655	Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure	13.10	13.10	2	3
32657	Thoracoscopy, surgical; with wedge resection of lung, single or multiple	13.65	13.65	2	3
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	8.04	8.04	2	7
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	7.82	7.82	2	7
33235	Removal of transvenous pacemaker electrode(s); dual lead system	9.40	9.40	2	7
33400	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass	25.34	28.50	4	3
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61	35.00	1	3

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33406	Replacement, aortic valve, with cardiopulmonary bypass; with homograft valve (freehand)	32.30	37.50	1	3
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	32.46	32.46	2	7
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp	32.47	36.25	1	3
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79	42.00	1	3
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with homograft replacement of pulmonary valve (Ross procedure)	35.24	43.50	1	3
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	27.15	27.15	2	3
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	27.00	27.00	2	3
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	31.03	33.00	1	3
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	33.72	40.00	1	3
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43	33.50	1	3
33468	Tricuspid valve repositioning and plication for Ebstein anomaly	30.12	30.12	2	3
33475	Replacement, pulmonary valve	28.41	33.00	1	3
33506	Repair of anomalous coronary artery; by translocation from pulmonary artery to aorta	26.71	35.50	1	3
33510	Coronary artery bypass, vein only; single coronary venous graft	25.12	29.00	1	3
33511	Coronary artery bypass, vein only; two coronary venous grafts	27.40	30.00	1	3
33512	Coronary artery bypass, vein only; three coronary venous grafts	29.67	31.80	1	3
33513	Coronary artery bypass, vein only; four coronary venous grafts	31.95	32.00	1	3
33514	Coronary artery bypass, vein only; five coronary venous grafts	35.00	32.75	3	3
33516	Coronary artery bypass, vein only; six or more coronary venous grafts	37.40	35.00	3	3
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for arterial graft)	2.57	2.57	2	3

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33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)	4.85	4.85	2	3
33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)	7.12	7.12	2	3
33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft)	9.40	9.40	2	3
33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)	11.67	11.67	2	3
33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (List separately in addition to code for arterial graft)	13.95	13.95	2	3
33530	Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (List separately in addition to code for primary procedure)	5.86	5.86	2	3
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	25.83	30.00	1	3
33534	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts	28.82	32.20	1	3
33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	31.81	34.50	1	3
33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts	34.79	37.50	1	3
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	32.30	34.00	1	3
33612	Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction	33.26	35.00	1	3
33615	Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)	32.06	34.00	1	3
33617	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	34.03	37.00	1	3
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	37.57	45.00	1	3
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	21.39	21.39	2	3
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	25.54	30.00	1	3

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33670	Repair of complete atrioventricular canal, with or without prosthetic valve	32.73	35.00	1	3
33681	Closure of ventricular septal defect, with or without patch;	27.67	30.61	1	3
33694	Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch	31.73	34.00	1	3
33697	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	33.71	36.00	1	3
33730	Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)	31.67	34.25	1	3
33750	Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)	21.41	21.41	2	3
33767	Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)	24.50	24.50	2	3
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	33.29	37.00	1	3
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);	35.82	40.00	1	3
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	36.94	41.75	1	3
33786	Total repair, truncus arteriosus (Rastelli type operation)	34.84	39.00	1	3
33820	Repair of patent ductus arteriosus; by ligation	16.29	16.29	2	3
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	20.63	20.63	2	3
33860	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;	33.96	38.00	1	3
33861	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction	34.52	42.00	1	3
33863	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction	36.47	45.00	1	3
33870	Transverse arch graft, with cardiopulmonary bypass	40.31	44.00	1	3

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33875	Descending thoracic aorta graft, with or without bypass	33.06	33.06	5	7
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	42.60	42.60	5	7
33917	Repair of pulmonary artery stenosis by reconstruction with patch or graft	24.50	24.50	2	3
33919	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; with cardiopulmonary bypass	32.67	40.00	1	3
33945	Heart transplant, with or without recipient cardiectomy	42.10	42.10	2	3
34001	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	12.91	12.91	2	7
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	9.97	10.00	4	1
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	8.07	10.00	4	1
34151	Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision	16.86	25.00	4	1
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	9.13	10.03	4	1
34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	12.21	16.50	1	1
34401	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision	12.86	25.00	4	1
34421	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision	9.93	12.00	4	1
34451	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	14.44	27.00	4	1
34490	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision	7.60	9.86	4	1
34501	Valvuloplasty, femoral vein	10.93	16.00	1	1
34510	Venous valve transposition, any vein donor	13.25	18.95	4	1
34520	Cross-over vein graft to venous system	13.74	17.95	4	1
34530	Saphenopopliteal vein anastomosis	17.61	16.64	4	1

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
35011	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision	11.65	18.00	4	1
35013	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision	17.40	22.00	1	1
35045	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, radial or ulnar artery	11.26	17.57	4	1
35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta	28.01	28.01	2	1
35082	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	36.35	38.50	1	1
35092	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	38.39	45.00	1	1
35103	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	33.57	40.50	1	1
35111	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, splenic artery	16.43	25.00	4	1
35112	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	18.69	30.00	1	1
35121	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery	25.99	30.00	4	1
35122	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	33.45	35.00	1	1

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
35131	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)	18.55	25.00	4	1
35132	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)	21.95	30.00	1	1
35141	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)	14.46	20.00	1	1
35142	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)	15.86	23.30	4	1
35151	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, popliteal artery	17.00	22.64	4	1
35152	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery	16.70	25.62	4	1
35182	Repair, congenital arteriovenous fistula; thorax and abdomen	17.74	30.00	1	1
35184	Repair, congenital arteriovenous fistula; extremities	12.25	18.00	4	1
35189	Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen	18.43	28.00	1	1
35190	Repair, acquired or traumatic arteriovenous fistula; extremities	12.75	12.75	2	1
35201	Repair blood vessel, direct; neck	9.99	16.14	4	1
35206	Repair blood vessel, direct; upper extremity	9.25	13.25	4	1
35221	Repair blood vessel, direct; intra-abdominal	16.42	24.39	4	1
35226	Repair blood vessel, direct; lower extremity	9.06	14.50	4	1
35231	Repair blood vessel with vein graft; neck	12.00	20.00	1	1
35236	Repair blood vessel with vein graft; upper extremity	10.54	17.11	4	1
35246	Repair blood vessel with vein graft; intrathoracic, without bypass	19.84	26.45	4	1

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
35251	Repair blood vessel with vein graft; intra-abdominal	17.49	30.20	4	1
35256	Repair blood vessel with vein graft; lower extremity	11.38	18.36	4	1
35261	Repair blood vessel with graft other than vein; neck	11.63	17.80	4	1
35266	Repair blood vessel with graft other than vein; upper extremity	10.30	14.91	4	1
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass	18.75	24.25	4	1
35281	Repair blood vessel with graft other than vein; intra-abdominal	16.48	28.00	1	1
35286	Repair blood vessel with graft other than vein; lower extremity	11.87	16.16	4	1
35311	Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision	23.85	27.00	4	1
35321	Thromboendarterectomy, with or without patch graft; axillary-brachial	11.97	16.00	4	1
35331	Thromboendarterectomy, with or without patch graft; abdominal aorta	23.52	26.20	4	1
35351	Thromboendarterectomy, with or without patch graft; iliac	20.11	23.00	4	1
35355	Thromboendarterectomy, with or without patch graft; iliofemoral	16.09	18.50	4	1
35361	Thromboendarterectomy, with or without patch graft; combined aortoiliac	23.59	28.20	4	1
35363	Thromboendarterectomy, with or without patch graft; combined aortoiliofemoral	24.66	30.20	4	1
35371	Thromboendarterectomy, with or without patch graft; common femoral	11.64	14.72	4	1
35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	13.56	18.00	4	1
35381	Thromboendarterectomy, with or without patch graft; femoral and/or popliteal, and/or tibioperoneal	15.81	15.81	5	7
35511	Bypass graft, with vein; subclavian-subclavian	16.83	21.20	4	1
35518	Bypass graft, with vein; axillary-axillary	15.42	21.20	4	1
35521	Bypass graft, with vein; axillary-femoral	16.17	22.20	4	1
35526	Bypass graft, with vein; aortosubclavian or carotid	20.00	29.95	4	1
35531	Bypass graft, with vein; aortoceliac or aortomesenteric	25.61	36.20	4	1
35533	Bypass graft, with vein; axillary-femoral-femoral	20.52	28.00	1	1

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
35536	Bypass graft, with vein; splenorenal	23.11	31.70	4	1
35541	Bypass graft, with vein; aortoiliac or bi-iliac	25.80	25.80	5	7
35546	Bypass graft, with vein; aortofemoral or bifemoral	25.54	25.54	5	7
35551	Bypass graft, with vein; aortofemoral-popliteal	26.67	26.67	5	7
35556	Bypass graft, with vein; femoral-popliteal	21.76	21.76	2	1
35558	Bypass graft, with vein; femoral-femoral	14.04	21.20	4	1
35560	Bypass graft, with vein; aortorenal	23.56	32.00	1	1
35563	Bypass graft, with vein; ilioiliac	15.14	24.20	4	1
35565	Bypass graft, with vein; iliofemoral	15.14	23.20	4	1
35571	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	18.58	24.06	4	1
35582	In-situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in-situ)	27.13	27.13	5	7
35587	In-situ vein bypass; popliteal-tibial, peroneal	19.05	24.75	4	1
35621	Bypass graft, with other than vein; axillary-femoral	14.54	20.00	4	1
35623	Bypass graft, with other than vein; axillary-popliteal or -tibial	16.62	24.00	1	1
35626	Bypass graft, with other than vein; aortosubclavian or carotid	23.63	27.75	4	1
35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	24.60	34.00	1	1
35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)	22.46	29.50	1	1
35641	Bypass graft, with other than vein; aortoiliac or bi-iliac	24.57	24.57	5	7
35646	Bypass graft, with other than vein; aortofemoral or bifemoral	25.81	25.81	5	7
35650	Bypass graft, with other than vein; axillary-axillary	14.36	19.00	4	1
35654	Bypass graft, with other than vein; axillary-femoral-femoral	18.61	25.00	1	1
35661	Bypass graft, with other than vein; femoral-femoral	13.18	19.00	4	1
35663	Bypass graft, with other than vein; ilioiliac	14.17	22.00	4	1
35665	Bypass graft, with other than vein; iliofemoral	15.40	21.00	4	1
35666	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	19.19	22.19	1	1

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35671	Bypass graft, with other than vein; popliteal-tibial or -peroneal artery	14.80	19.33	4	1
35701	Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery	5.55	8.50	4	1
35721	Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery	5.28	7.18	4	1
35741	Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery	5.37	8.00	4	1
35840	Exploration for postoperative hemorrhage, thrombosis or infection; abdomen	9.77	9.77	5	7
35860	Exploration for postoperative hemorrhage, thrombosis or infection; extremity	5.55	5.55	5	7
35905	Excision of infected graft; thorax	18.19	31.25	4	1
35907	Excision of infected graft; abdomen	19.24	35.00	4	1
36400	Venipuncture, under age 3 years; femoral, jugular or sagittal sinus	0.18	0.38	4	6
36405	Venipuncture, under age 3 years; scalp vein	0.18	0.32	4	6
36406	Venipuncture, under age 3 years; other vein	0.18	0.18	5	6
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	1.22	2.50	4	6
36520	Therapeutic apheresis; plasma and/or cell exchange	1.74	1.74	5	7
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	5.32	5	6
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	2.80	5	6
36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2.27	2.27	5	6
36600	Arterial puncture, withdrawal of blood for diagnosis	0.32	0.32	2	7
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	1.15	1.15	5	6
36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown	2.11	2.11	2	6
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)	5.42	5.42	2	6
37565	Ligation, internal jugular vein	4.44	10.88	4	1

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37600	Ligation; external carotid artery	4.57	11.25	4	1
37605	Ligation; internal or common carotid artery	6.19	13.11	4	1
37609	Ligation or biopsy, temporal artery	2.30	3.00	4	1
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	5.73	5.73	5	1
37617	Ligation, major artery (eg, post-traumatic, rupture); abdomen	15.95	22.06	4	1
37618	Ligation, major artery (eg, post-traumatic, rupture); extremity	4.84	4.84	5	1
37650	Ligation of femoral vein	5.13	7.80	4	1
37660	Ligation of common iliac vein	10.61	21.00	4	1
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	3.73	3.73	5	7
37720	Ligation and division and complete stripping of long or short saphenous veins	5.66	5.66	5	7
37730	Ligation and division and complete stripping of long and short saphenous veins	7.33	7.33	5	7
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	10.53	10.53	5	7
37760	Ligation of perforators, subfascial, radical (Linton type), with or without skin graft	10.47	10.47	5	7
37785	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg	3.84	3.84	5	7
38100	Splenectomy; total (separate procedure)	13.01	14.50	4	2
38101	Splenectomy; partial (separate procedure)	13.74	15.31	4	2
38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy	14.19	15.82	4	2
38300	Drainage of lymph node abscess or lymphadenitis; simple	1.53	1.99	4	2
38305	Drainage of lymph node abscess or lymphadenitis; extensive	4.61	6.00	4	2
38308	Lymphangiectomy or other operations on lymphatic channels	4.95	6.45	4	2
38500	Biopsy or excision of lymph node(s); superficial (separate procedure)	2.88	3.75	1	2
38510	Biopsy or excision of lymph node(s); deep cervical node(s)	4.14	6.43	4	2
38520	Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad	5.12	6.67	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
38525	Biopsy or excision of lymph node(s); deep axillary node(s)	4.66	6.07	4	2
38530	Biopsy or excision of lymph node(s); internal mammary node(s) (separate procedure)	6.13	7.98	4	2
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	12.38	12.38	2	5
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	14.32	16.59	4	5
38740	Axillary lymphadenectomy; superficial	6.77	8.42	4	2
38745	Axillary lymphadenectomy; complete	8.84	11.00	4	2
38746	Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)	4.39	4.89	4	3
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)	8.74	10.88	4	2
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	16.06	19.98	4	2
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	16.59	16.59	2	5
39010	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy	11.79	11.79	2	3
39220	Excision of mediastinal tumor	17.42	17.42	2	3
39400	Mediastinoscopy, with or without biopsy	5.61	5.61	2	3
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	34.85	95.00	1	6
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	9.59	13.29	4	6
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (transhiatal)	28.79	28.79	6	3
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty	31.22	31.22	6	3

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	30.02	40.00	1	3
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty	29.11	29.11	6	3
43215	Esophagoscopy, rigid or flexible; with removal of foreign body	2.60	2.60	5	6
43217	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.90	2.90	2	6
43219	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent	2.80	3.18	1	6
43228	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3.77	3.77	2	6
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	2.69	2.87	4	6
43244	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices	4.59	5.05	1	6
43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube	4.33	4.33	2	6
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body	3.39	3.59	4	6
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	2.90	3.35	4	6
43251	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.70	3.70	2	6
43255	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method	4.40	4.82	4	6

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
43258	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	4.55	4.55	2	6
43259	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination	4.89	8.59	4	6
43263	Endoscopic retrograde cholangio-pancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	6.19	7.29	4	6
43265	Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of stone(s), any method	8.90	10.02	4	6
43269	Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent	6.04	8.21	4	6
43305	Esophagoplasty, (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula	17.15	17.15	2	7
43310	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	25.39	25.39	5	6
43312	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	28.42	28.42	5	6
43320	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	16.07	19.93	4	2
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	16.58	20.57	4	2
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	16.17	20.06	4	2
43326	Esophagogastric fundoplasty; with gastroplasty (eg, Collis)	15.91	19.74	4	2
43330	Esophagomyotomy (Heller type); abdominal approach	15.94	19.77	4	2
43331	Esophagomyotomy (Heller type); thoracic approach	16.23	20.13	4	2
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	15.81	19.61	4	2
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach	16.81	20.85	4	2
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach	12.72	15.78	4	2

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43351	Esophagostomy, fistulization of esophagus, external; thoracic approach	14.79	18.35	4	2
43352	Esophagostomy, fistulization of esophagus, external; cervical approach	12.30	15.26	4	2
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	28.78	35.70	4	2
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small bowel reconstruction, including bowel mobilization, preparation, and anastomosis(es)	32.65	40.50	4	2
43400	Ligation, direct, esophageal varices	17.09	21.20	4	2
43401	Transection of esophagus with repair, for esophageal varices	17.81	22.09	4	2
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	16.13	20.01	4	2
43410	Suture of esophageal wound or injury; cervical approach	10.86	13.47	4	2
43415	Suture of esophageal wound or injury; transthoracic or transabdominal approach	17.06	25.00	4	2
43420	Closure of esophagostomy or fistula; cervical approach	11.57	14.35	4	2
43425	Closure of esophagostomy or fistula; transthoracic or transabdominal approach	16.95	21.03	4	2
43500	Gastrotomy; with exploration or foreign body removal	8.44	11.05	4	2
43501	Gastrotomy; with suture repair of bleeding ulcer	15.31	20.04	4	2
43502	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	17.67	23.13	4	2
43510	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	9.99	13.08	4	2
43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	7.63	9.99	4	2
43605	Biopsy of stomach; by laparotomy	9.15	11.98	4	2
43610	Excision, local; ulcer or benign tumor of stomach	11.15	14.60	4	2
43611	Excision, local; malignant tumor of stomach	13.63	17.84	4	2
43620	Gastrectomy, total; with esophagoenterostomy	22.54	30.04	4	2

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43621	Gastrectomy, total; with Roux-en-Y reconstruction	23.06	30.73	4	2
43622	Gastrectomy, total; with formation of intestinal pouch, any type	24.41	32.53	4	2
43631	Gastrectomy, partial, distal; with gastroduodenostomy	19.66	22.59	4	2
43632	Gastrectomy, partial, distal; with gastrojejunostomy	19.66	22.59	4	2
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	20.10	23.10	4	2
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	21.86	25.12	4	2
43638	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;	21.76	29.00	4	2
43639	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloroplasty or pyloromyotomy	22.25	29.65	4	2
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	14.81	17.02	4	2
43641	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	15.03	17.27	4	2
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	10.15	10.15	2	2
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	12.15	12.15	2	2
43800	Pyloroplasty	10.46	13.69	4	2
43810	Gastroduodenostomy	11.19	14.65	4	2
43820	Gastrojejunostomy; without vagotomy	11.74	15.37	4	2
43825	Gastrojejunostomy; with vagotomy, any type	14.68	19.22	4	2
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	7.28	9.53	4	2
43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)	11.92	15.60	4	2
43840	Gastorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	11.89	15.56	4	2
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	14.71	18.47	4	2
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	14.85	18.65	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastro enterostomy	19.15	24.05	4	2
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small bowel reconstruction to limit absorption	21.44	26.92	4	2
43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)	23.41	29.39	4	2
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	19.69	24.72	4	2
43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	20.83	26.16	4	2
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; without vagotomy	19.91	25.00	4	2
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; with vagotomy	21.12	26.52	4	2
43870	Closure of gastrostomy, surgical	7.40	9.69	4	2
43880	Closure of gastrocolic fistula	19.63	24.65	4	2
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	13.84	16.23	4	2
44010	Duodenotomy, for exploration, biopsy(s), or foreign body removal	10.68	12.52	4	2
44020	Enterotomy, small bowel, other than duodenum; for exploration, biopsy(s), or foreign body removal	11.93	13.99	4	2
44021	Enterotomy, small bowel, other than duodenum; for decompression (eg, Baker tube)	12.01	14.08	4	2
44025	Colotomy, for exploration, biopsy(s), or foreign body removal	12.18	14.28	4	2
44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	11.40	14.03	4	2
44055	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)	13.14	22.00	1	6
44110	Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization, or fistulization; single enterotomy	10.07	11.81	4	2
44111	Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies	12.19	14.29	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
44120	Enterectomy, resection of small intestine; single resection and anastomosis	14.50	17.00	1	2
44125	Enterectomy, resection of small intestine; with enterostomy	14.96	17.54	4	2
44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	12.36	14.49	4	2
44140	Colectomy, partial; with anastomosis	18.35	18.35	2	2
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	20.17	20.17	2	2
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	18.89	18.89	2	2
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	23.18	23.18	2	2
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	24.16	24.16	2	2
44147	Colectomy, partial; abdominal and transanal approach	18.17	18.17	2	6
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	21.01	21.01	2	2
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	20.04	20.04	2	2
44152	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy	24.41	24.41	2	2
44153	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	26.83	26.83	2	2
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	24.44	24.44	2	2
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	23.01	23.01	2	2
44160	Colectomy with removal of terminal ileum and ileocolostomy	15.88	18.62	4	2
44200	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)	14.44	14.44	2	2
44300	Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure)	8.88	12.11	4	2
44310	Ileostomy or jejunostomy, non-tube (separate procedure)	11.70	15.95	4	2
44312	Revision of ileostomy; simple (release of superficial scar) (separate procedure)	5.88	8.02	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
44314	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	11.04	15.05	4	2
44316	Continent ileostomy (Kock procedure) (separate procedure)	15.47	21.09	4	2
44320	Colostomy or skin level cecostomy; (separate procedure)	12.94	17.64	1	2
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	5.66	7.72	4	2
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	11.32	15.43	4	2
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	12.46	16.99	4	2
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.82	3.70	4	6
44389	Colonoscopy through stoma; with biopsy, single or multiple	3.13	4.26	4	6
44390	Colonoscopy through stoma; with removal of foreign body	3.83	4.81	4	6
44391	Colonoscopy through stoma; with control of bleeding, any method	4.32	5.18	4	6
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.82	4.81	4	6
44393	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	4.84	5.00	4	6
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.43	4.43	2	6
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	10.61	11.91	4	2
44603	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations	14.00	15.72	4	2
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	14.28	16.03	1	2
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy	15.37	17.25	4	2
44615	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction	14.19	15.93	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
44620	Closure of enterostomy, large or small intestine;	10.87	12.20	4	2
44625	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal	13.41	15.05	4	2
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	25.36	4	2
44640	Closure of intestinal cutaneous fistula	14.83	16.65	4	2
44650	Closure of enteroenteric or enterocolic fistula	15.25	17.12	4	2
44660	Closure of enterovesical fistula; without intestinal or bladder resection	14.63	16.42	4	2
44661	Closure of enterovesical fistula; with bowel and/or bladder resection	16.99	19.07	4	2
44680	Intestinal plication (separate procedure)	13.72	15.40	4	2
44700	Exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	14.35	16.11	4	2
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	11.23	11.23	2	2
44820	Excision of lesion of mesentery (separate procedure)	10.31	12.09	4	2
44850	Suture of mesentery (separate procedure)	9.57	10.74	4	2
44900	Incision and drainage of appendiceal abscess; open	8.82	10.14	4	2
44950	Appendectomy;	8.70	10.00	1	2
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	10.74	12.34	4	2
44970	Laparoscopy, surgical, appendectomy	8.70	8.70	2	2
45000	Transrectal drainage of pelvic abscess	4.52	3.88	3	2
45020	Incision and drainage of deep supralelevator, pelvirectal, or retrorectal abscess	4.72	4.05	3	2
45100	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	3.68	3.16	3	2
45108	Anorectal myomectomy	4.76	4.09	3	2
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	23.80	28.00	1	2
45111	Proctectomy; partial resection of rectum, transabdominal approach	16.48	16.48	2	6
45112	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)	25.96	30.54	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	25.99	30.58	4	2
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	23.22	27.32	4	2
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	20.89	24.58	4	2
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy	26.21	30.84	4	2
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	24.60	24.60	2	6
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	27.04	27.04	2	6
45123	Proctectomy, partial, without anastomosis, perineal approach	14.20	16.71	4	2
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	38.39	45.16	4	2
45130	Excision of rectal procidentia, with anastomosis; perineal approach	13.97	16.44	4	2
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	16.39	19.28	4	2
45160	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach	13.02	15.32	4	2
45170	Excision of rectal tumor, transanal approach	9.77	11.49	4	2
45190	Destruction of rectal tumor, any method (eg, electrodesiccation) transanal approach	8.28	9.74	4	2
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.01	1.01	2	6
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	2.01	2.01	2	6
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.96	0.96	2	6
45337	Sigmoidoscopy, flexible; with decompression of volvulus, any method	2.36	2.36	2	6

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3.14	3.14	2	6
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70	3.70	2	6
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	4.01	4.44	4	6
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	5.87	5.87	2	6
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	4.70	4.70	2	6
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	5.31	5.31	2	6
45505	Proctoplasty; for prolapse of mucous membrane	6.02	7.58	4	2
45540	Proctopexy for prolapse; abdominal approach	12.92	16.27	4	2
45541	Proctopexy for prolapse; perineal approach	10.64	13.40	4	2
45550	Proctopexy combined with sigmoid resection, abdominal approach	18.26	23.00	1	2
45560	Repair of rectocele (separate procedure)	8.40	10.58	4	2
45562	Exploration, repair, and presacral drainage for rectal injury;	12.21	15.38	4	2
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	18.63	23.47	4	2
45800	Closure of rectovesical fistula;	14.11	17.77	4	2
45805	Closure of rectovesical fistula; with colostomy	16.50	20.78	4	2
45820	Closure of rectourethral fistula;	14.67	18.48	4	2
45825	Closure of rectourethral fistula; with colostomy	16.87	21.25	4	2
45900	Reduction of procidentia (separate procedure) under anesthesia	1.83	2.61	4	2
45905	Dilation of anal sphincter (separate procedure) under anesthesia other than local	1.61	2.30	4	2
45910	Dilation of rectal stricture (separate procedure) under anesthesia other than local	1.96	2.80	4	2
45915	Removal of fecal impaction or foreign body (separate procedure) under anesthesia	2.20	3.14	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	4.96	4.26	3	2
46045	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia	4.32	3.71	3	2
46060	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	5.69	4.89	3	2
46083	Incision of thrombosed hemorrhoid, external	1.40	1.40	2	2
46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	1.43	2.04	4	2
46230	Excision of external hemorrhoid tags and/or multiple papillae	2.57	2.57	2	2
46250	Hemorrhoidectomy, external, complete	4.53	3.89	3	2
46255	Hemorrhoidectomy, internal and external, simple;	5.36	4.60	3	2
46257	Hemorrhoidectomy, internal and external, simple; with fissurectomy	6.28	5.40	3	2
46258	Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy	6.67	5.73	3	2
46260	Hemorrhoidectomy, internal and external, complex or extensive;	7.42	6.37	3	2
46261	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy	8.24	7.08	3	2
46262	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy	8.73	7.50	3	2
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	3.72	3.20	3	2
46275	Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular	4.56	3.92	3	2
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton	5.98	5.14	3	2
46288	Closure of anal fistula with rectal advancement flap	7.13	6.13	3	2
46320	Enucleation or excision of external thrombotic hemorrhoid	1.61	1.61	2	2
46700	Anoplasty, plastic operation for stricture; adult	7.25	9.13	4	2
46705	Anoplasty, plastic operation for stricture; infant	7.17	6.90	3	7
46715	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)	7.46	7.20	3	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
46716	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula	12.15	15.07	1	6
46730	Repair of high imperforate anus without fistula; perineal or sacroperineal approach	21.57	26.75	1	6
46735	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches	25.94	32.17	1	6
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	23.11	30.00	1	6
46742	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches	29.67	35.80	4	6
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach	33.21	52.63	1	6
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;	36.74	58.22	1	6
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps	40.52	64.21	1	6
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	8.14	10.25	4	2
46753	Graft (Thiersch operation) for rectal incontinence and/or prolapse	6.58	8.29	4	2
46754	Removal of Thiersch wire or suture, anal canal	1.54	2.20	4	2
46760	Sphincteroplasty, anal, for incontinence, adult; muscle transplant	11.46	14.43	4	2
46761	Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)	10.99	13.84	4	2
46762	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter	10.09	12.71	4	2
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	1.91	1.91	2	2
46910	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	1.86	1.86	2	2
46916	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	1.86	1.86	2	2
46917	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	1.86	1.86	2	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
46922	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	1.86	1.86	2	2
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method	2.76	2.76	2	2
46934	Destruction of hemorrhoids, any method; internal	4.08	3.51	3	2
46935	Destruction of hemorrhoids, any method; external	2.43	2.43	2	2
46936	Destruction of hemorrhoids, any method; internal and external	4.30	3.69	3	2
46940	Curettage or cauterization of anal fissure, including dilation of anal sphincter (separate procedure); initial	2.32	2.32	2	2
46942	Curettage or cauterization of anal fissure, including dilation of anal sphincter (separate procedure); subsequent	2.04	2.04	2	2
46945	Ligation of internal hemorrhoids; single procedure	2.14	1.84	3	2
46946	Ligation of internal hemorrhoids; multiple procedures	3.00	2.58	3	2
47010	Hepatotomy; for open drainage of abscess or cyst, one or two stages	10.28	16.01	4	2
47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	9.70	15.11	4	2
47100	Biopsy of liver, wedge	7.49	11.67	4	2
47120	Hepatectomy, resection of liver; partial lobectomy	22.79	35.50	1	2
47122	Hepatectomy, resection of liver; trisegmentectomy	35.39	55.13	4	2
47125	Hepatectomy, resection of liver; total left lobectomy	31.58	49.19	4	2
47130	Hepatectomy, resection of liver; total right lobectomy	34.25	53.35	4	2
47134	Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor	39.15	39.15	5	7
47300	Marsupialization of cyst or abscess of liver	9.68	15.08	4	2
47350	Management of liver hemorrhage; simple suture of liver wound or injury	12.56	19.56	4	2
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	17.28	26.92	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
47361	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	30.25	47.12	4	2
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	11.88	18.51	4	2
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	20.86	32.49	4	2
47420	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty	16.72	19.88	4	2
47425	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	16.68	19.83	4	2
47460	Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)	15.17	18.04	4	2
47480	Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure)	9.10	10.82	4	2
47562	Laparoscopy, surgical; cholecystectomy	11.09	11.09	2	2
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.94	11.94	2	2
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	14.23	14.23	2	2
47570	Laparoscopy, surgical; cholecystoenterostomy	12.58	12.58	2	2
47600	Cholecystectomy;	11.42	13.58	4	2
47605	Cholecystectomy; with cholangiography	12.36	14.69	4	2
47610	Cholecystectomy with exploration of common duct;	15.83	18.82	4	2
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy	15.80	18.78	4	2
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	17.36	20.64	4	2
47701	Portoenterostomy (eg, Kasai procedure)	27.81	27.81	2	6
47711	Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic	19.37	23.03	4	2
47712	Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic	25.44	30.24	4	2
47715	Excision of choledochal cyst	15.81	18.80	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
47716	Anastomosis, choledochal cyst, without excision	13.83	16.44	4	2
47720	Cholecystoenterostomy; direct	13.38	15.91	4	2
47721	Cholecystoenterostomy; with gastroenterostomy	16.08	19.12	4	2
47740	Cholecystoenterostomy; Roux-en-Y	15.54	18.48	4	2
47741	Cholecystoenterostomy; Roux-en-Y with gastroenterostomy	17.95	21.34	4	2
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	21.74	25.85	4	2
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	20.93	24.88	4	2
47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	22.29	26.50	1	2
47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract	26.23	31.18	4	2
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	19.60	23.30	4	2
47801	Placement of choledochal stent	12.76	15.17	4	2
47802	U-tube hepaticoenterostomy	18.13	21.55	4	2
47900	Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)	16.74	19.90	4	2
48000	Placement of drains, peripancreatic, for acute pancreatitis;	14.91	28.07	4	2
48001	Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy	18.83	35.45	4	2
48005	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis	22.40	42.17	4	2
48020	Removal of pancreatic calculus	14.22	15.70	4	2
48100	Biopsy of pancreas, open, any method (eg, fine needle aspiration, needle core biopsy, wedge biopsy)	11.08	12.23	4	2
48120	Excision of lesion of pancreas (eg, cyst, adenoma)	14.36	15.85	4	2
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	20.78	22.94	4	2
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	21.76	24.02	4	2
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	23.91	26.40	4	2
48148	Excision of ampulla of Vater	15.71	17.34	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	43.48	48.00	4	2
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	39.63	43.75	4	2
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	43.38	47.89	4	2
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	39.95	44.10	4	2
48155	Pancreatectomy, total	22.32	24.64	4	2
48180	Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)	22.39	24.72	4	2
48500	Marsupialization of cyst of pancreas	13.84	15.28	4	2
48510	External drainage, pseudocyst of pancreas; open	12.96	14.31	4	2
48520	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct	14.12	15.59	4	2
48540	Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y	17.86	19.72	4	2
48545	Pancreatorrhaphy for trauma	16.47	18.18	4	2
48547	Duodenal exclusion with gastrojejunostomy for pancreatic trauma	23.40	25.83	4	2
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	11.68	11.68	2	2
49002	Reopening of recent laparotomy	10.49	10.49	2	2
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	12.28	12.28	2	2
49020	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open	16.79	20.73	4	2
49040	Drainage of subdiaphragmatic or subphrenic abscess; open	9.94	12.27	4	2
49060	Drainage of retroperitoneal abscess; open	11.66	14.40	4	2
49085	Removal of peritoneal foreign body from peritoneal cavity	8.93	11.03	4	2



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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
49200	Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas;	10.25	10.25	2	2
49201	Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive	14.84	14.84	2	2
49215	Excision of presacral or sacrococcygeal tumor	22.36	33.50	1	6
49220	Staging celiotomy (laparotomy) for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	14.88	14.88	2	2
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	11.14	11.14	2	2
49320	Laparoscopy, surgical, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.10	5.10	2	2
49321	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with biopsy (single or multiple)	5.40	5.40	2	7
49322	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)	5.70	5.70	2	7
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent	5.54	5.54	2	2
49422	Removal of permanent intraperitoneal cannula or catheter	6.25	6.25	2	2
49425	Insertion of peritoneal-venous shunt	11.37	11.37	2	2
49426	Revision of peritoneal-venous shunt	9.63	9.63	2	2
49428	Ligation of peritoneal-venous shunt	2.38	6.06	1	2
49429	Removal of peritoneal-venous shunt	7.40	7.40	2	2
49495	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; reducible	5.89	5.89	5	6
49496	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; incarcerated or strangulated	8.79	8.79	5	6
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	4.68	5.48	4	2
49501	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated	7.58	8.88	4	2
49505	Repair initial inguinal hernia, age 5 years or over; reducible	6.49	7.60	4	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
49507	Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated	8.17	9.57	4	2
49520	Repair recurrent inguinal hernia, any age; reducible	8.22	9.63	4	2
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	10.22	11.97	4	2
49525	Repair inguinal hernia, sliding, any age	7.32	8.57	4	2
49540	Repair lumbar hernia	8.87	10.39	4	2
49550	Repair initial femoral hernia, any age; reducible	7.37	8.63	4	2
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	8.06	9.44	4	2
49555	Repair recurrent femoral hernia; reducible	7.71	9.03	4	2
49557	Repair recurrent femoral hernia; incarcerated or strangulated	9.52	11.15	4	2
49560	Repair initial incisional or ventral hernia; reducible	9.88	11.57	4	2
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	12.17	14.25	4	2
49565	Repair recurrent incisional or ventral hernia; reducible	9.88	11.57	4	2
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	12.30	14.40	4	2
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)	4.86	5.69	4	2
49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated	5.75	6.73	4	2
49580	Repair umbilical hernia, under age 5 years; reducible	3.51	4.11	4	2
49582	Repair umbilical hernia, under age 5 years; incarcerated or strangulated	5.68	6.65	4	2
49585	Repair umbilical hernia, age 5 years or over; reducible	5.32	6.23	4	2
49587	Repair umbilical hernia, age 5 years or over; incarcerated or strangulated	6.46	7.56	4	2
49590	Repair spigelian hernia	7.29	8.54	4	2
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	22.66	76.00	1	6
49606	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	18.60	18.60	2	6
49650	Laparoscopy, surgical; repair initial inguinal hernia	6.27	6.27	2	2

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	8.24	8.24	2	2
49900	Suture, secondary, of abdominal wall for evisceration or dehiscence	12.28	12.28	2	2
49905	Omental flap (eg, for reconstruction of sternal and chest wall defects) (List separately in addition to code for primary procedure)	6.55	6.55	5	6
50200	Renal biopsy; percutaneous, by trocar or needle	2.63	2.63	5	7
50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	22.07	22.07	5	5
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	37.14	37.14	2	5
51596	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large bowel to construct neobladder	39.52	39.52	2	5
52300	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	5.31	5.31	2	7
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	5.19	5.19	2	7
52340	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	9.68	9.68	2	7
56515	Destruction of lesion(s), vulva; extensive, any method	1.88	2.76	4	5
56740	Excision of Bartholin's gland or cyst	3.76	4.57	4	5
57100	Biopsy of vaginal mucosa; simple (separate procedure)	0.97	1.20	1	5
57130	Excision of vaginal septum	2.43	2.43	2	5
57292	Construction of artificial vagina; with graft	13.09	13.09	2	5
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	15.93	15.93	2	5
57410	Pelvic examination under anesthesia	1.75	1.75	2	7
57505	Endocervical curettage (not done as part of a dilation and curettage)	1.14	1.14	2	5
57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair	8.95	8.95	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	15.24	15.24	2	5
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocytopexy (eg, Marshall-Marchetti-Krantz, Burch)	15.09	20.60	1	5
58260	Vaginal hysterectomy;	12.20	12.98	4	5
58262	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)	13.99	14.77	4	5
58263	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s), with repair of enterocele	15.28	16.06	1	5
58267	Vaginal hysterectomy; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)	15.00	17.04	4	5
58270	Vaginal hysterectomy; with repair of enterocele	13.48	14.26	1	5
58275	Vaginal hysterectomy, with total or partial colectomy;	14.98	15.76	4	5
58280	Vaginal hysterectomy, with total or partial colectomy; with repair of enterocele	15.41	17.01	1	5
58285	Vaginal hysterectomy, radical (Schauta type operation)	18.57	22.26	4	5
58323	Sperm washing for artificial insemination	0.23	0.23	2	5
58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)	6.36	6.36	2	5
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	3.84	5.60	1	5
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	3.34	5.00	1	5
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	0.63	1.45	4	5
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	6.49	12.05	1	5
58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.83	14.00	1	5
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	5.88	5.88	2	5
58820	Drainage of ovarian abscess; vaginal approach, open	4.22	4.22	2	7
58825	Transposition, ovary(s)	6.13	10.98	4	5

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
58920	Wedge resection or bisection of ovary, unilateral or bilateral	6.78	11.36	1	5
58950	Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy;	15.27	16.93	1	5
58951	Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	21.81	22.38	4	5
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	6.89	11.67	1	5
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	7.86	11.49	1	5
59812	Treatment of incomplete abortion, any trimester, completed surgically	3.25	4.01	4	5
59870	Uterine evacuation and curettage for hydatidiform mole	4.28	6.01	1	5
60100	Biopsy thyroid, percutaneous core needle	0.97	1.56	1	6
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	10.53	11.90	4	2
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	18.20	20.57	4	2
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	23.88	26.99	4	2
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	15.46	17.47	4	2
60270	Thyroidectomy, including substernal thyroid gland; sternal split or transthoracic approach	17.94	20.27	4	2
60271	Thyroidectomy, including substernal thyroid gland; cervical approach	14.89	16.83	4	2
60280	Excision of thyroglossal duct cyst or sinus;	6.08	6.08	2	7
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);	17.03	17.03	2	2
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	19.88	19.88	2	2
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)	6.02	7.20	1	6

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	1.91	2.20	1	6
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	1.54	1.78	1	6
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	2.04	2.35	1	6
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	1.87	2.15	1	6
65855	Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)	4.30	3.85	3	5
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	12.16	12.16	2	7
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	15.04	15.04	2	7
66180	Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	14.55	14.55	2	5
66986	Exchange of intraocular lens	12.28	12.28	2	5
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	2.52	2.52	2	5
67108	Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	20.82	20.82	2	7
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)	13.52	18.53	1	5

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
67904	Repair of blepharoptosis; (tarso)levator resection or advancement, external approach	6.26	6.26	2	5
69000	Drainage external ear, abscess or hematoma; simple	1.45	1.45	2	7
69005	Drainage external ear, abscess or hematoma; complicated	2.11	2.11	2	7
69020	Drainage external auditory canal, abscess	1.48	1.48	2	7
69100	Biopsy external ear	0.81	0.81	2	7
69105	Biopsy external auditory canal	0.85	0.85	2	7
69110	Excision external ear; partial, simple repair	3.44	3.44	2	7
69120	Excision external ear; complete amputation	4.05	4.05	2	7
69140	Excision exostosis(es), external auditory canal	7.97	7.97	2	7
69145	Excision soft tissue lesion, external auditory canal	2.62	2.62	2	7
69150	Radical excision external auditory canal lesion; without neck dissection	13.43	13.43	2	7
69155	Radical excision external auditory canal lesion; with neck dissection	20.80	20.80	2	7
69200	Removal foreign body from external auditory canal; without general anesthesia	0.77	0.77	2	7
69205	Removal foreign body from external auditory canal; with general anesthesia	1.20	1.20	2	7
69210	Removal impacted cerumen (separate procedure), one or both ears	0.61	0.61	2	7
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	0.83	0.83	2	7
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)	1.40	1.40	2	7
69300	Otoplasty, protruding ear, with or without size reduction	6.36	6.36	2	7
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to trauma, infection) (separate procedure)	10.79	10.79	2	7
69320	Reconstruction external auditory canal for congenital atresia, single stage	16.96	16.93	2	7
69400	Eustachian tube inflation, transnasal; with catheterization	0.83	0.83	2	7
69401	Eustachian tube inflation, transnasal; without catheterization	0.63	0.63	2	7
69405	Eustachian tube catheterization, transtympanic	2.63	2.63	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
69410	Focal application of phase control substance, middle ear (baffle technique)	0.33	0.33	2	7
69420	Myringotomy including aspiration and/or eustachian tube inflation	1.33	1.33	2	7
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	1.73	1.73	2	7
69424	Ventilating tube removal when originally inserted by another physician	0.85	0.85	2	7
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	1.52	1.52	2	7
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	1.96	1.96	2	7
69440	Middle ear exploration through postauricular or ear canal incision	7.57	7.57	2	7
69450	Tympanolysis, transcanal	5.57	5.57	2	7
69501	Transmastoid antrotomy (simple mastoidectomy)	9.07	9.07	2	7
69502	Mastoidectomy; complete	12.38	12.38	2	7
69505	Mastoidectomy; modified radical	12.99	12.99	2	7
69511	Mastoidectomy; radical	13.52	13.52	2	7
69530	Petrous apicectomy including radical mastoidectomy	19.19	19.19	2	7
69535	Resection temporal bone, external approach	36.14	36.14	2	7
69540	Excision aural polyp	1.20	1.20	2	7
69550	Excision aural glomus tumor; transcanal	10.99	10.99	2	7
69552	Excision aural glomus tumor; transmastoid	19.46	19.46	2	7
69554	Excision aural glomus tumor; extended (extratemporal)	33.16	33.16	2	7
69601	Revision mastoidectomy; resulting in complete mastoidectomy	13.24	13.24	2	7
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	13.58	13.58	2	7
69603	Revision mastoidectomy; resulting in radical mastoidectomy	14.02	14.02	2	7
69604	Revision mastoidectomy; resulting in tympanoplasty	14.02	14.02	2	7
69605	Revision mastoidectomy; with apicectomy	18.49	18.49	2	7
69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch	4.43	4.43	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
69620	Myringoplasty (surgery confined to drumhead and donor area)	5.89	5.89	2	7
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	9.86	9.86	2	7
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.75	12.75	2	7
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))	12.10	12.10	2	7
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	13.33	13.33	2	7
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	15.22	15.22	2	7
69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))	15.11	15.11	2	7
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	12.71	12.71	2	7
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.84	16.84	2	7
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	15.32	15.32	2	7
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	16.97	16.97	2	7
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	16.38	16.38	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	17.99	17.99	2	7
69650	Stapes mobilization	9.66	9.66	2	7
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	11.90	11.90	2	7
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	15.74	15.74	2	7
69662	Revision of stapedectomy or stapedotomy	15.44	15.44	2	7
69666	Repair oval window fistula	9.75	9.75	2	7
69667	Repair round window fistula	9.76	9.76	2	7
69670	Mastoid obliteration (separate procedure)	11.51	11.51	2	7
69676	Tympanic neurectomy	9.52	9.52	2	7
69700	Closure postauricular fistula, mastoid (separate procedure)	8.23	8.23	2	7
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	10.44	10.44	2	7
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion	14.38	14.38	2	7
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion	25.38	25.38	2	7
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	15.96	15.96	2	7
69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	16.69	16.69	2	7
69801	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal	8.56	8.56	2	7
69802	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy	13.10	13.10	2	7
69805	Endolymphatic sac operation; without shunt	13.82	13.82	2	7
69806	Endolymphatic sac operation; with shunt	12.35	12.35	2	7
69820	Fenestration semicircular canal	10.34	10.34	2	7
69840	Revision fenestration operation	10.26	10.26	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
69905	Labyrinthectomy; transcanal	11.10	11.10	2	7
69910	Labyrinthectomy; with mastoidectomy	13.63	13.63	2	7
69915	Vestibular nerve section, translabyrinthine approach	21.23	21.23	2	7
69930	Cochlear device implantation, with or without mastoidectomy	16.81	16.81	2	7
69950	Vestibular nerve section, transcranial approach	25.64	25.64	2	7
69955	Total facial nerve decompression and/or repair (may include graft)	27.04	27.04	2	7
69960	Decompression internal auditory canal	27.04	27.04	2	7
69970	Removal of tumor, temporal bone	30.04	30.04	2	7
69990	Use of operating microscope (List separately in addition to code for primary procedure)	3.47	3.47	2	6
72275	Epidurography, radiological supervision and interpretation	0.54	0.83	1	6
76005	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	0.60	0.60	1	6
76065	Radiologic examination, osseous survey, infant	0.28	0.70	1	6
76090	Mammography; unilateral	0.58	0.70	4	6
76091	Mammography; bilateral	0.69	0.87	4	6
76095	Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation	1.59	1.59	2	6
88170	Fine needle aspiration with or without preparation of smears; superficial tissue (eg, thyroid, breast, prostate)	1.27	1.27	2	6
88171	Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance	1.27	1.27	2	6
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	0.89	0.89	2	6
90935	Hemodialysis procedure with single physician evaluation	1.22	1.22	5	7
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.11	2.11	5	7
90945	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration), with single physician evaluation	1.28	1.28	5	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
90947	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration) requiring repeated evaluations, with or without substantial revision of dialysis prescription	2.16	2.16	5	7
90989	Dialysis training, patient, including helper where applicable, any mode, completed course	0.00	0.00	5	7
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session	0.00	0.00	5	7
90997	Hemoperfusion (eg, with activated charcoal or resin)	1.84	1.84	5	7
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	1.51	2.50	4	5
93350	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	0.78	1.48	4	6
94640	Nonpressurized inhalation treatment for acute airway obstruction	0.00	0.00	2	6
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	0.00	0.00	5	6
94665	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	0.00	0.00	5	6
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.	1.51	1.51	2	6
99273	Confirmatory consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	1.19	1.19	2	6

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
99274	Confirmatory consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.	1.73	1.73	2	6
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	3.60	4.00	4	6
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)	1.80	2.00	4	6
99295	Initial neonatal intensive care, per day, for the evaluation and management of a critically ill neonate or infant This code is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician reevaluations, and constant observation by the health care team under direct physician supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code.	16.00	16.00	2	7
99296	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant A critically ill and unstable neonate will require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision. In addition, most will require frequent ventilator changes, intravenous fluid alterations, and/or early initiation of parenteral nutrition. Neonates in the immediate post-operative period or those who become critically ill and unstable during the hospital stay will commonly qualify for this level of care. This code encompasses intensive care provided on dates subsequent to the admission date.	8.00	8.00	2	7

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CPT code	Descriptor	2000 Work RVU	RUC Rec Work	RUC Final Action Key	Work group
99297	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant Critically ill though stable neonates require cardiac and/or respiratory support (including ventilator and nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24 hour period, and constant observation by the health care team under direct physician supervision. Neonates at this level of care would be expected to require less frequent changes in respiratory, cardiovascular and fluid and electrolyte therapy as those included under code 99296. This code encompasses intensive care provided on dates subsequent to the admission date.	4.00	4.00	2	7
99298	Subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams) Very low birth weight neonates who are no longer critically ill continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct physician supervision. Neonates of this level of care would be expected to require infrequent changes in respiratory, cardiovascular and/or fluid and electrolyte therapy as those induced under 99296 or 99297. This code encompasses intensive care provided on days subsequent to the	2.75	2.75	2	7
99436	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	1.50	1.50	2	7
99440	Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	2.93	2.93	2	6

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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Vascular Surgery

History/Identification of the Undervaluation by the Specialty

The Society for Vascular Surgery (SVS) and the North American Chapter of the International Society for Cardiovascular Surgery (ISCVS) has commented on several occasions to the Health Care Financing Administration (HCFA) that non-cardiac peripheral vascular surgical procedures have been systematically undervalued since the original Hsaio/Harvard studies. At each opportunity to comment on the Resource-Based Relative Value System (RBRVS), the SVS/ISCVS has argued that the representation and process utilized to evaluate vascular surgery was unfair. This undervaluation has an enormous impact on vascular surgery as 60-70% of all patients requiring peripheral vascular reconstruction belong to the Medicare population.

Following publication of the November 1991 Final Rule and the SVS/ISCVS public comment letter, HCFA made modest adjustments to a small number of medium and high complexity vascular surgical procedures. The specialty had offered to review and realign all of the peripheral vascular codes, however, HCFA announced that consideration of further broad-based adjustments would be deferred until the initial Five-Year Review.

On February 6, 1995, the SVS/ISCVS submitted a public comment letter to HCFA, in response to HCFA's request for comments on the initial Five-Year Review of the RBRVS. Although vascular surgeons contended that their specialty continued to be systematically undervalued, they requested a review of only nine specific vascular surgical procedures. The SVS/ISCVS understood that the RUC and HCFA preferred to review only a limited number of codes from each specialty in this initial Five-Year Review and this specialty wished to comply with these instructions. The RUC found the arguments presented by the SVS then (and detailed below) to be compelling. However, the RUC reviewed and recommended increases for only the specific vascular surgical procedures that were identified by the specialty for review.

On March 1, 2000, the SVS/ISCVS presented the same core arguments that they have expressed to HCFA in previous comment letters. Unlike the previous Five-Year Review, vascular surgery argued that the majority (94 surgical procedures) of their services should be specifically reviewed on a code-by-code basis and to address their overall concern regarding the valuation of vascular surgery 10 years after the implementation of the RBRVS.

In all of the correspondence presented to HCFA over the previous decade, the vascular surgeons have consistently presented the same arguments regarding their specific exclusion from the Harvard study. SVS/ISCVS reviewed the RUC's guidelines regarding compelling evidence, which are included in the RUC's *Instructions for Specialty Societies Developing Work Value Recommendations*, and addressed these guidelines in their comments as follows:

Proof that incorrect assumptions were made in the initial valuation of the service, as documented, for example, by a misleading vignette in the Harvard study, data from the study, and flawed crosswalk assumptions.

The physician work RVUs for more than 200 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations (infrarenal aortic aneurysm repair and carotid endarterectomy). The vascular surgeons have commented that inappropriate vignettes and flawed assumptions were made for the only two codes that were in fact directly surveyed. For example, the vignette in the Harvard study of abdominal aortic aneurysm recounted a healthy 65 year old male with a five centimeter aneurysm. However, most patients with abdominal aortic aneurysms (CPT codes 35081 and 35102) are older than 65, and virtually all have one or more comorbid conditions such as coronary artery disease, hypertension, or some compromise of kidney function.

Proof that the mechanism or methodology used in the original valuation was seriously flawed, for example, evidence that no pediatricians were consulted in assigning pediatric values.

Vascular surgeons were not including on the Phase I, II, or III Harvard technical consulting panels. The peripheral vascular codes were all grouped and evaluated with cardiac and general surgical procedures. The SVS or ISCVS were not asked to participate in this review. The actual vascular surgical experience of the surgeons who participated in these studies is unknown. However, the instructions given by Hsiao were for the surgeon evaluators to provide estimates of the time and intensity if the surgeon was "familiar" with the procedure, even if he or she didn't actually perform the procedure.

If Harvard surveyed one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to Medicare utilization data.

Clearly, Harvard utilized general and cardiac surgeons to determine work relative values for vascular surgical procedures. The SVS/ISCVS contends that Harvard researchers did not understand that vascular surgery is distinct from cardiothoracic surgery and, therefore, believed that these services were performed by cardiac surgeons. To further complicate the issue, Medicare claims data did not distinguish vascular surgery from general surgery until 1993. In reviewing the Medicare utilization data today, many claims that indicate that a “general surgeon” performed the procedure, are actual vascular surgeons that have not changed their specialty indication since this change was made by Medicare in the early 1990s.

An anomalous relationship between the code to be valued and multiple key reference services. For example, if code A describes a service that requires significantly more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay, and other factors for each of the other codes.

The vascular surgeons have commented that vascular surgical procedures are consistently undervalued in comparison to other surgical procedures and services included on the RUC’s Multi-specialty Points of Comparison (MPC). A 1990 study by Abt Associates was commissioned to confirm these arguments. Internal committees and workgroups of the SVS have also collected evidence on intra-service time and intensity to compare their services to other services on the Medicare RBRVS. With referral of the broader issue of vascular surgery finally referred from HCFA to the RUC to review in this Five-Year Review, the SVS/ISCVS employed several methodologies to provide compelling evidence that their services should be increased.

SVS/AAVS Data Collection Efforts

The SVS and the American Association for Vascular Surgery (AAVS) reviewed the entire scope of CPT codes that might be consider vascular surgery procedures. The range begins in the CPT manual with CPT 33875 (descending thoracic aortic graft) and ends with 37799 (unlisted procedure, vascular surgery). The SVS/AAVS then excluded all codes that are not typically performed by vascular surgeons, 9 codes that were considered in the initial five-year review, and 11 new or revised codes that were surveyed and valued after

the first five-year review. In addition, 17 codes were identified that were either obsolete, redundant, or described multiple procedures with a single descriptor. These 17 codes have been referred to the CPT Editorial Panel for consideration.

In order to develop compelling evidence to present to the RUC, the SVS/AAVS collected data from three specific sources, as follows:

RUC Survey Instrument

The SVS/AAVS conducted a standard RUC survey for 38 vascular procedures. A RUC approved “mini-survey” was utilized for 56 procedures where Medicare frequency was less than 1,000 cases per year. The mini-surveys were appended to the full RUC survey for “anchor” services within similar clinical families. Each mini-survey requested information on intra-service skin-to-skin time in minutes, hospital length of stay, critical care, outpatient visits, and a final estimate of total work RVUs. For several of the rarely performed codes (ie, <1000 in frequency) in which there was not a reasonable anchor service, the SVS/AAVS conducted completed surveys. The surveys were distributed randomly to vascular surgeon members of the SVS and the AAVS. In addition, general surgeons were randomly selected from a list of 17,000 Fellows from the American College of Surgeons who practice general surgery.

The SVS/AAVS conducted an internal validation of the mini-survey technique to determine if results from a full and mini-survey RUC survey would be similar. The following codes were reviewed under both approaches by different respondents:

CPT 34490 Embolectomy/thrombectomy axillary and subclavian vein

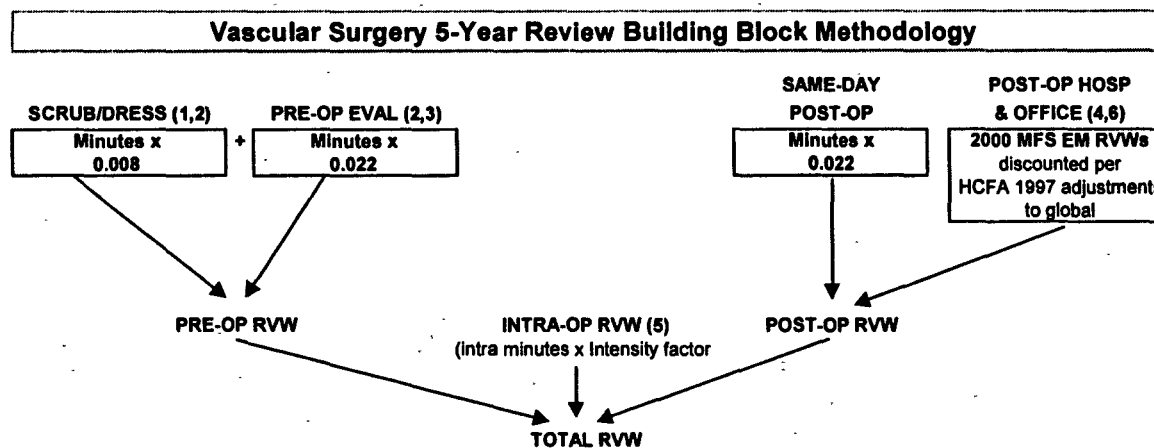
2000 work RVU	7.60	
Full Survey median work RVU	10.50	n=30
Mini Survey median work RVU	11.00	n=30

CPT 35621 Bypass graft with other than vein, axillary -femoral

2000 work RVU	14.54	
Full Survey median work RVU	21.50	n=30
Mini Survey median work RVU	21.50	n=30

Building Block Methodology

The SVS/AAVS also utilized a building block methodology to confirm their survey results. The approach utilized by vascular surgeons was very similar to the method developed by Harvard and HCFA as described below. Pre-service times undergoing a mini-survey were determined by the SVS/AAVS Consensus Panel by reviewing the surveyed pre-time for the anchor codes in the family. As instructed by the RUC at the April 2000 RUC meeting, discounted E/M work RVUs were utilized to compute the post-service work. A separate "intensity" survey was distributed to 100 vascular surgeons who were asked to estimate relative intra-service intensity values for the intra-service component. A reference range from 0.031 to 0.108 was utilized. A complete copy of this survey instrument is included in the attached recommendations.



- (1) SVS used survey median scrub/dress time in minutes
- (2) Harvard-assigned pre-service intensity factors were used.
- (3) Review records, obtain informed consent, discuss care with anesthesia, nursing, etc.
- (4) The 2000 MFS RVWs were "discounted" to be consistent with the HCFA adjustments made to global procedures in 1997.
- (5) Using a scale of 0.031 to 0.108, Intra-service intensity was determined during a completely separate "intensity survey" and multiplied by the intra-service minutes.
- (6) Visit levels from surveys

Data Collection of Actual Skin-to-Skin Time

The vascular surgeons have collected computer-log skin-to-skin time data from several major institutions and large private practice across the United States. This database contains more than 5,000 operations. The SVS/AAVS explained that they only included this data when the operation was the only service provided at that setting and where CPT codes are utilized by the institution. The society has included the data on actual skin-to-skin time for codes in which an adequate sample has been obtained on the RUC Summary of Recommendation forms as additional information. In nearly all codes, the actual skin-to-skin time is greater than the RUC survey estimates. For example, the median RUC survey time for code 34203 *Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision* is 108 minutes versus the 134.5 minutes (n=6) listed in the SVS intra-time database.

RUC Recommended Action

The RUC believes that the weight of the evidence described above and in the RUC's rationale related to specific CPT codes substantiates the vascular surgeons argument that this surgical specialty has been undervalued relative to other surgical specialties since the inception of the RBRVS. The RUC reviewed each service in great detail and considered the RUC survey data, building block analysis, and actual intra-service time (where available). For a large number of vascular surgical procedures, the RUC agreed that the service was indeed undervalued, but did not agree with the specific recommendation presented by the specialty society. In those cases, the RUC relied on the 25th percentile of the survey work RVU, comparison to other codes on the RUC's MPC, and computed increments that could be applied across all services. For example, the RUC calculated an increment for harvesting a vein during a bypass graft procedure and then applied this increment across numerous codes. The RUC's detailed review is attached in a code-by-code explanation of the RUC's recommendations. The specialty's Summary of Recommendation forms are also attached to this report.

**AMA/Specialty Society RVS Update Committee
RBRVS Five-Year Review
RUC Recommendations
Workgroup 1 - Vascular Surgery**

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 1 Aneurysm Repairs in the Abdomen							
35082	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	36.35	38.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC recommends a small increase in 35082 to 38.50 which is based on a survey median of 30 vascular surgeons. In addition to the survey, the value of 38.50 is validated via a building block analysis which calculates a work RVU of 38.23.</p> <p>Although this service was referred to HCFA, and then the RUC, by the American Society of General Surgeons (ASGS), during the initial five-year review, the society did not conduct a RUC survey. In absence of survey data, SVS made a recommendation of 37.00 work RVUs based on a relationship of to 35081 (elective aortic aneurysm repair), but the RUC recommended 24.20. SVS does not believe that the RUC recommendation at that time (34.20) was appropriate. Based on the current full RUC survey and the building block approach used by SVS, the RUC now agrees that the higher value is more representative of the work of this service in comparison to CPT code 35081 (work RVU = 28.01). An increment of increased E/M work work in the global period would also be added to the 37.00 work value recommended in 1995, which corresponds with the 38.50 now recommended by the RUC.</p>	1	110

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35092	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	38.39	45.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A mini-survey of 30 vascular surgeons validates that this service is presently undervalued. The RUC recommends the survey median of 45.00. The RUC also compared 35092 to a code on the MPC. Code 61700 Surgery of intracranial aneurysm, intracranial approach; carotid approach (work rvu= 50.52) has comparable intra-service time. The length of stay for 35092 is slightly higher than 61700. The RUC noted that the survey of vascular surgeons included 5 critical care visits. The RUC believes that these services are more accurately described as level 3 hospital visits and accordingly, changed the specialty's time data to reflect this more typical scenario. A recomputation of the specialty's building block methodology utilizing level 3 hospital visits, rather than critical care visits suggests a work RVU of 50.46, which is directly comparable to CPT code 61700.	1	116
35103	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	33.57	40.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase for code 35103 to correct a rank order anomaly between CPT code 35082 and this service, as this service is more difficult. The RUC recommends that the survey median of 40.50 based on a full RUC survey of 30 surgeons be implemented.	1	120

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35111	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, splenic artery	16.43	25.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	Based on a median min-survey value of 27.00, the RUC agreed that an increase in the work RVU was indicated, but the committee did not believe that the full value of 27.00 had been justified by the specialty. The RUC agreed that 35112 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery should serve as the base code and 35111 should be valued at 5.00 work RVU less to discount for the unruptured aneurysm repair. This 5.00 increment for repair of a ruptured artery was calculated to account for 30 additional minutes of intra-service time and additional critical care time.	4	127
35112	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	18.69	30.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A mini-survey of 25 vascular surgeons validates that this service is presently undervalued. The RUC recommends the survey median of 30.00. This change also corrects rank order anomalies in this family of codes.	1	131
35121	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery	25.99	30.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that the mini-survey 25th percentile work RVU of 30.00 be implemented. This recommendation preserves the RUC recommended increment of 5.00 between the repair of an unruptured and ruptured artery (35122 (rec work RVU = 35.00) less 5.00 = 30.00). This 5.00 increment for repair of a ruptured artery was calculated to account for 30 additional minutes of intra-service time and additional critical care time.	4	135

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35122	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	33.45	35.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A mini-survey of 25 vascular surgeons validates that this service is presently undervalued. The RUC recommends the survey median of 35.00.	1	139
35131	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)	18.55	25.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that 35132 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external) should serve as the base code and 35131 should be valued at 5.00 work RVU less to discount for the unruptured aneurysm repair. This recommended value is also similar to the 25th percentile survey RVU of 26.00. This 5.00 increment for repair of a ruptured artery was calculated to account for 30 additional minutes of intra-service time and additional critical care time.	4	143
35132	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)	21.95	30.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A mini-survey of 25 vascular surgeons validates that this service is presently undervalued. The RUC recommends the survey median of 30.00.	1	150

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 2 Bypass Grafts In the Abdomen							
35531	Bypass graft, with vein; aortoceliac or aortomesenteric	25.61	36.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35531 is calculated by adding this increment to code 35631 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal (rec work RVU= 34.00). 35631 underwent a full RUC survey with a median survey value of 34.75.	4	315
35536	Bypass graft, with vein; splenorenal	23.11	31.70	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35536 is calculated by adding this increment to code 35636 Bypass graft, with other than vein; splenorenal (rec work RVU = 29.50).	4	324

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35560	Bypass graft, with vein; aortorenal	23.56	32.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that the work of this service has changed over the past five years. Most straightforward renal stenoses are now treated by percutaneous transluminal angioplasty. Only the most difficult renals (oftentimes completely occluded arteries) are treated by using open surgical reconstruction. The RUC recommends that the survey median of 32.00 based on a mini-survey of 29 surgeons be implemented.	1	332
35563	Bypass graft, with vein; ilioiliac	15.14	24.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35563 is calculated by adding this increment to code 35663 Bypass graft, with other than vein; ilioiliac (rec. work RVU = 22.00).	4	336
35565	Bypass graft, with vein; iliofemoral	15.14	23.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35565 is calculated by adding this increment to code 35665 Bypass graft, with other than vein; iliofemoral (rec. work RVU = 21.00).	4	340

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	24.60	34.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service has changed over the last five years. The more straightforward cases are now treated with percutaneous angioplasty, and only the most complex cases undergo open surgery. In addition, the service was not accurately evaluated during the original Harvard/Hsiao extrapolations. The RUC recommends a work RVU of 34.00, slightly less than the survey median of 34.75. The RUC also compared this service to a code on the MPC, 61518 Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull (work RVU = 37.32). The intra-service time is comparable for both services. Code 61518 includes additional critical care time. 35631 may also be directly compared to code 35102 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external) (work RVU = 30.76). The time for each service is identical, however 35631 is a more intense service.	1	371
35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)	22.46	29.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends the 25th percentile of the survey work RVU based on a survey of 30 surgeons. A building block calculation of 29.03 confirms these survey results.	1	376

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35663	Bypass graft, with other than vein; ilioliac	14.17	22.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A work RVU of 22.00 is recommended to correct a current rank order anomaly between this service and 35665. The RUC agreed that the 25th percentile of a mini-survey of 27 surgeons and a 1.00 additional increment over 35665 is appropriate.	4	397
35665	Bypass graft, with other than vein; iliofemoral	15.40	21.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase to 21.00 based on a RUC survey of 30 surgeons. In addition, the Building Block Methodology calculates a work relative value of 21.07, which further supports this recommendation.	4	401

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 3 Embolectomy/Thrombectomy in the Abdomen							
34151	Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision	16.86	25.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase to 25.00 work RVUs based on the 25th percentile survey work RVU of a full RUC survey of 30 surgeons. This survey compared this service with code 35081 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta. The time for both procedures is similar, however, 34151 is more intense. The previous RUC survey data for 35081 is 203 minutes, versus the 150 minutes for 34151, therefore, the RUC agreed that the 25th percentile as more appropriate than the survey median.	4	46
34401	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision	12.86	25.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that 34401 be increased to correct a current rank order anomaly. 34401 is identical in time and intensity to code 34151 and the RUC recommends that it also be increased to 25.00 work RVUs.	4	63
34451	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	14.44	27.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that code 34451 is similar to codes 34151 and 34401, however, it requires approximately 30 more minutes of intra-service time. The RUC recommends that 34451 be valued slightly higher than these services to account for this additional intra-service time.	4	71

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 4 Endarterectomy in the Abdomen							
35331	Thromboendarterectomy, with or without patch graft; abdominal aorta	23.52	26.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC compared this service to a service on the MPC, code 61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma (work RVU = 28.40). The committee deducted the work value of one office visit and an increment for the 20 minutes of additional intra-service time included in 61510 from the RUC database to arrive at a value of 26.20 for code 35331. This value is also consistent with the building block calculation of 25.82 for this code.	4	265
35351	Thromboendarterectomy, with or without patch graft; iliac	20.11	23.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that the relationship between 35331 and 35351 should be retained. 35351 typically reflects 30 minutes less intra-service time and one less office visit than 35331, and therefore a calculated work relative value of 23.00 is recommended.	4	270
35361	Thromboendarterectomy, with or without patch graft; combined aortoiliac	23.59	28.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	This service is similar to 35331 in time and intensity. The intra-service time for 35361 is 30 minutes greater than 35331 and the RUC recommends an increment of 2.00 to account for this additional time.	4	279

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35363	Thromboendarterectomy, with or without patch graft; combined aortoiliiofemoral	24.66	30.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	This service is similar to 35361 in time and intensity. The intra-service time for 35363 is 30 minutes greater than 35361 and the RUC recommends an increment of 2.00 to account for this additional time.	4	283

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		2000 RUC					
CPT Code	Description	Work RVU	Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 5 Repair Blood Vessels in the Abdomen							
35221	Repair blood vessel, direct; intra-abdominal	16.42	24.39	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agrees that this service is similar in work to 35111 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, splenic artery (rec. work RVU = 25.00). 35111 has approximately 30 minutes greater intra-service time, however, the post-operative period is more involved in the trauma patient that is typical for code 35221. The building block methodology also calculates a work relative value of 24.39 for this service.	4	196
35251	Repair blood vessel with vein graft; intra-abdominal	17.49	30.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35251 is calculated by adding this increment to code 35281 Repair blood vessel with graft other than vein; intra-abdominal (rec. work RVU = 28.00)	4	222
35281	Repair blood vessel with graft other than vein; intra-abdominal	16.48	28.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	A survey median work RVU of 28.00 based on a survey of 38 surgeons is recommended for code 35281. This recommendation is also confirmed by the building block methodology calculation of 28.65 for this service.	1	246

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
37617	Ligation, major artery (eg, post-traumatic, rupture); abdomen	15.95	22.06	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that the 25th percentile survey work RVU based on a survey of 30 surgeons be implemented.	4	461
37660	Ligation of common iliac vein	10.61	21.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that the 25th percentile survey work rvu of 21.00 be implemented for this service.	4	474

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 6 Explorations, Revisions in Chest and Abdomen							
35182	Repair, congenital arteriovenous fistula; thorax and abdomen	17.74	30.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	This rare procedure (no Medicare frequency in 1998 data) has been significantly undervalued since the inception of the RBRVS. The RUC recommends that the survey median of 30.00 based on a survey of 17 vascular surgeons be implemented.	1	174
35189	Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen	18.43	28.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends the specialty's survey median of 28.00, based on a survey of 18 vascular surgeons. This recommendation also corrects a rank order anomaly as 35189 is slightly less work than 35182.	1	182
35905	Excision of infected graft; thorax	18.19	31.25	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In July 1993, the RUC recommended that this services was more work than 35081 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta (work RVU = 28.01). 35081 was increased in the previous five-year review, however this service was not reviewed at that time and a rank order anomaly was created. The RUC recommends the 25th percentile work RVU of 31.25 be implemented.	4	430

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35907	Excision of infected graft; abdomen	19.24	35.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In July 1993, the RUC recommended that this services was more work than 35081 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta (work RVU = 28.01). 35081 was increased in the previous five-year review, however this service was not reviewed at that time and a rank order anomaly was created. The RUC recommends the 25th percentile work RVU of 35.00 be implemented.	4	434

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 7 Extra-anatomic Bypass Grafts							
35511	Bypass graft, with vein; subclavian-subclavian	16.83	21.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that 35511 be valued the same as 35518 and 35558 at 21.20. The mini-survey survey median for this service was 22.00.	4	299
35518	Bypass graft, with vein; axillary-axillary	15.42	21.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35518 is calculated by adding this increment to code 35650 Repair blood vessel with graft other than vein; axillary-axillary (rec. work RVU = 19.00).	4	303
35521	Bypass graft, with vein; axillary-femoral	16.17	22.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35521 is calculated by adding this increment to code 35621 Repair blood vessel with graft other than vein; axillary-femoral (rec. work RVU = 20.00).	4	307

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35533	Bypass graft, with vein; axillary-femoral-femoral	20.52	28.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends an increase to the survey median of 28.00.	1	319
35558	Bypass graft, with vein; femoral-femoral	14.04	21.20	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC reviewed the current increment for a bypass graft with vein versus a bypass graft with other than vein and determined that an appropriate increment was 2.20. This increment was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). The RUC recommendation for 35558 is calculated by adding this increment to code 35661 Repair blood vessel with graft other than vein; femoral-femoral (rec. work RVU = 19.00).	4	328
35621	Bypass graft, with other than vein; axillary-femoral	14.54	20.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the 25th percentile survey work RVU based on a full RUC survey of 30 surgeons.	4	356
35623	Bypass graft, with other than vein; axillary-popliteal or -tibial	16.62	24.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the survey median work RVU based on a survey of 29 surgeons.	1	361

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35650	Bypass graft, with other than vein; axillary-axillary	14.36	19.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the 25th percentile survey work RVU based on a survey of 30 surgeons.	4	380
35654	Bypass graft, with other than vein; axillary-femoral-femoral	18.61	25.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the survey median work RVU based on a survey of 29 surgeons. The society also based their justification on a building block method using actual skin-to-skin time of 230 minutes resulting in a work RVU of 28.00.	1	384
35661	Bypass graft, with other than vein; femoral-femoral	13.18	19.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the 25th percentile survey work RVU based on a survey of 30 surgeons. This recommendation would also correct a rank order anomaly as 35661 is currently valued less than code 35650, but the work for these two services is the same.	4	391

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 8 Arterial Bypass Grafts In Extremities							
35571	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	18.58	24.06	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The work of this service has changed over the last five years. As the benefits of limb salvage become increasingly apparent, surgeons have pushed the envelope in terms of performing bypass grafts to even more distal and more diseased target vessels in older and more frail individuals. In addition, the service was not accurately evaluated during the original Harvard/Hsaio extrapolations. The work value was computed utilizing 35671 as the base code and adding an increment for the vein harvesting of 4.73 (19.33 + 4.73 = 24.06). This increment was calculated by deducting the work RVU for code 35666 (22.19) from code 35566 (26.92).	4	344
35587	In-situ vein bypass; popliteal-tibial, peroneal	19.05	24.75	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The work of this service has changed over the last five years. As the benefits of limb salvage become increasingly apparent, surgeons have pushed the envelope in terms of performing bypass grafts to even more distal and more diseased target vessels in older and more frail individuals. In addition, this service was not accurately evaluated during the original Harvard/Hsaio extrapolations. The RUC agreed that this service is very similar to code 35571 with nearly identical survey time. The survey for 35587 did include slightly more pre-service time (13 minutes). To preserve the work increment between 35571 and 35587 and to account for this small difference in time, the RUC recommends a .69 increment be added to the recommended value of 24.06 for 35571 (24.06 + 0.69 = 24.75).	4	350

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35666	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	19.19	22.19	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued and recommends the survey median work RVU based on a survey of 30 surgeons. This survey indicated a median intra-service time of 150 minutes. This time is confirmed by the SVS operating room time database with a skin-to-skin time of 149 minutes (n=11). The building block methodology calculated work RVU of 21.64 also confirmed the survey results.	1	406
35671	Bypass graft, with other than vein; popliteal-tibial or -peroneal artery	14.80	19.33	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is presently undervalued. The RUC compared the work of this service to 35666 and deducted 2.86 work RVUs to account for the additional 40 minutes pre-time, 15 minutes intra-service time, and 1 hospital visit for code 35666.	4	413

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 9 Embolectomy/Thrombectomy by Extremity Incision							
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	9.97	10.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the 25th percentile survey work RVU based on a survey of 30 surgeons.	4	37
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	8.07	10.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the 25th percentile survey work RVU based on a survey of 56 surgeons.	4	42
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	9.13	10.03	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the 25th percentile survey work RVU based on a survey of 30 surgeons.	4	52
34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	12.21	16.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the median survey work RVU based on a survey of 34 surgeons. The survey median is also confirmed via the building block methodology calculation of 16.45 for this service.	1	57

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
34421	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision	9.93	12.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the 25th percentile survey work RVU based on a survey of 52 surgeons.	4	67
34490	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision	7.60	9.86	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC reviewed the survey data and determined that the Length of Stay data should be reduced by one day. The survey median of 10.50 was therefore reduced by one 99231 (work RVU = 0.64) to arrive at a recommended work RVU of 9.86.	4	75

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 10 Aneurysm Repairs in the Extremity							
35011	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision	11.65	18.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the 25th percentile survey work RVU based on a survey of 30 surgeons.	4	97
35013	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision	17.40	22.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the median survey work RVU based on a survey of 30 surgeons.	1	102
35045	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, radial or ulnar artery	11.26	17.57	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase for this service based on the survey median of 18.00. The RUC did reduce this value by 0.43 to account for an office visit (99213) that is not typically performed.	4	106
35141	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)	14.46	20.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is undervalued. The RUC recommends the median survey work RVU based on a survey of 30 surgeons. The survey median is also confirmed via the building block methodology calculation of 19.71 for this service. This service is also comparable to code 35621 (recommended work rvu = 20.00).	1	154

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35142	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)	15.86	23.30	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service should be increased to be greater than 35141. Although the intra-service time for both services is identical, the post-service time for code 35142 is greater. The RUC recommends that the mid-point between the 25th percentile and the survey median be implemented for this service.	4	159
35151	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, popliteal artery	17.00	22.64	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed that this service is currently undervalued. The RUC recommends that the current increment between the existing values for 35141 and 35151 is correct and recommends that this incremental difference of 2.64 be added to the recommended value of 20.00 for code 35141.	4	163
35152	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery	16.70	25.62	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase for this service based on the recommended increase of 35151 of 22.64 plus an additional increment for 30 minutes of intra-service time and one 99212 office visit.	4	170

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 11 Endarterectomy of Extremity Arteries							
35321	Thromboendarterectomy, with or without patch graft; axillary-brachial	11.97	16.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be increased to the 25th percentile survey work RVU of 16.00 based on a survey of 38 surgeons.	4	260
35355	Thromboendarterectomy, with or without patch graft; iliofemoral	16.09	18.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be increased to the 25th percentile survey work RVU of 18.50 based on a survey of 30 surgeons. The RUC reviewed the building block method calculation for additional rationale. The RUC determined that the intensity of 0.090 was too high and suggested an intensity of 0.82 to reflect less intensive work as the femoral component is 75% of the procedure and the more intensive ilio component is only 25% of the procedure. A recomputation of the building block method for this code indicates a work RVU of 18.40, which is consistent with the recommended 25th percentile of the survey work RVU.	4	274
35371	Thromboendarterectomy, with or without patch graft; common femoral	11.64	14.72	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	According to the SVS database of 5,000 vascular surgery operations, CPT code 35371 (109 minutes intra-service, n=19) requires 41 less minutes in the intra-service period than CPT code 35372 (150 minutes intra-service, n=10). The RUC recommends, therefore that an increment of 3.28 (41 minutes x 0.080 IWPUT) be deducted from the RUC recommended work value for 35372 of 18.00. The specialty's building block method calculation of 14.31 for this service also confirms this recommendation.	4	287

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CPT		2000	RUC			
Code	Description	Work RVU	Rec RVU	Public Comment to HCFA	RUC Rationale	Key Page
35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	13.56	18.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase in the work RVU for this service to 18.00 which is based on the 25th percentile of a RUC survey of 31 surgeons. In addition, the specialty's building block method calculation of 18.09 for this service confirms this recommendation. The RUC also noted the intra-service time from a database of 5,000 vascular surgery operations indicated an intra-service time of 150 minutes (n=10) for this service.	4 293

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 12 Arteriovenous Fistula Repairs in the Extremities							
35184	Repair, congenital arteriovenous fistula; extremities	12.25	18.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC agreed with the specialty that a clear rank order anomaly currently exists between CPT code 35190 and this service. Code 35184 is more difficult than 35190, typically requiring an addition hour of intra-service time. The intra-service intensity is also greater for 35184 than 35190. The RUC recommends the 25th percentile survey work RVU based on a mini-survey of 44 surgeons.	4	178
35190	Repair, acquired or traumatic arteriovenous fistula; extremities	12.75	12.75	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	No compelling evidence was presented to increase the relative value for this service. The RUC also notes that this is not the appropriate code to report the takedown of a dialysis fistula and that those claims that indicate an outpatient hospital setting as the site-of-service should be reported using the newer codes 36831-36833 as appropriate.	2	186

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
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Family: 13 Peripheral Artery and Vein Ligations

35701	Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery	5.55	8.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>In reviewing this specific service, the RUC agreed that the survey work RVUs and the building block methodology produced work RVUs that were not appropriate. The RUC did agree that 35701 should be valued higher than 35741 (rec work RVU = 8.00). The committee recommends a work RVU of 8.50 to retain the current relativity between these two codes and to indicate that the work is greater for 35701.</p>	4	417
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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35721	Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery	5.28	7.18	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC recommends the 25th percentile for code 35721 at 7.18. The RUC also noted that this code includes the language "with or without lysis of artery." The specialty indicated that this phrase is not meaningful in current practice and that it could be mistakenly confused with the newer term "thrombolysis." Therefore, the specialty society will request that CPT delete this phrase from the nomenclature for this family of codes.</p>	4	421

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35741	Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery	5.37	8.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC recommends the 25th percentile of 8.00 for this service.</p>	4	426

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
37565	Ligation, internal jugular vein	4.44	10.88	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC recommends the 25th percentile of 10.88 for this service. The specialty's building block method calculation on 10.26 for this service also confirms this recommendation.</p>	4	439

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
37600	Ligation; external carotid artery	4.57	11.25	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC recommends the 25th percentile of 11.25 for this service. The specialty's building block method calculation on 11.26 for this service also confirms this recommendation.</p>	4	443

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
37605	Ligation; internal or common carotid artery	6.19	13.11	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC agreed that this service is more work than 37600, with 20 minutes of additional intra-service time and a greater level of intensity as there is an increased chance of stroke. The workgroup computed an increment of 1.86 to account for this additional work. The specialty's building block methodology calculation of 13.11 confirms this recommendation.</p>	4	447
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	5.73	5.73	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In reviewing the work of this individual service and all of the other ligation codes for arteries in the neck, the RUC was concerned that this code was not well defined. The RUC recommends that the specialty specifically identify which arteries are specifically included in 37615 as the external and internal carotid arteries are described in codes 37600 and 37605.	5	457

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
37618	Ligation, major artery (eg, post-traumatic, rupture); extremity	4.84	4.84	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In reviewing the work of this individual service and all of the other ligation codes for arteries in the extremities, the RUC was concerned that this code was not well defined. The RUC recommends that the specialty specifically identify which arteries are specifically included in 37618.	5	466
37650	Ligation of femoral vein	5.13	7.80	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the peripheral artery and vein ligations family of codes and determined that a number of rank order anomalies existed in this entire family of services. In addition, the RUC agreed that these services are undervalued when compared to CPT code 36831 Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) (work RVU = 8.00). The RUC agrees that these services were not accurately evaluated during the original Harvard/Hsaio extrapolations. To correct these rank order anomalies and to determine the appropriate work relative values, the RUC relied primarily on the 25th percentile survey work RVUs as determined by a survey of more than 30 surgeons.</p> <p>The RUC agrees that this service is more work than 35721 as this service includes the exploration. The RUC determined that this service should therefore be valued at 7.80, which is greater than the 25th percentile of 7.10 and accounts for an increment for the exploration.</p>	4	470

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
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Family: 14 Vessel Repairs in Extremities and Neck

35201	Repair blood vessel, direct; neck	9.99	16.14	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC computed a work RVU for this service by deducting the synthetic graft increment of 1.66 from code 35261 Repair neck vessel with graft other than vein; neck (rec. work RVU = 17.80). The calculated work RVU is 16.14 (17.80 - 1.66).</p>	4	
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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35206	Repair blood vessel, direct; upper extremity	9.25	13.25	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC recommends the 25th percentile of the survey work RVU of 13.25 for this base code.</p>	4	191

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35226	Repair blood vessel, direct; lower extremity	9.06	14.50	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC recommends the 25th percentile of the survey work RVU of 14.50 for this base code.</p> <p>The RUC notes that the frequency of this service has increased substantially between 1995 and 1998. The site-of-service and specialty mix data indicate that cardiologists are utilizing this code to report services performed in the outpatient setting. The committee understands that miscoding is occurring where placement of a collagen-type vascular sealant is utilized to achieve hemostasis following a diagnostic or therapeutic vascular catheterization procedure. The CPT Assistant, as well as the CPT</p>	4	201

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Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus)

CPT Code Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
				Companion publication, have clarified that this is not appropriate. Achieving hemostatis of an arteriotomy or venotomy site following a diagnostic or therapeutic vascular catheterization procedure is considered an integral component of the primary procedure. The technique or device used to close the arteriotomy or venotomy site(s) does not warrant additional reporting. The RUC recommends that CPT consider adding notes or guidelines to CPT to further provide instruction on this issue.		

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35231	Repair blood vessel with vein graft; neck	12.00	20.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC recommends the survey median of 20.00 for this service based on a mini-survey of 27 surgeons.</p>	1	209

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35236	Repair blood vessel with vein graft; upper extremity	10.54	17.11	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The work RVU for this service was computed by adding the vein increment of 2.20 to the synthetic graft code 35266 (rec work RVU = 14.91) for a calculated work RVU of 17.11 (14.91 + 2.20).</p>	4	212

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35256	Repair blood vessel with vein graft; lower extremity	11.38	18.36	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC computed the work RVU for this code by adding the vein increment of 2.20 to the synthetic graft code 35286 (rec work RVU = 16.16) for a calculated work RVU of 18.36 (16.16 + 2.20).</p>	4	226

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35261	Repair blood vessel with graft other than vein; neck	11.63	17.80	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWP/UT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC accepted the survey median for code 35231(work RVU = 20.00) and deducted the vein increment of 2.20 from this survey median to derive a recommendation of 17.80 code 35261.</p>	4	233

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35266	Repair blood vessel with graft other than vein; upper extremity	10.30	14.91	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined that current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWPUT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The work RVU for 35266 was calculated by increasing the base code 35206 (rec work RVU=13.25) by the synthetic graft increment of 1.66 (13.25+1.66=14.91).</p>	4	237

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35286	Repair blood vessel with graft other than vein; lower extremity	11.87	16.16	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	<p>The RUC reviewed the family of codes describing vessel repairs in extremities and neck and determined current rank order anomalies exist for codes in this family. In addition, the codes are undervalued as they were not evaluated accurately during the original Harvard/Hsaio extrapolations. In general, the 25th percentile survey work RVU is recommended for the base code based on a survey of 30 surgeons. The RUC agreed that an increment of 1.66 to value the additional work of utilizing a synthetic graft was appropriate to apply to the base code. The synthetic graft increment as calculated by an IWP/UT of 0.083 for the twenty minutes of additional intra-service time (20 minutes X 0.083 = 1.66). An additional increment of 2.20 is added to the codes that reflect repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53).</p> <p>The RUC added the synthetic increment of 1.66 to the base code 35226 (rec work RVU = 14.50) to calculate a work RVU of 16.16 for this service.</p>	4	250

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 15 Reconstructions for Chronic Venous Disease							
34501	Valvuloplasty, femoral vein	10.93	16.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends an increase for this service to 16.00 based on the survey median of 53 surgeons. The specialty's building block methodology calculation of 16.35 confirms this recommendation.	1	80
34510	Venous valve transposition, any vein donor	13.25	18.95	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends the 25th percentile survey work RVU of 18.95 based on a survey of 30 surgeons. This recommendation also corrects a rank order anomaly created in the 1994 RUC recommendations for these codes. At that time, these rare procedures were carrier-priced and the specialty did not conduct a RUC survey, but rather estimated the relationship of codes 34510, 34520, and 34530 to each other and other vascular surgery codes. This information was incorrect and the RUC now recommends that code 34510 is more work than both 34520 and 34530.	4	84
34520	Cross-over vein graft to venous system	13.74	17.95	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be ranked between 34510 and 34530 at 17.95. This recommendation also corrects a rank order anomaly created in the 1994 RUC recommendations for these codes. At that time, these rare procedures were carrier-priced and the specialty did not conduct a RUC survey, but rather estimated the relationship of codes 34510, 34520, and 34530 to each other and other vascular surgery codes. The RUC recommends that 34520 is more work than 34530.	4	89

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
34530	Saphenopopliteal vein anastomosis	17.61	16.64	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service is similar in time and intensity to code 34501 (rec work RVU = 16.00) with an additional one day length of stay. One 99231 hospital visits at 0.64 is added to 16.00 to calculate a work RVU recommendation of 16.64. This recommendation is slightly less than the survey median of 17.25. This recommendation also corrects a rank order anomaly created in the 1994 RUC recommendations for these codes. At that time, these rare procedures were carrier-priced and the specialty did not conduct a RUC survey, but rather estimated the relationship of codes 34510, 34520, and 34530 to each other and other vascular surgery codes.	4	93

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 16 Repairs, Bypass Grafts, Endarterectomies in the Chest							
35246	Repair blood vessel with vein graft; intrathoracic, without bypass	19.84	26.45	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	An increment of 2.20 is added to this code to reflect the repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). This increment is added to code 35276 (rec. work RVU = 24.25) to calculate a recommended work RVU of 26.45.	4	218
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass	18.75	24.25	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be increased to 24.25 which is based on the 25th percentile survey work RVU from a survey of 36 surgeons.	4	242
35311	Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision	23.85	27.00	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be increased to 27.00 which is based on the 25th percentile survey work RVU from a mini-survey of 28 surgeons. This recommendation retains the appropriate rank order for the codes in this family of services.	4	256

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
35526	Bypass graft, with vein; aortosubclavian or carotid	20.00	29.95	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	An increment of 2.20 is added to this code to reflect the repair of blood vessel with vein graft. This increment of 2.20 was calculated by comparing existing codes 35556 Bypass graft, with vein; femoral-popliteal (work RVU = 21.76) and 35656 Bypass graft, with other than vein; femoral-popliteal (19.53). This increment is added to code 35626 (rec. work RVU = 27.75) to calculate a recommended work RVU of 29.95.	4	311
35626	Bypass graft, with other than vein; aortosubclavian or carotid	23.63	27.75	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	The RUC recommends that this service be increased to 27.75 which is based on the 25th percentile survey work RVU from a mini-survey of 30 surgeons.	4	365

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 17 Ligation or biopsy of temporal artery							
37609	Ligation or biopsy, temporal artery	2.30	3.00	ASGS commented that the service is currently undervalued.	The RUC agrees that this service was not accurately evaluated during the original Harvard/Hsiao extrapolations. The RUC reviewed survey results from 62 general and vascular surgeons. The respondents included a hospital discharge day in the survey median of 4.00. The RUC reviewed Medicare utilization data and determined that this service is most typically performed in an outpatient hospital (48%) or office (19%) setting. The RUC compared this service to CPT code 38500 Biopsy or excision of lymph node(s); superficial (separate procedure) (work RVU=2.88) which has similar intra-service time of 33 minutes and includes one office visit in the global period. To account for the typical setting of outpatient hospital and office and to retain the value closer to 38500, the RUC recommends the specialties 25th percentile of their survey RVU at 3.00.	4	451

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key	Page
Family: 18 Not included in SVS Presentation							
35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta	28.01	28.01	ASGS commented that the service is currently undervalued.	No data or rationale were presented to increase work relative value.		2
35556	Bypass graft, with vein; femoral-popliteal	21.76	21.76	ASGS commented that the service is currently undervalued.	No data or rationale were presented to increase work relative value.		2

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1 = Adopt the recommended increase in RVUs; 2 = Maintain the current RVU; 3 = Adopt the recommended decrease in RVUs; 4 = Establish a new RVU; 5 = Refer the code to CPT; 6 = No consensus)

The Society for Vascular Surgery / The American Association for Vascular Surgery

Thirteen Elm Street • Manchester, Massachusetts 01944-1314 • (978) 526-8330 • FAX (978) 526-4018 • E-Mail: jvs@prri.com

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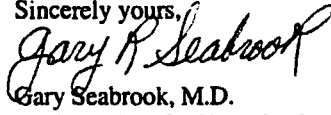
RE: AAVS/SVS RUC Submission for Five-Year Review

Dear Dr. Hoehn;

Please accept this submission from the American Association for Vascular Surgery (AAVS) and the Society for Vascular Surgery (SVS). Our two societies represent more than 1,600 surgeons in the United States whose practice is composed of non-cardiac peripheral vascular surgical procedures and vascular medical care. This document provides supporting data for 94 "vascular surgery" codes as part of the second 5-year review of physician work relative value units (RVWs). It is organized in seven main sections including 1) a Table of Contents, 2) a tabular presentation of recommended RVWs, 3) a compelling evidence discussion, 4) a detailed discussion of methods, 5) RVW results by family, 6) individual Summary Recommendations presented in ascending CPT order, and 7) a summary of our separate intensity evaluation project.

We apologize for the large size of this document; we have made every effort to present only the information that we believe to be important. We extend our sincere appreciation to the RUC members for taking the time to review it. We have been impressed with the dedication displayed by the RUC and are confident that our serious concerns will be given appropriate and fair consideration. We look forward to working with you in this important process.

Sincerely yours,



Gary Seabrook, M.D.

RUC Advisor for Vascular Surgery



Robert M. Zwolak, M.D., Ph.D.

Chair, AAVS/SVS Government Relations Committee

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Table of RVWs Recommended by SVS/AAVS

1998 Frequencies are taken from HCFA Utilization file. These values do not include frequency for PA's or modifiers -80, -55, -56. The "Fam" column refers to the clinical family used in this proposal to help compare the work RVUs of similar services.

CPT	Short Descriptor	Glob	1998 Freq	2000 RVW	SVS Recommend RVW	Fam
34101	Embolectomy / thrombectomy; axillary, brachial, innominate, subclavian artery, arm incision	90	6482	9.97	11.50	9
34111	Embolectomy / thrombectomy; radial or ulnar artery, arm incision	90	839	8.07	10.50	9
34151	Embolectomy / thrombectomy; renal, celiac, mesenteric, aortoiliac, abd incision	90	464	16.86	28.00	3
34201	Embolectomy / thrombectomy; femoropopliteal, aortoiliac artery, leg incision	90	8870	9.13	11.50	9
34203	Embolectomy / thrombectomy; popliteal-tibio-peroneal artery, leg incision	90	2181	12.21	16.50	9
34401	Vena cava, iliac vein thrombectomy, by abdominal incision	90	109	12.86	28.00	3
34421	Vena cava, iliac vein thrombectomy, leg incision	90	358	9.93	15.00	9
34451	Vena cava, iliac fem-pop vein thrombectomy, abd and leg incision	90	46	14.44	28.01	3
34490	Axillary and subclavian vein thrombectomy, arm incision	90	1331	7.60	10.50	9
34501	Valvuloplasty of femoral vein	90	86	10.93	16.00	15
34510	Venous valve transposition, any vein donor	90	31	13.25	20.00	15
34520	Cross-over vein graft to venous system	90	104	13.74	19.00	15
34530	Saphenopopliteal vein anastomosis	90	27	17.61	17.25	15
35011	Axillary, brachial artery aneurysm repair, arm incision	90	1465	11.65	18.50	10
35013	Axillary, brachial artery aneurysm repair, arm incision, ruptured	90	206	17.40	22.00	10
35045	Radial or ulnar artery aneurysm repair	90	414	11.26	18.00	10
35082	Infrarenal abdominal aortic aneurysm repair, tube, ruptured	90	3677	36.35	38.50	1
35092	AAA repair involving visceral arteries, ruptured	90	398	38.39	45.00	1
35103	Infrarenal AAA repair with bifurcated graft, ruptured	90	1095	33.57	40.50	1
35111	Splenic artery aneurysm repair	90	52	16.43	27.00	1
35112	Splenic artery aneurysm repair, ruptured	90	23	18.69	30.00	1
35121	Hepatic, celiac, renal, SMA aneurysm repair	90	231	25.99	32.00	1
35122	Hepatic, celiac, renal, SMA aneurysm repair, ruptured	90	33	33.45	35.00	1

CPT	Short Descriptor	Glob	1998 Freq	2000 RVW	SVS Recommend RVW	Fam
35131	Iliac artery (common, hypogastric, external) aneurysm repair	90	1118	18.55	27.50	1
35132	Iliac artery aneurysm repair, ruptured	90	184	21.95	30.00	1
35141	Femoral artery aneurysm repair (common, profunda, SFA)	90	6053	14.46	20.00	10
35142	Femoral artery aneurysm repair (common, profunda, SFA), ruptured	90	528	15.86	25.00	10
35151	Popliteal artery aneurysm repair	90	979	17.00	23.00	10
35152	Popliteal artery aneurysm repair, ruptured	90	50	16.70	27.00	10
35182	Congenital AV Fistula; thorax and abdomen	90	14	17.74	30.00	6
35184	Congenital AV Fistula; extremities	90	145	12.25	20.00	12
35189	Acquired or Traumatic AVF thorax and abdomen	90	75	18.43	28.00	6
35190	Acquired or Traumatic AVF extremities	90	2104	12.75	16.00	12
35206	Direct repair blood vessel upper extremity	90	2031	9.25	16.00	14
35221	Direct repair intra-abdominal blood vessel	90	739	16.42	28.01	5
35226	Direct repair blood vessel lower extremity	90	10487	9.06	16.50	14
35231	Repair neck vessel with vein graft (e.g. trauma)	90	129	12.00	20.00	14
35236	Repair blood vessel with vein graft; upper extremity	90	930	10.54	20.00	14
35246	Repair blood vessel with vein graft; intrathoracic, without bypass	90	31	19.84	28.00	16
35251	Repair intra-abdominal blood vessel with vein graft	90	123	17.49	31.00	5
35256	Repair blood vessel with vein graft; lower extremity	90	1694	11.38	21.76	14
35261	Repair neck vessel with synthetic graft (e.g. trauma)	90	122	11.63	19.00	14
35266	Repair blood vessel with synthetic graft; upper extremity	90	1004	10.30	18.00	14
35276	Repair blood vessel with synthetic graft; intrathoracic without bypass	90	22	18.75	27.50	16
35281	Repair intra-abdominal blood vessel with synthetic graft	90	134	16.48	28.01	5
35286	Repair with synthetic graft; lower extremity	90	1448	11.87	19.53	14
35311	Subclavian, innominate by thoracic incision	90	48	23.85	30.00	16
35321	Axillary, brachial endarterectomy with or without patch	90	1074	11.97	18.00	11
35331	Abdominal aorta endarterectomy with or without patch	90	241	23.52	28.01	4
35351	Iliac endarterectomy with or without patch	90	830	20.11	26.00	4
35355	Iliofemoral endarterectomy with or without patch	90	1241	16.09	19.77	11
35361	Combined aorto-iliac endarterectomy with or without patch	90	113	23.59	30.00	4

CPT	Short Descriptor	Glob	1998 Freq	2000 RVW	SVS Recommend RVW	Fam
35363	Combined aortoiliofemoral endarterectomy with or without patch	90	87	24.66	32.00	4
35371	Common femoral endarterectomy with or without patch	90	4711	11.64	18.00	11
35372	Deep (profunda) femoral endarterectomy with or without patch	90	3249	13.56	18.50	11
35511	Subclavian-subclavian bypass using vein	90	24	16.83	22.00	7
35518	Axillary-axillary bypass using vein	90	175	15.42	22.50	7
35521	Axillary-femoral bypass using vein	90	124	16.17	24.50	7
35526	Aortosubclavian or Aorto-carotid bypass using vein	90	18	20.00	30.98	16
35531	Aortoceliac or Aortomesenteric bypass using vein	90	276	25.61	36.00	2
35533	Axillary-femoral-femoral bypass using vein	90	149	20.52	28.00	7
35536	Splenorenal bypass using vein	90	70	23.11	31.50	2
35558	Femoral-femoral bypass using vein	90	817	14.04	22.00	7
35560	Aorto-renal bypass using vein	90	449	23.56	32.00	2
35563	Ilio-iliac bypass using vein	90	20	15.14	26.00	2
35565	Iliofemoral bypass using vein	90	360	15.14	24.60	2
35571	Popliteal-tibial, -peroneal, other distal vessel using vein	90	4510	18.58	26.96	8
35587	Popliteal-tibial, peroneal, using in-situ vein	90	1053	19.05	27.25	8
35621	Axillary-femoral bypass using prosthetic conduit	90	1173	14.54	21.50	7
35623	Axillary-popliteal or -tibial bypass using prosthetic conduit	90	78	16.62	24.00	7
35626	Aorto-subclavian or Aorto-carotid bypass using prosthetic	90	180	23.63	30.00	16
35631	Aorto-celiac, Aorto-mesenteric, Aorto-renal using prosthetic	90	1374	24.60	34.00	2
35636	Spleno-renal bypass using prosthetic	90	48	22.46	29.50	2
35650	Axillary-axillary bypass using prosthetic conduit	90	205	14.36	20.00	7
35654	Axillary-femoral-femoral bypass using prosthetic conduit	90	1400	18.61	25.00	7
35661	Femoral-femoral bypass using prosthetic conduit	90	5108	13.18	19.53	7
35663	Ilio-iliac bypass using prosthetic conduit	90	91	14.17	24.00	2
35665	Ilio-femoral bypass using prosthetic conduit	90	2095	15.40	22.00	2
35666	Femoral-tibial, or -peroneal bypass using prosthetic conduit	90	3139	19.19	22.19	8
35671	Popliteal-tibial or -peroneal bypass using prosthetic conduit	90	537	14.80	23.00	8
35701	Exploration without repair, carotid artery	90	506	5.55	14.50	13
35721	Exploration without repair, femoral artery	90	1180	5.28	8.65	13
35741	Exploration without repair, popliteal artery	90	465	5.37	10.00	13

CPT	Short Descriptor	Glob	1998 Freq	2000 RVW	SVS Recommend RVW	Fam
35905	Excision of infected graft; thorax	90	105	18.19	35.00	6
35907	Excision of infected graft; abdomen	90	441	19.24	40.00	6
37565	Ligation, internal jugular vein	90	79	4.44	14.00	13
37600	Ligation, external carotid artery	90	125	4.57	14.50	13
37605	Ligation internal or common carotid artery	90	138	6.19	16.00	13
37609	Ligation or biopsy of temporal artery	10	26567	2.30	4.00	17
37615	Ligation, major artery (e.g. post-traumatic, rupture) neck	90	88	5.73	16.00	13
37617	Ligation, major artery (e.g. post-traumatic, rupture) abdomen	90	444	15.95	26.00	5
37618	Ligation, major artery (e.g. post-traumatic, rupture) extremity	90	1016	4.84	10.70	13
37650	Ligation of femoral vein	90	98	5.13	8.80	13
37660	Ligation of common iliac vein	90	74	10.61	25.00	5

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Compelling Evidence Discussion

The majority of codes in the vascular surgery portion of this second “five-year review” are being submitted because they have never undergone a fair and reasonable evaluation for physician work. These are not codes where there has been a change in work during the last five years. Instead, we believe these services were valued incorrectly during the initial phases of the Harvard / Hsiao studies. The following paragraphs review vascular surgery’s efforts in the RBRVS arena since inception of the “new” Medicare payment system in 1992. We present this information under the heading “compelling evidence” because in each prior situation where HCFA and the RUC have had an opportunity to consider vascular surgery procedures it has been agreed that these services deserved reevaluation. In the current submission we are attempting to realign a large number of infrequently performed procedures among our benchmark procedures that have undergone RUC and HCFA analysis during the initial five-year evaluation and thereafter.

Inception of the Resource-based Relative Value Scale (RBRVS)

Introduction of the RBRVS in 1992 had an enormous impact on vascular surgery because 60% to 70% of all patients requiring peripheral vascular reconstruction belong to the Medicare population. From our members’ perspective, it was of great concern that the RBRVS had seemingly undervalued most medium and high complexity vascular surgery procedures. Attempts to determine the validity of this impression and initiate corrective action were started immediately by the Council of the Society for Vascular Surgery (SVS) and the sister society, the North American Chapter of the ISCVS¹. As outlined in detail by Hertzner and Noether, the Hsiao/Harvard team that developed the RBRVS failed to recognize peripheral vascular surgery as a distinct discipline.² The physician work RVWs for 170 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). The lack of an adequate basis for setting relative value work units has been a widely acknowledged problem, and it was extremely apparent for our specialty.

In the early phases of RBRVS development, peripheral vascular CPT codes were grouped with cardiac surgery. This was an especially unfortunate situation since cardiac operations, but not peripheral vascular procedures, had long been targets of critics who felt they were overcompensated. As a result, payment reductions were harsh for both disciplines. Medicare has now acknowledged that cardiothoracic and vascular surgery procedures are fundamentally distinct, but at that time many non-physicians had difficulty even understanding the difference between a “cardiothoracic surgeon” and a “vascular surgeon”. Thus, it is not surprising that the initial physician RVWs in vascular surgery appeared low overall and contained undeniable rank order anomalies. As an example of an overt rank order anomaly within the initial vascular surgery RVWs, elective repair of an infrarenal aortic aneurysm extending into the iliac arteries and requiring a bifurcated prosthesis was assigned a lower RVW than tube graft repair of an aneurysm isolated to the infrarenal aorta.²

Initial Response by Vascular Surgery in 1993

Following publication of Harvard Phase 1, an independent assessment of peripheral vascular procedures was sponsored by our societies. Abt Associates Inc. of Cambridge MA was retained to perform this evaluation, and methodology was developed to avoid the perceived sources of error embedded in the Harvard studies. Upon thorough analysis of the Harvard/Hsiao extrapolations it

¹ The North American Chapter of the ISCVS was renamed as the American Association for Vascular surgery (AAVS) in June 2000.

² Hertzner NR, Noether MG. The resource-based relative value scale in vascular surgery. A report of the activities of the Joint Council of the Society for Vascular Surgery and the North American Chapter of the ISCVS. J Vasc Surg 1993; 18:692-701.

became clear that physicians evaluating the vascular surgery services were not even obligated to have a working knowledge of the services as a condition for participation. For the Abt study, surgeons with significant vascular experience were recruited to participate. Although HCFA looked favorably on the results overall, modest adjustments were made in only a small number of medium and high complexity procedures in 1993. Thereafter, a committee of SVS members offered to review and realign all peripheral vascular codes. Although their offer was based on a request for such proposals published in the Federal Register, HCFA announced that consideration of further broad-based adjustments would be deferred until the initial five-year review.

Vascular Surgery and the Initial Five-Year Review

In preparation for the first five-year review the SVS initiated a study to determine whether vascular surgery intra-service work had been treated appropriately and fairly in the RBRVS. The RBRVS is based on the concept that "work = time x intensity". Thus, a relative measure of intensity may be derived if one divides work RVUs by time, or "intensity = work/time". We reasoned that if work RVUs had been assigned fairly, and if actual time could be determined, the "intensity" calculated in this manner should provide a metric that could be compared from one procedure to another. Procedures with obviously greater clinical intensity should generate relatively high work RVUs/time while those with less clinical intensity would have lower work RVUs/time. If this relationship were not found, it would mean that the work RVUs assigned by HCFA to the intra-service portion of the procedure lacked appropriate relativity.

We chose to focus on the intra-service portion of a surgical procedure for two reasons. First, this is where a large portion of the total physician work RVU is focused, and second, we felt there was some chance of obtaining accurate skin-to-skin time for this aspect of the service. We planned to divide the intra-service (e.g. skin-to-skin) work RVUs by the skin-to-skin time to determine work RVUs per minute ascribed to an operation. The committee obtained accurate, computer-based skin-to-skin surgery times for nine common vascular surgery CPT codes and eleven benchmark nonvascular procedures from ten medical centers. The hospitals were located in different states and represented both teaching and private facilities. Although the cohort did not represent a wide-ranging national data sample it did allow for reasonable comparisons of vascular and nonvascular operations performed at a substantial number of major medical centers. In addition, the data set vastly surpassed the quality and accuracy of any time estimates used in the Hsiao study because it used real skin-to-skin times derived from skilled operating surgeons from a variety of disciplines.

Study results for the vascular and nonvascular procedures revealed a wide range of intra-service "intensity", from a minimum of 0.026 to a maximum of 0.120 RVUs/min.³ The vascular surgical procedures accounted for 8 of the 9 lowest calculated intra-service RVUs/min, despite the fact that these operations are universally acknowledged to be complex, high intensity procedures. For example, the lowest value of all 17 procedures (0.026 RVUs/min) was determined for femoral-popliteal bypass using vein conduit (CPT 35556). This service requires significant clinical judgment and technical skill to achieve a favorable outcome, and the operation is usually performed on elderly patients with multiple comorbidities. This procedure is clearly not what any clinician would describe as a low intensity operation. Another example is repair of an abdominal aortic aneurysm involving the iliac arteries (CPT 35102). This highly complex procedure carries significant risk, yet it had only a slightly higher derived numeric intensity of 0.045 RVUs per minute. In contrast, the benchmark services from other specialties evaluated in this study were found to generate 2-3 times more RVUs/minute.³ It was felt that these data provided nearly irrefutable proof that on a relative basis the vascular procedures we evaluated were undervalued compared to benchmarks from other specialties.

³ Zwolak RM, Trout HHIII. Vascular Surgery and the Resource-Based Relative Value Scale five year review. J Vasc Surg 1997; 25:1077-86.

The results of this study, undertaken in 1995, were submitted to the initial five-year review as a compelling evidence argument. Although we believed that similar findings would have accrued for the entire spectrum of medium and high-intensity vascular surgery codes, the instructions provided by the RUC in 1995 indicated that we should submit only a limited number of our specialty's most undervalued services. Thus, we requested RVW reconsideration for nine vascular surgery operations. These included two aortic aneurysm reconstructions, 5 lower extremity revascularizations, carotid endarterectomy, and placement of a synthetic hemodialysis graft.

Much to our surprise, more than 3500 procedures were submitted for consideration at the initial five-year refinement, despite the instructions to send a limited number of codes. In order to deal with the number of submitted codes, the RUC divided itself into work groups. Vascular surgery was assigned to a workgroup that was considered, in retrospect, to be exceptionally rigorous. Regardless, the data we provided withstood intense scrutiny. The RUC and HCFA agreed that the submitted codes deserved RVW upgrades.

Conclusion

We believe that the results described above, including the response of the RUC and HCFA during the initial five-year review, constitute a compelling argument that the remainder of the vascular surgery codes deserve reconsideration even in the absence of a significant change in work over the past five years. For the current refinement we reviewed most of the vascular codes that have not undergone the RUC survey process, although for reasons of limited resources we were unable to study all such codes. In the analysis, we attempted to apply a logical, objective, and data-driven approach towards fair valuation of all elements of the global package. We used the standard RUC survey methodology coupled with a building block method that is described in the following paragraphs. For references we used codes that underwent survey during the initial five-year review plus the new and revised codes that have passed through the RUC and HCFA since the initial five-year exercise. In addition, we used several non-vascular surgery codes that were contained in the list of proposed references published by HCFA. Details of our methods are presented next.

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Methods

Code Selection

The SVS/AAVS performed a standard RUC survey on 38 procedures, and we undertook a RUC-approved "mini-survey" on 56 procedures for a total of 94 codes in this proposal. In addition, we performed a building block analysis of the work entailed in each procedure to help validate the survey results. In order to determine which codes to review, the Government Relations Committee⁴ or our two societies reviewed the entire scope of CPT codes that might be considered vascular surgery procedures. The range begins in the CPT manual with CPT 33875 (descending thoracic aortic graft) and ends at CPT 37799 (unlisted procedure, vascular surgery). Within that spectrum, we excluded entire categories of procedures that are not typically performed by vascular surgeons (e.g. pulmonary artery repairs, heart/lung transplantation, cardiac assist, vascular injections, etc.). Next, we excluded 9 procedures that underwent the full RUC survey process and consideration during the initial five-year review and 11 new or revised codes that were surveyed and valued after the first five-year review.

We reviewed the CPT definition of each remaining code to determine if it met the current concept of a distinct service, and we found 17 codes that were either entirely obsolete, completely

⁴ The Government Relations Committee is referred to throughout this document as the "Consensus Panel". The committee consists of seven participating vascular surgeons representing private practice and academia, urban and rural setting, and a wide geographic base (California, Michigan, Wisconsin, New York, New Hampshire, Maryland, and Washington, D.C.).

redundant, or not a single procedure. We referred these to CPT for consideration.⁵ An example is CPT 35646 "Bypass graft, other than vein, aortofemoral or bifemoral". An aortofemoral bypass requires two separate skin incisions plus two vascular anastomoses while an aortobifemoral bypass requires three incisions and three anastomoses. Thus, 35646 describes two significantly different operations that never should have been lumped in a single CPT category. The fact that this was done reflects the imprecise nature in which vascular surgery codes were defined and valued in the Hsiao/Harvard studies.

Exclusion of the above-noted codes left approximately 132 codes (131 x 90-day global and 1 x 10-day global) to evaluate. For reasons of limited resources (and clerical error for 11 codes) we dropped a total of 38 of these from consideration, leaving 94 codes in this analysis. For the most part these are rarely performed procedures. Only one of the 90-day codes was performed more than 10,000 times in the 1998 Medicare population (CPT 35226, repair artery in leg, n=10,487). The only other procedure performed >10,000 per year is the 10-day global procedure, temporal artery biopsy (CPT 37609). Although for purposes of this five-year review we considered 37609 a "vascular surgery" code, 60% are performed by general surgeons, while vascular surgeons perform only 8%. Thus, American Society of General Surgery chose to participate in collection of data for this code, and ASGS representatives will present 37609 at the work-group. Of the remaining codes, four have an annual frequency between 5-10,000, 24 are performed 1-5,000 times per year, and 64 are performed <1,000 per year in the Medicare population.

Full RUC Survey or Mini-Survey?

For procedures performed >1,000 per year, we decided to undertake a full RUC survey while most procedures performed <1000 per year were evaluated by "mini-survey". The mini-surveys were appended to the full RUC survey for "anchor" services within similar clinical families. For example, a mini-survey for CPT code 35671 (Bypass graft, other than vein; popliteal-tibial, n=518 in 1998) was appended to the full RUC survey for code 35666 (Bypass graft, other than vein; femoral-tibial, n=3,402 in 1998). For several of the rarely performed codes we could not identify a reasonable anchor service, and the decision was made to perform a complete RUC survey on those.

Full RUC Survey

RUC surveys were distributed randomly to vascular surgeon members of the SVS and the AAVS. Since a substantial number of vascular surgical operations are performed by individuals listed in the Medicare data base as general surgeons, the American College of Surgeons was kind enough to send us a list of 17,000 Fellows who practice general surgery. We selected names at random from this source and, therefore, sent surveys to general surgeons as well. The surveys were sent out primarily by fax and returned in a similar manner.

In anticipation of the magnitude of this project we began distributing surveys in February 2000, and the majority of our full surveys were sent before the RUC decided to add the "Five-year Review Questions" at its April 2000 meeting. Thus, our numerical response in this category is low. We discussed this issue during the Work Group conference call in June. The work-group suggested we provide the data that was available from respondents for this question, and they also asked that our Consensus Panel evaluate the 5-year specific questions. These data are provided in two separate columns on the Summary Recommendation forms.

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⁵ Codes referred to CPT for consideration of redefinition or deletion are CPT 35381, 35541, 35546, 35551, 35582, 35646, 35641, 35840, 35860, 37700, 37720, 37730, 37735, 37760, 37785, 33875, 33877.

RUC Survey Reference Table

The RUC Survey Reference Table used for our Five-Year Review is provided here:

CPT Code	2000 Descriptor	2000 Work RVU	Global Period
36140	Introduce needle or intracatheter for angiography, extremity artery	2.01	XXX
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	2.58	XXX
35454	Open iliac artery transluminal balloon angioplasty	6.04	0
35473	Percutaneous iliac artery transluminal balloon angioplasty	6.04	0
35474	Percutaneous transluminal balloon angioplasty; femoral-popliteal	7.36	0
36831	Open surgical thrombectomy of hemodialysis fistula, autogenous or synthetic graft, without revision	8.00	90
37205	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; initial vessel	8.28	0
36821	Arteriovenous anastomosis, direct, any site (e.g., Cimino type)	8.93	90
35875	Thrombectomy of arterial or venous bypass graft (other than hemodialysis graft or fistula)	10.13	90
36832	Open surgical revision, arteriovenous hemodialysis fistula; without thrombectomy, autogenous or nonautogenous graft	10.50	90
47562	Laparoscopic Cholecystectomy	11.09	90
36833	Revision, arteriovenous hemodialysis fistula; with thrombectomy, autogenous or nonautogenous graft	11.95	90
36830	Creation of arteriovenous hemodialysis fistula by other than direct arteriovenous anastomosis; nonautogenous graft	12.00	90
36819	Arteriovenous anastomosis for hemodialysis, by basilic vein transposition	14.00	90
35879	Revise lower extremity bypass graft (venous conduit) with vein patch angioplasty	16.00	90
35876	Thrombectomy with revision of arterial or venous graft (synthetic conduit, other than hemodialysis graft or fistula)	17.00	90
35881	Revise lower extremity bypass graft (venous conduit) with segmental vein interposition	18.00	90

CPT five-digit codes, two-digit number modifiers, and descriptions only are copyright by the American Medical Association. No payment schedules, fee schedules, relative value units, scales, conversion factors, or components thereof are included in CPT. The AMA is not recommending that any specific relative values, fees, payment schedules, or related listings be attached to CPT. Any relative value scales or relative listings assigned to CPT codes are not those of the AMA, and the AMA is not recommending use of these relative values.

Vascular Surgery Five-Year Review RUC Survey Reference Table Continued:

CPT Code	2000 Descriptor	2000 Work RVU	Global Period
35301	Carotid Endarterectomy	18.70	90
35656	Femoral-popliteal bypass graft using synthetic conduit	19.53	90
35556	Femoral-popliteal bypass graft using autogenous vein conduit	21.76	90
35583	Femoral-popliteal bypass graft using In-situ vein conduit	22.37	90
35566	Femoral-anterior tibial, -posterior tibial, -peroneal artery or other distal vessel bypass graft using autogenous vein conduit	26.92	90
35081	Direct repair (infrarenal) aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta, tube graft	28.01	90
35585	Femoral-anterior tibial, -posterior tibial, -peroneal artery or other distal vessel bypass graft using in-situ autogenous vein conduit	28.39	90
35102	Direct repair (infrarenal) aneurysm, false aneurysm, and associated occlusive disease involving iliac vessels (common, hypogastric, external) (bifurcated graft)	30.76	90
33513	CABG, four coronary venous grafts	31.95	90
35091	Direct repair aortic aneurysm involving visceral vessels	35.40	90
48150	Pancreatectomy, Whipple-type	43.48	90
61520	Craniectomy for excision of cerebellopontine angle tumor	54.84	90

Mini-Survey

Each mini-survey asked for intra-service skin-to-skin time in minutes, in-hospital length of stay, critical care, outpatient visits, and a final estimate of total work RVW. The mini-surveys were appended to full surveys that evaluated services within the same family of codes. We believe this allowed respondents to make informed judgments for the infrequent services having just completed a thorough analysis of a related and more commonly performed family member.

Internal Validation of Mini-Survey

Two codes in our series underwent both a full RUC survey and a mini-survey, and these were sent to entirely different cohorts of survey respondents. This provided a means to determine if results from full and mini-surveys would be similar. We were pleased to find the following:

CPT 34490 Embolectomy / Thrombectomy Axillary and Subclavian Vein

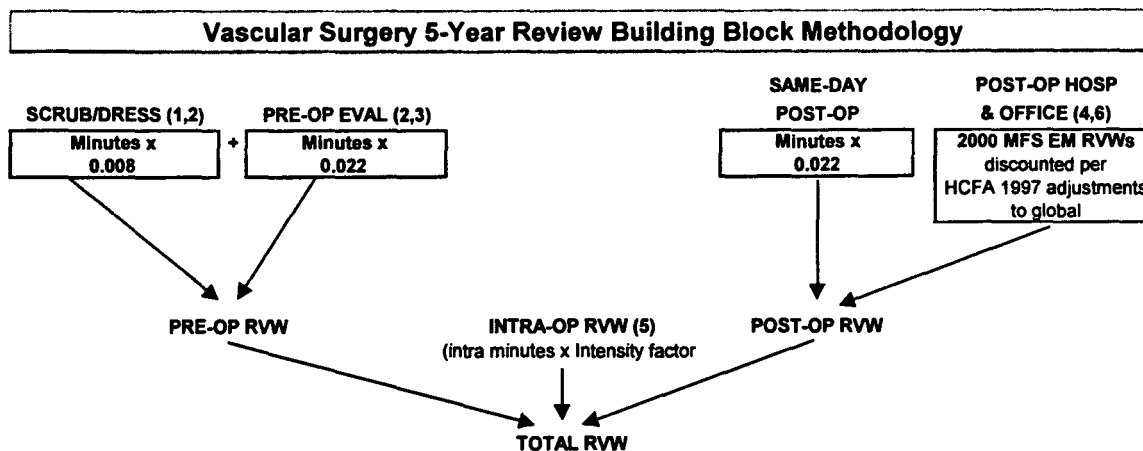
2000 RVW	7.60	
Full Survey median RVW	10.50	n=30
Mini Survey median RVW	11.00	n=30

CPT 35621 Bypass graft with other than vein, axillary-femoral

2000 RVW	14.54	
Full Survey median RVW	21.50	n=30
Mini Survey median RVW	21.50	n=30

Building Block Algorithm: The Stone Formula

Although the RUC relies on the full survey instrument as its primary metric, members of that body seem to express skepticism when Summary Recommendations are based exclusively on survey results. In order to help validate our survey results by another method, we chose a Building Block Analysis. The approach attempts to value the individual components of the global service, with the sum of the components representing the global RVW. We followed this algorithm:



(1) SVS used survey median scrub/dress time in minutes

(2) Harvard-assigned pre-service intensity factors were used.

(3) Review records, obtain informed consent, discuss care with anesthesia, nursing, etc.

(4) The 2000 MFS RVWs were "discounted" to be consistent with the HCFA adjustments made to global procedures in 1997.

(5) Using a scale of 0.031 to 0.108, Intra-service intensity was determined during a completely separate "intensity survey" and multiplied by the intra-service minutes.

(6) Visit levels from surveys

Building Block Method Pre-service Work

Pre-service RVWs were calculated using survey pre-service minutes multiplied by intensity levels HCFA has traditionally used for this purpose (Stone formula). We applied an intensity factor of 0.0224 for cognitive services such as reviewing preoperative diagnostic studies, reviewing risk/benefit analysis with patient and family immediately prior to surgery, and holding final discussions with anesthesia and nursing. We used an intensity factor of 0.0081 for the less cognitive services such as scrub, prep, and drape. The time values used for this calculation were taken from the RUC survey for those codes undergoing full survey. Pre-service times for codes undergoing mini-survey were determined by the Consensus Panel with attention paid to the anchor codes. Calculated by this approach, our pre-service RVWs range from 0.6 to 2.4, with most 90-day procedures falling in the tighter range of 1.2 to 1.5 RVWs.

Building Block Method Intra-service Work

For most 90-day global surgical services, intra-service work represents a large and focused component of the total RVW. Using the formula "work = time x intensity", we calculated intra-service work as survey median intra-service time (skin-to-skin time was requested on both full and mini-surveys) multiplied by intra-service intensity.

To determine intra-service intensity we performed an entirely separate and distinct "intensity survey". One hundred vascular surgeons were asked to submit relative intra-service intensity values for the operative portion of 179 vascular operations. For the reference scale we used

common general surgery anchor codes similar to those employed by the American College of Surgeons (ACS) in their five-year review effort. A reference range from 0.031 to 0.108 was used. The lower value of this range equals the intra-service intensity for evaluation and management. The upper value equals the ACS value assigned to a complex general surgery procedure, hepatic trisegmentectomy, CPT 47122 and we cautioned the vascular respondents to exceed this maximum only for services of ultimate intensity. For simplicity sake, we removed the decimal point such that the survey reference table contained integer values from 31 to 108, and we reinserted it during the analysis. We received 44 completed intensity surveys by February 25, 2000. The survey data were analyzed for minimum, 25th percentile, median, mean, 75th percentile, and maximum (Addendum A).

Median intensity values ranged from 0.040 (CPT 36468 & 36470 injection of sclerosing solution) to 0.110 (CPT 33877 Repair of thoracoabdominal aortic aneurysm). It was reassuring that vascular surgeons recommended an intensity factor >0.108 for only the most complex operations (repair of ruptured abdominal aortic aneurysm, repair of aortic aneurysm involving visceral arteries, and repair of thoracoabdominal aortic aneurysm). This finding contributed to our confidence in the objectivity of the data. It is also important to recall that some calculated intensity (IWPUT) values currently within the existing HCFA/Harvard/RUC databases exceed 0.108, some reaching as high as 0.200.

Building Block Post-service Work:

Post-service work in our building block algorithm was calculated for in-hospital and office visits at the "discounted" rate determined by HCFA in 1997 for E/M services provided within the global package. We derived the median number and level of hospital and office visits directly from survey data for procedures undergoing the full RUC survey. For mini-survey codes we used median length of stay from the survey and hospital visits for each of those days provided by our Consensus Panel with attention paid to the anchor codes. Office visits and RVUs were calculated in the same way. For full-survey codes the median visit level was multiplied by the corresponding discounted E/M value. For mini-survey codes we used the outpatient visit numbers provided on the mini-survey and the Consensus Panel applied the visit level.

Building Block Algorithm Enhanced by Actual Skin-to-Skin Intra-time

At recent meetings and in the Federal Register, HCFA representatives have emphasized the importance of time in determination of fair relative values. The vascular surgery societies have had an interest in collecting accurate time data since the initial five-year review, but our experience is that time data at the CPT code level is nearly impossible to capture. In preparation for this five-year review we collected accurate computer-log skin-to-skin time data from several major institutions and large private practices across the country. Our database now contains >5,000 operations, and on occasion in the Summary Recommendations we used these "hard numbers" as a supplemental Building Block analysis. Real median skin-to-skin intra-time was substituted for survey median skin-to-skin time. What we found in almost every case (where skin-to-skin data was available) was that the actual skin-to-skin time was greater than the RUC survey estimates (e.g. CPT 34203).

Unfortunately, because the services in this submission are performed rarely, many codes were not represented in our skin-to-skin database despite its considerable size. Our conclusion regarding skin-to-skin data collection is that a truly representative and accurate sample for surgery is still nearly impossible to obtain. For those CPT codes where data was available, our conclusion regarding the Building Block Method is that real skin-to-skin time exceeds surgeons' estimates more often than not.

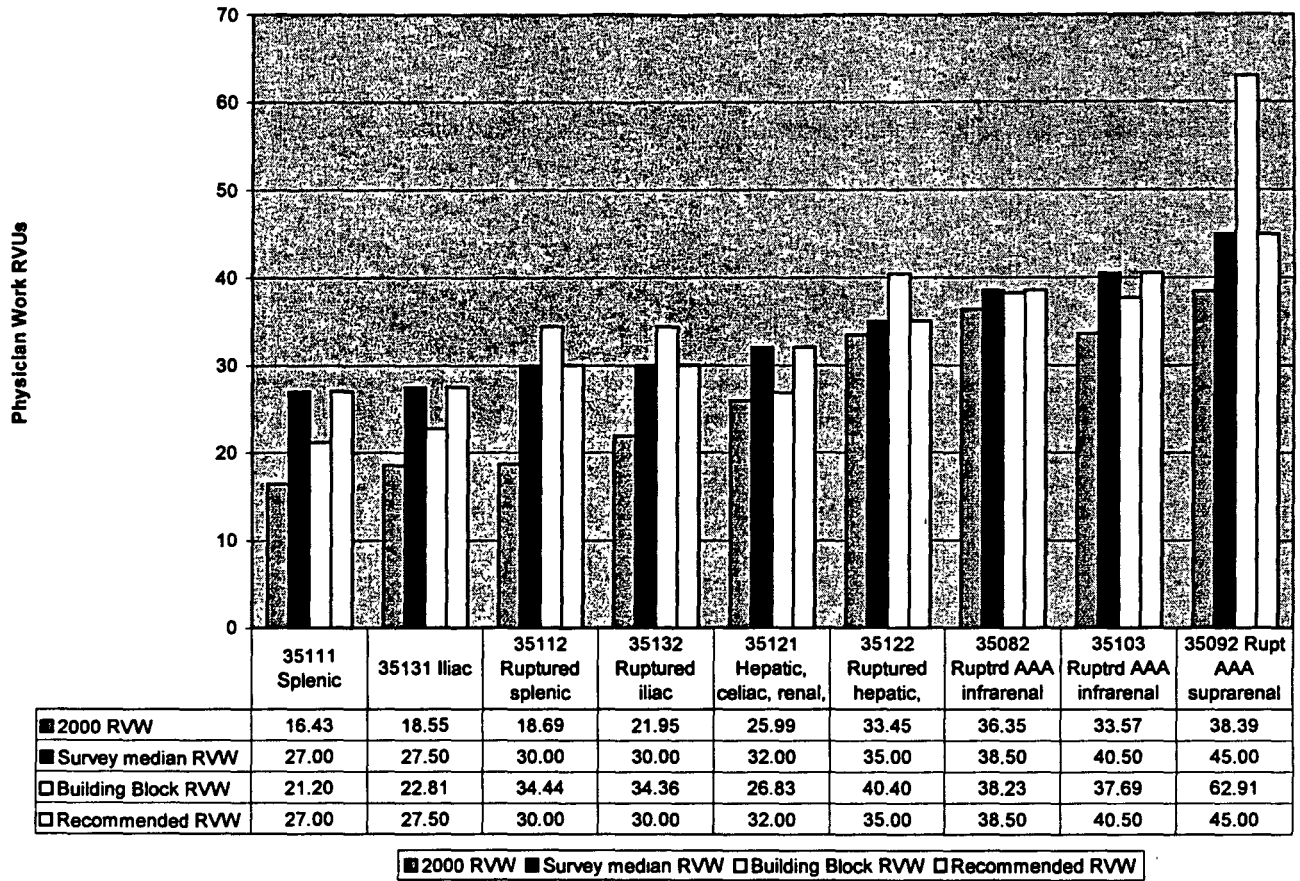
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RVW Recommendations by Clinical Families

The following section contains RVW bar graphs of our CPT code submission grouped by clinical family. The codes are ordered from left to right in ascending RVW order rather than by CPT code. We feel this will allow the reviewer a better sense of the relativity within each family. Typical reference services are noted in order that the reviewer will get a sense of how the submitted services relate to current values of benchmark vascular surgery services.

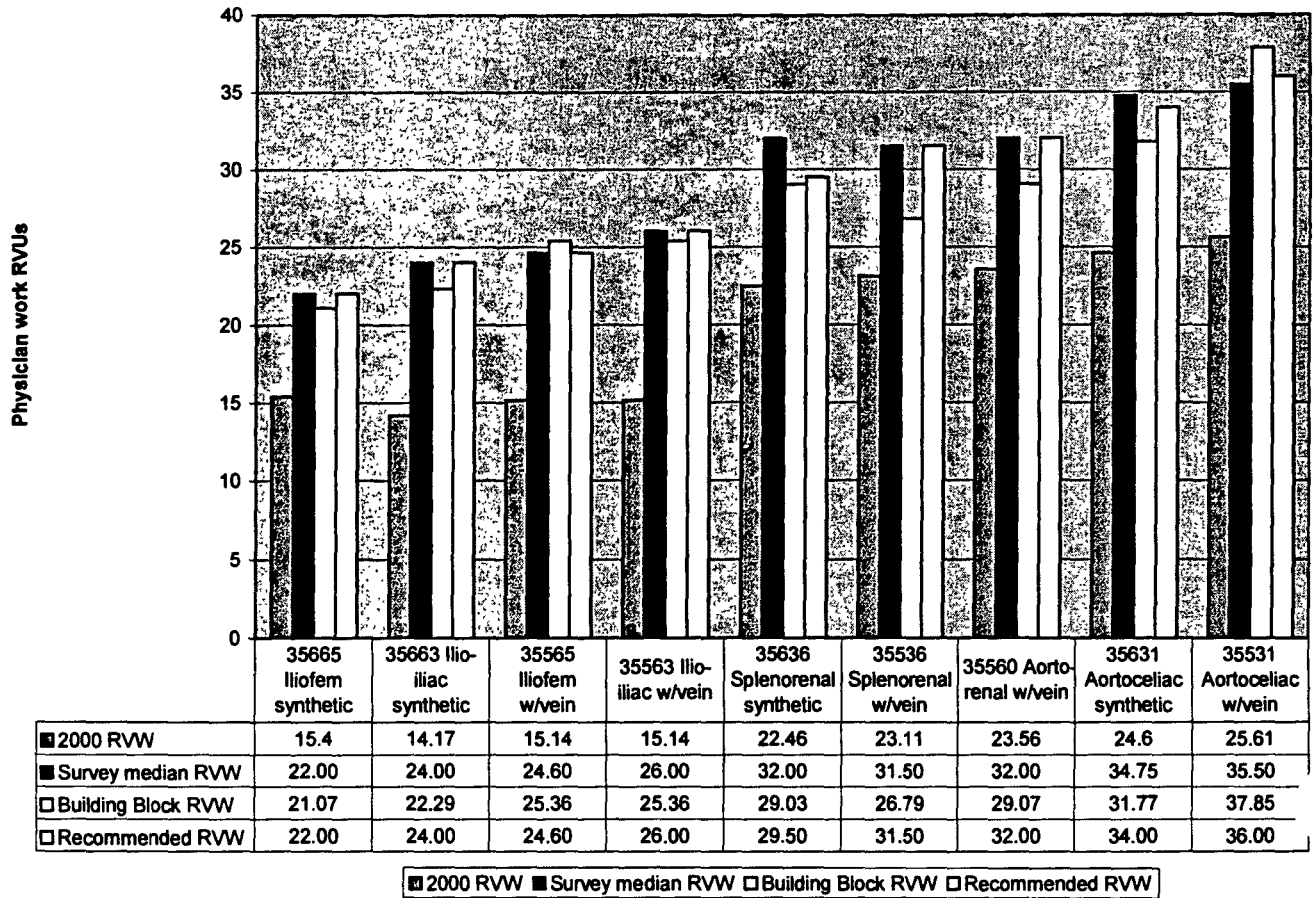
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Family 1 Aneurysm Repairs in the Abdomen



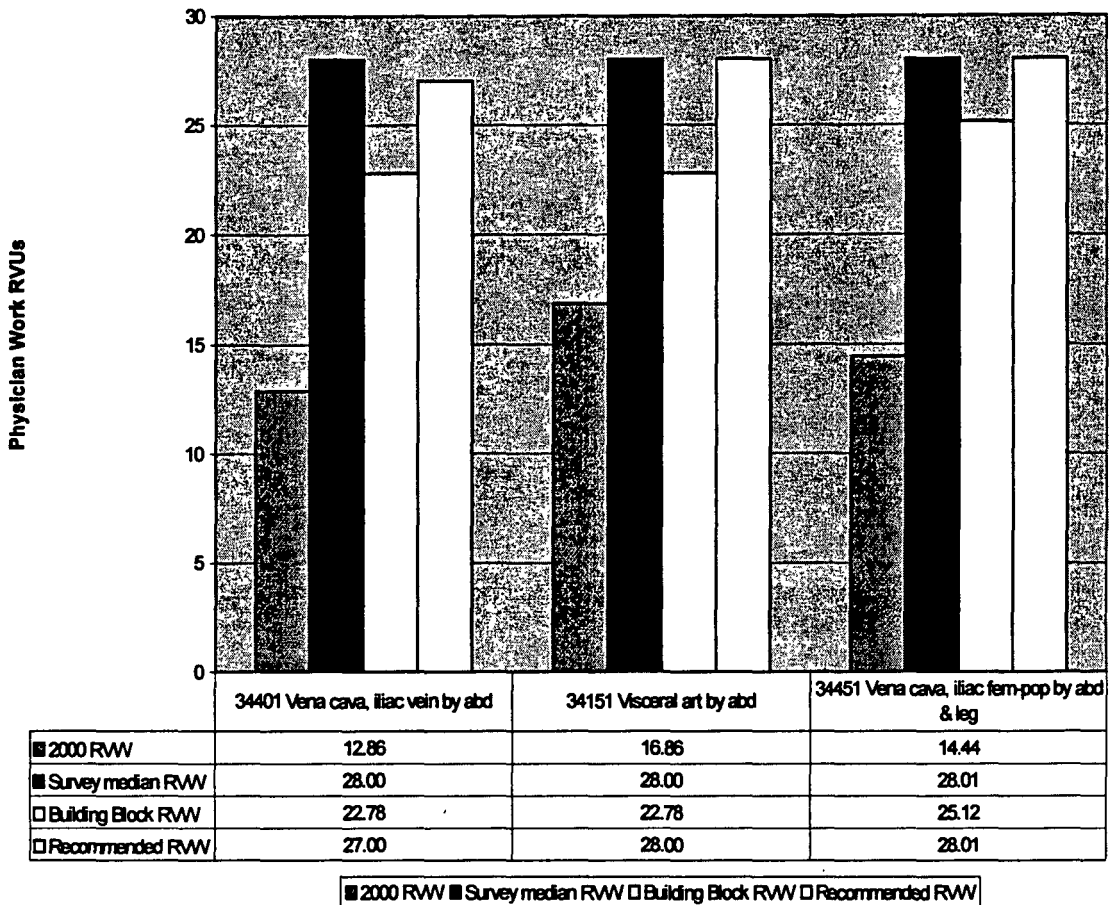
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Family 2 Bypass Grafts in the Abdomen



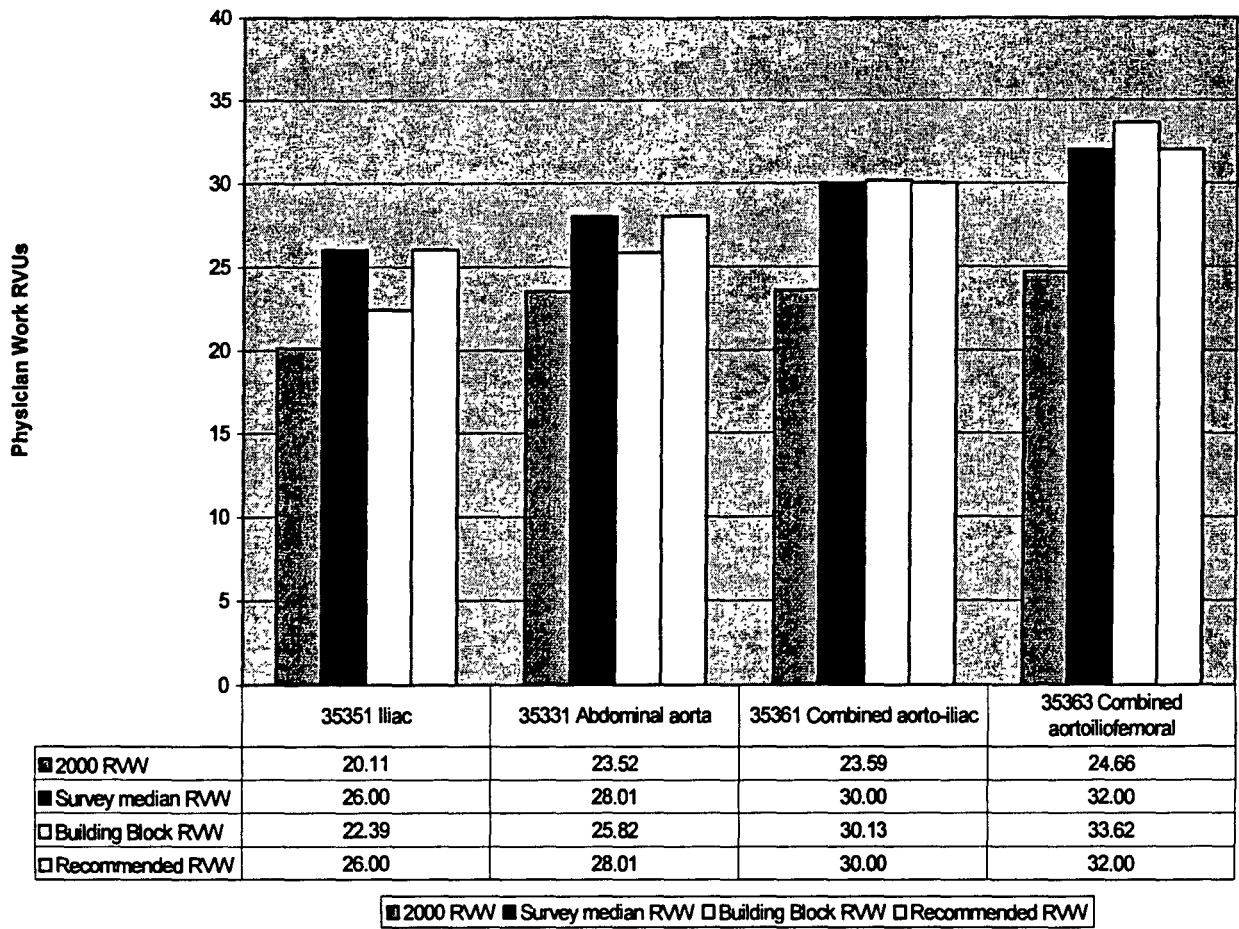
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Family 3 Embolectomy / Thrombectomy in the Abdomen



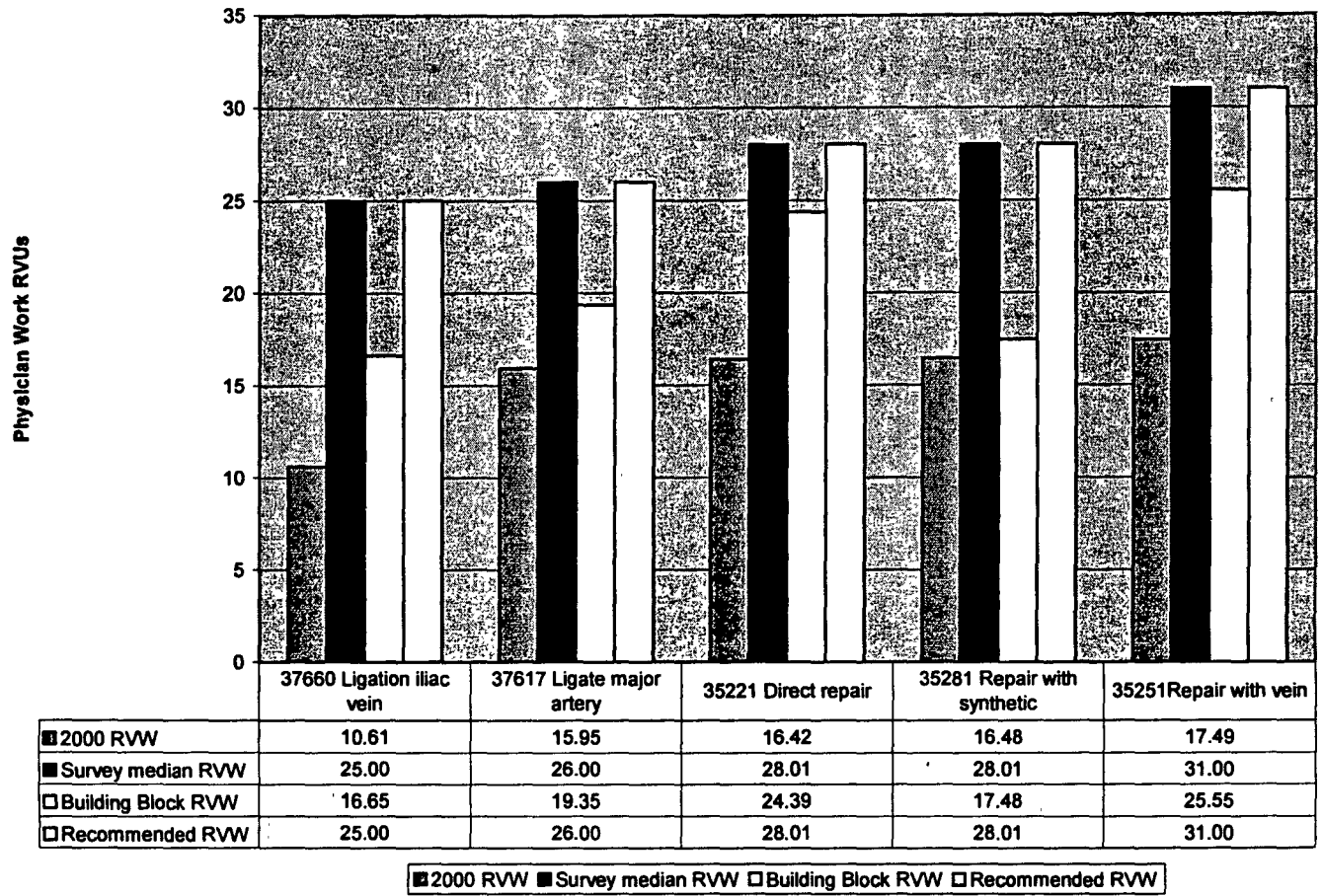
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Family 4 Endarterectomy in the Abdomen



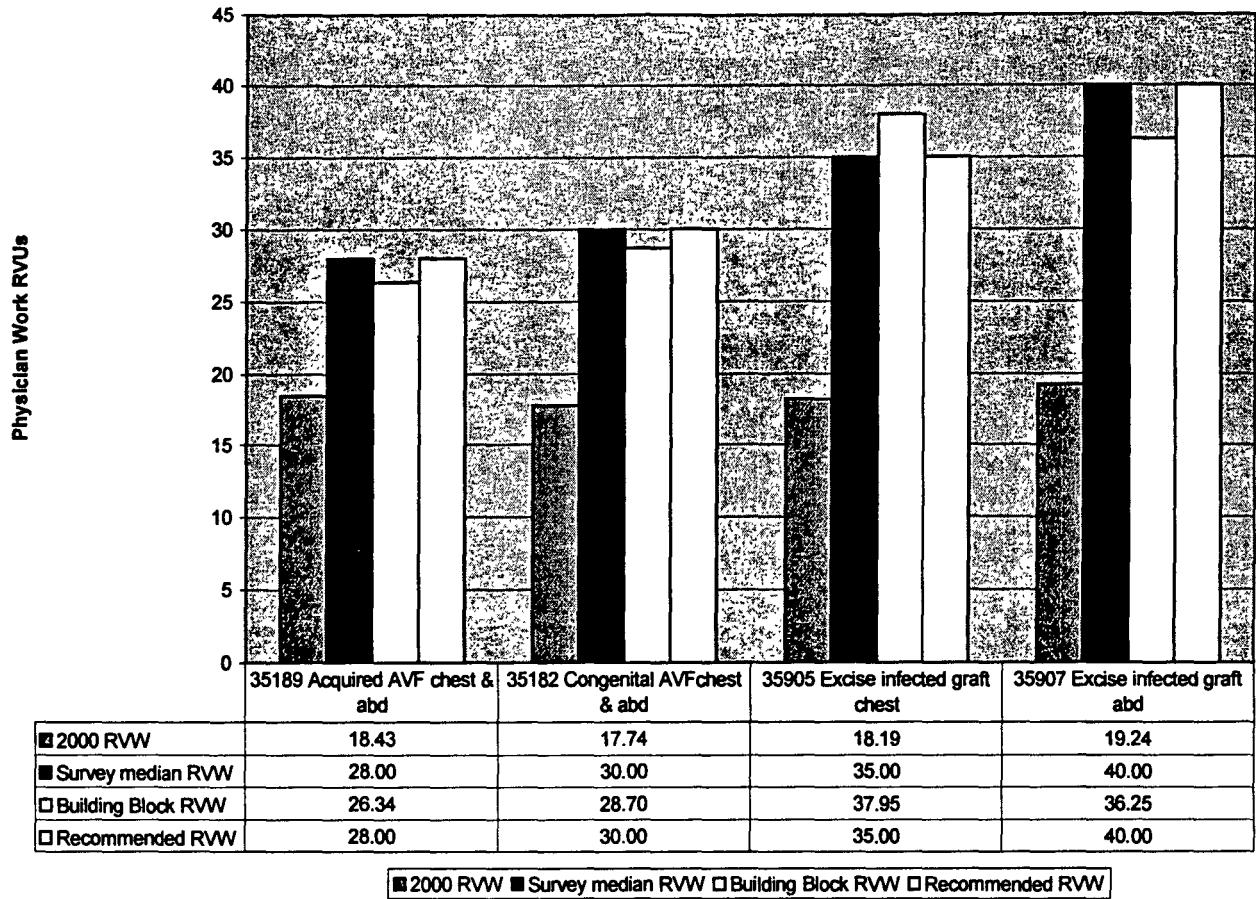
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Family 5 Repair Blood Vessels in the Abdomen



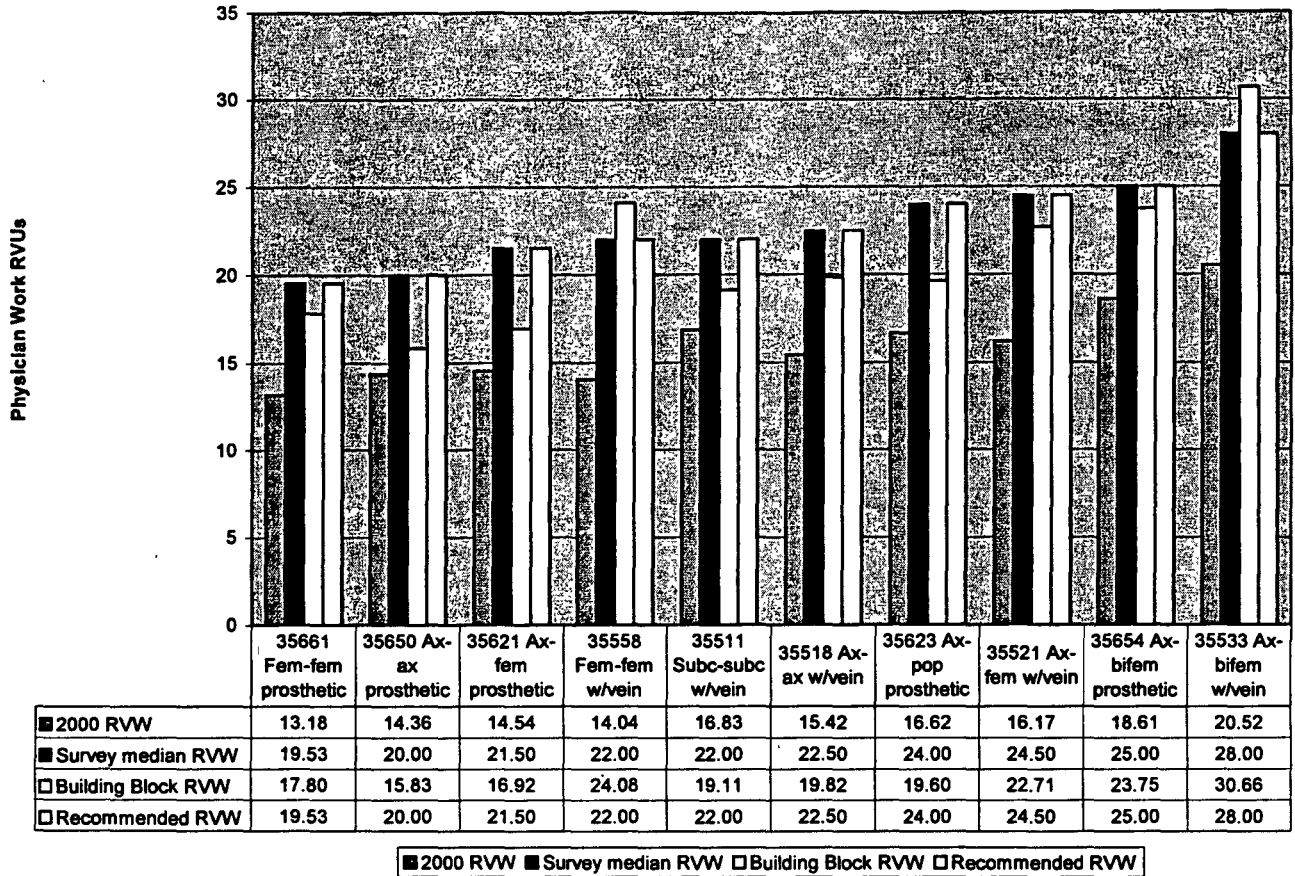
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Family 6 Explorations, Revisions, Other in Chest & Abdomen



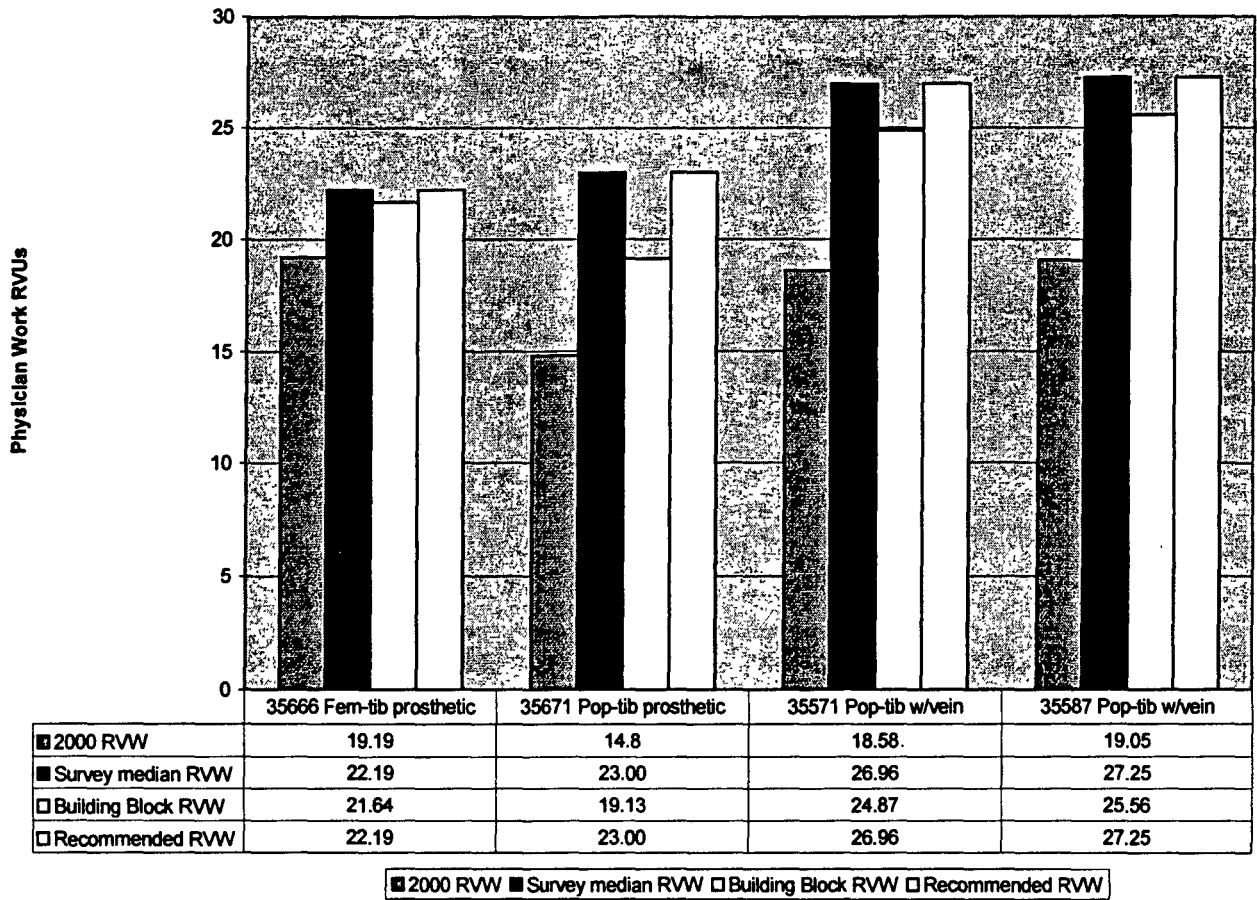
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Family 7 Extra-anatomic Bypass Grafts



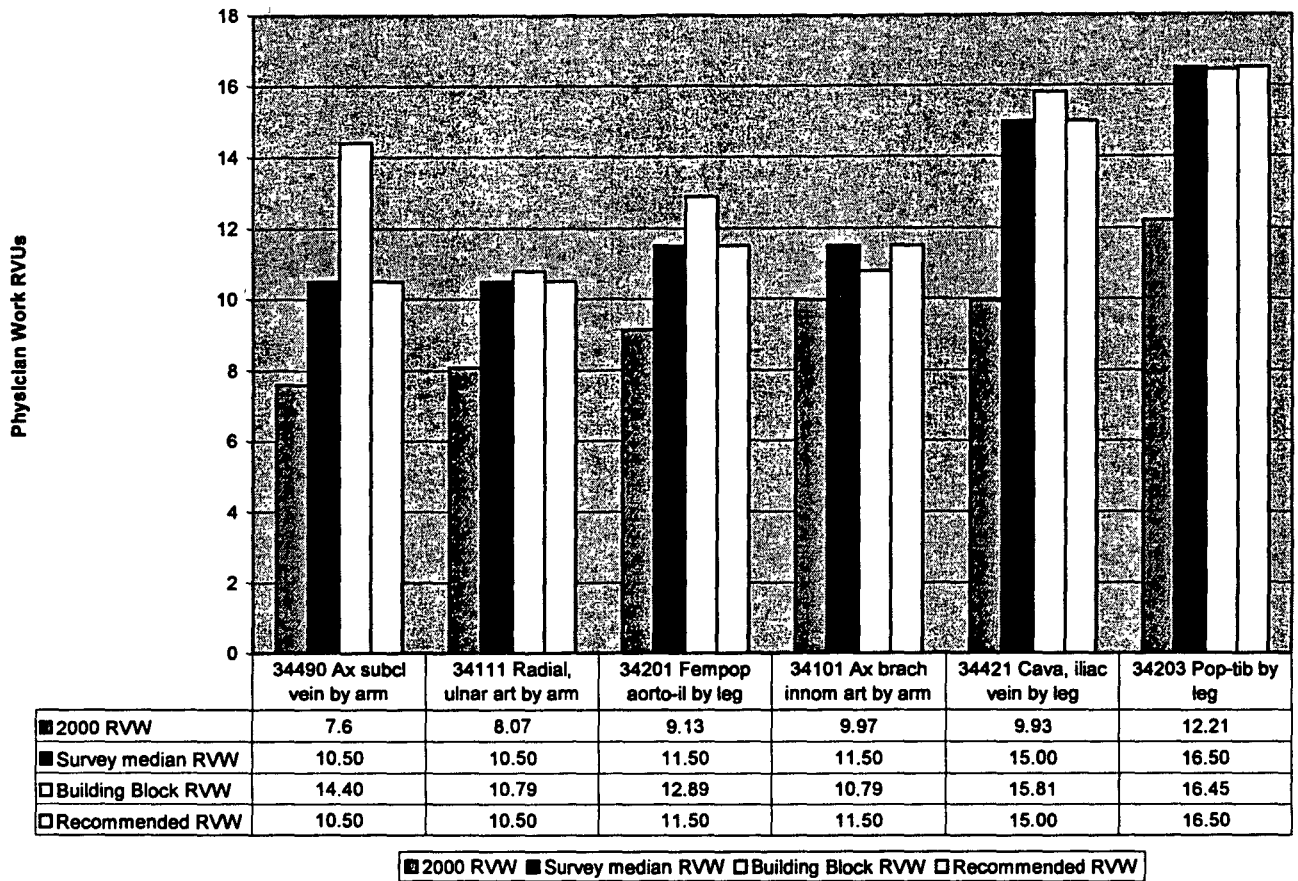
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Family 8 Arterial Bypass Grafts in Extremities



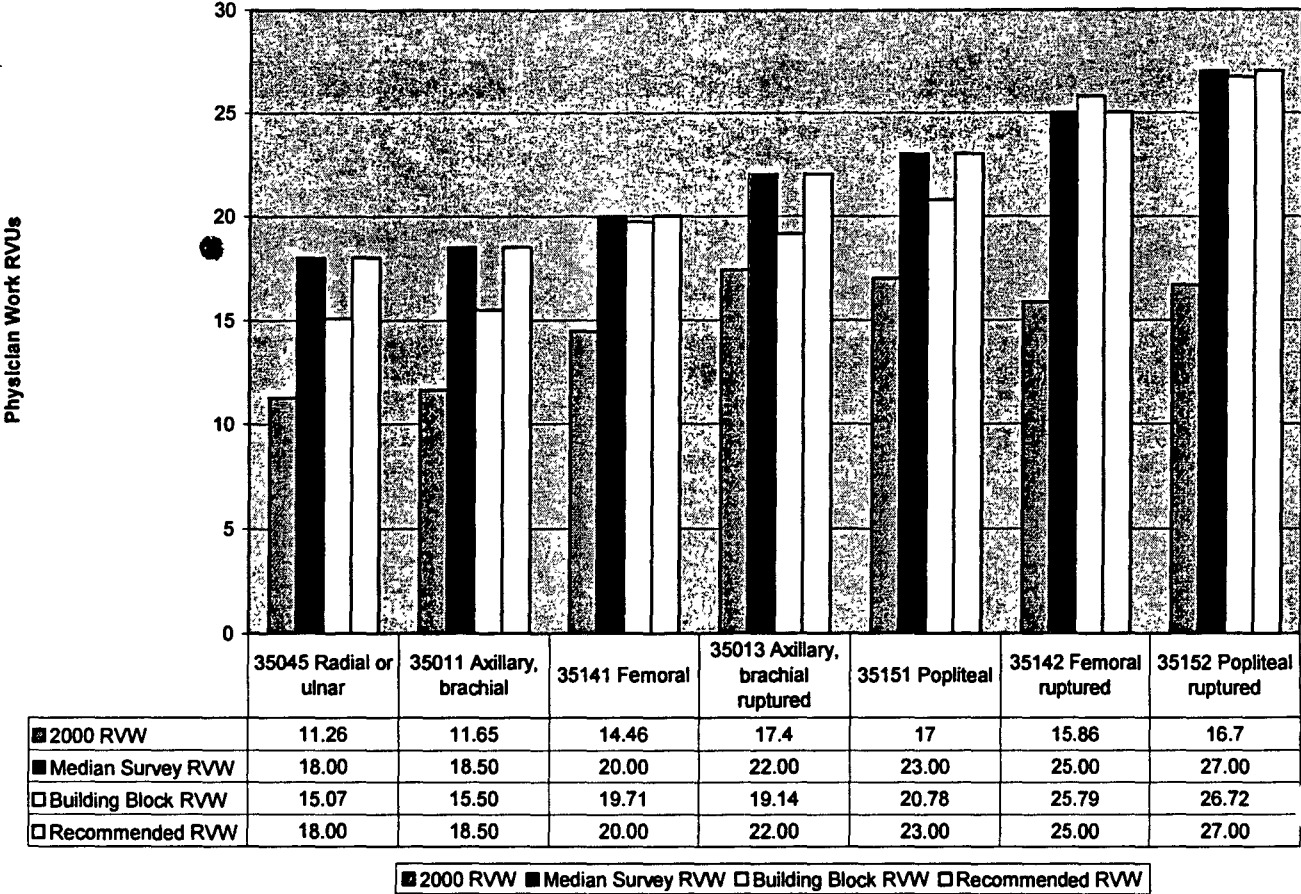
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Family 9 Embolectomy / Thrombectomy by extremity incision



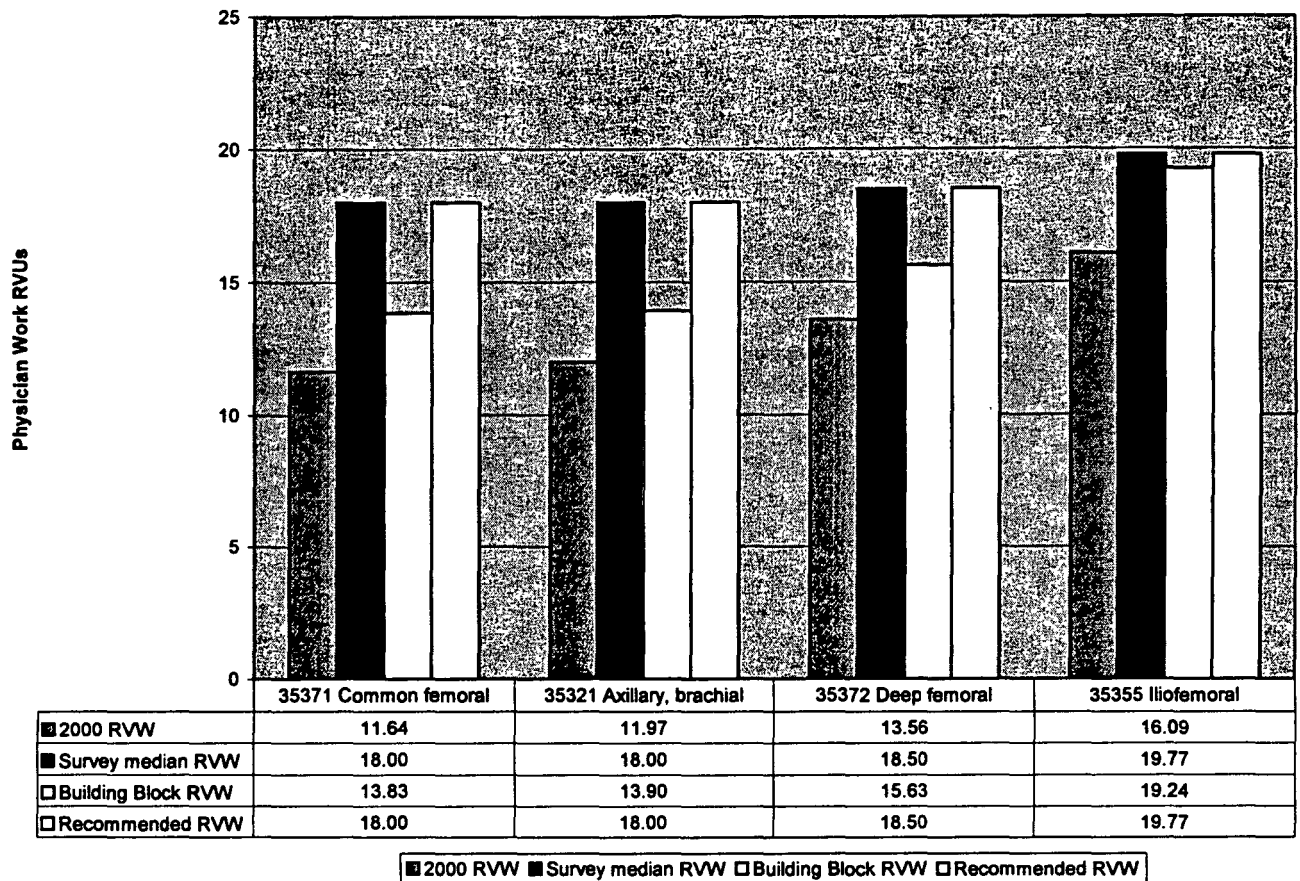
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Family 10 Aneurysm Repairs in the Extremity



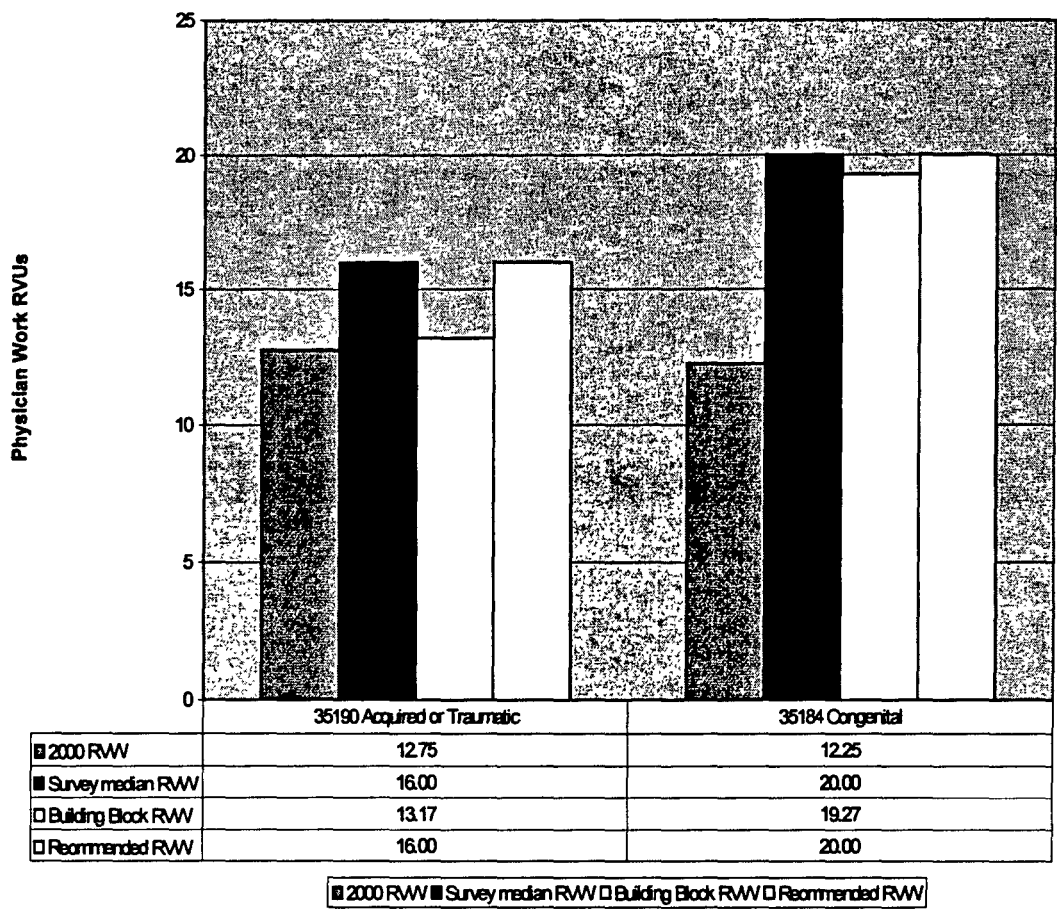
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Family 11 Endarterectomy of Extremity Arteries



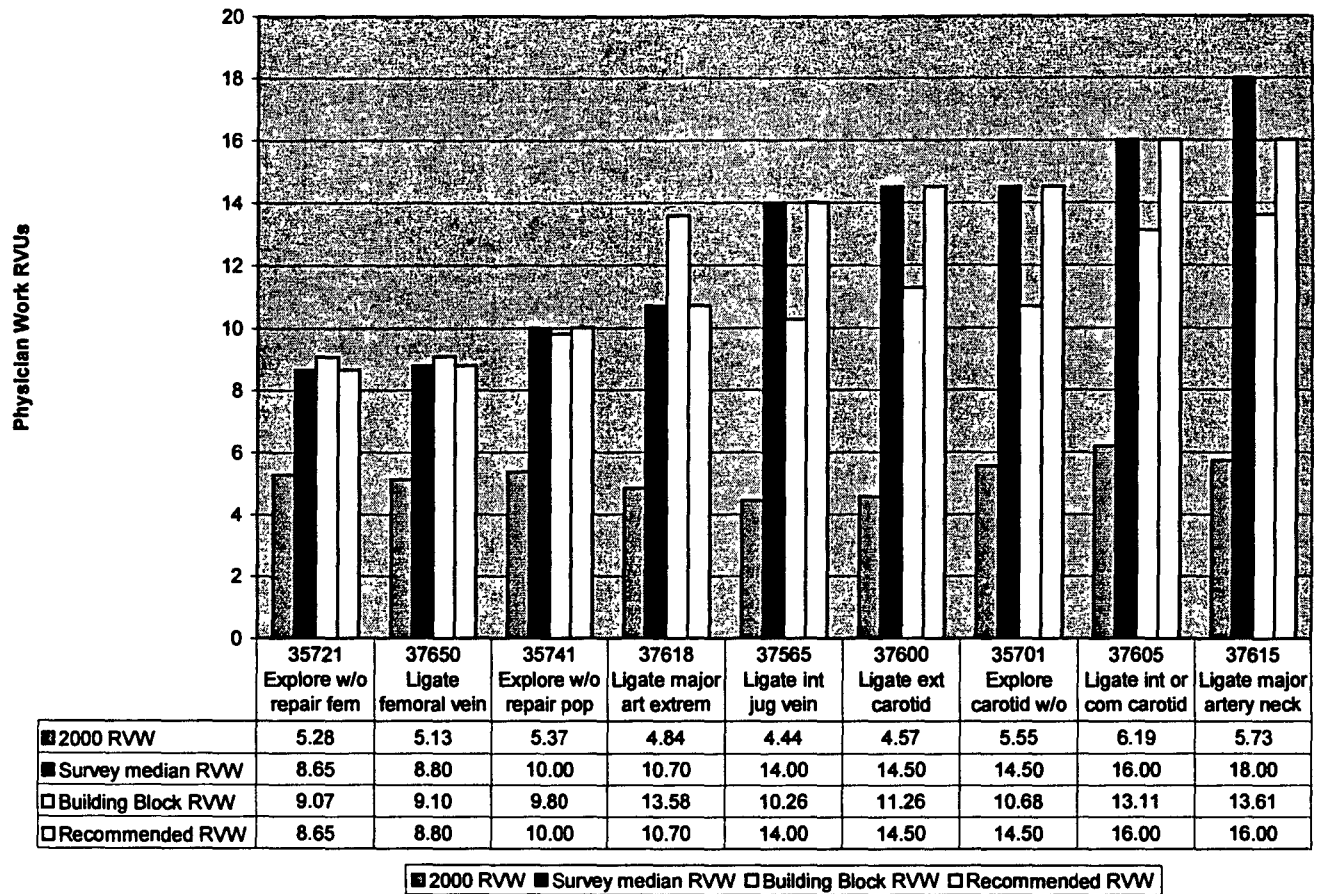
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Family 12 Arteriovenous Fistula Repairs in the Extremities



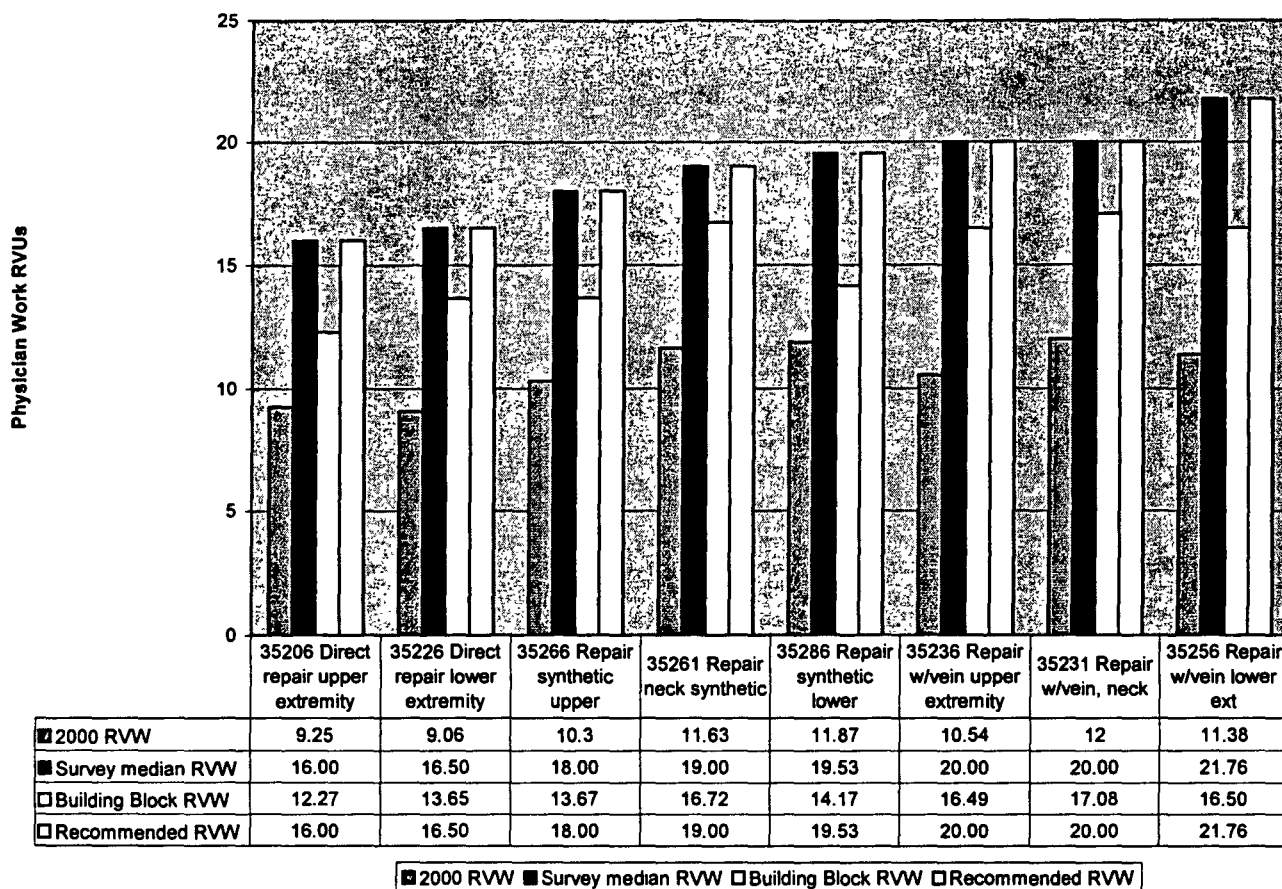
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Family 13 Peripheral Artery and Vein Ligations



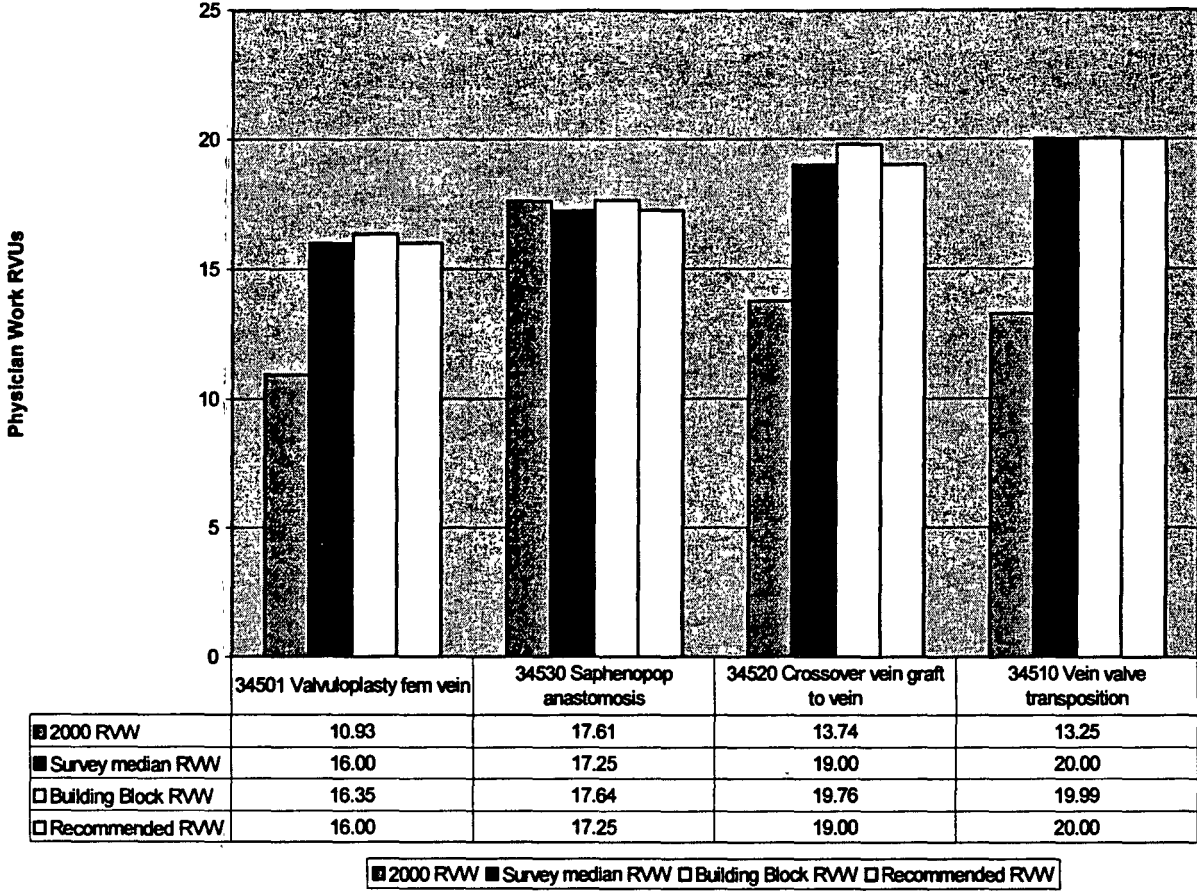
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Family 14 Vessel Repairs in Extremities and Neck



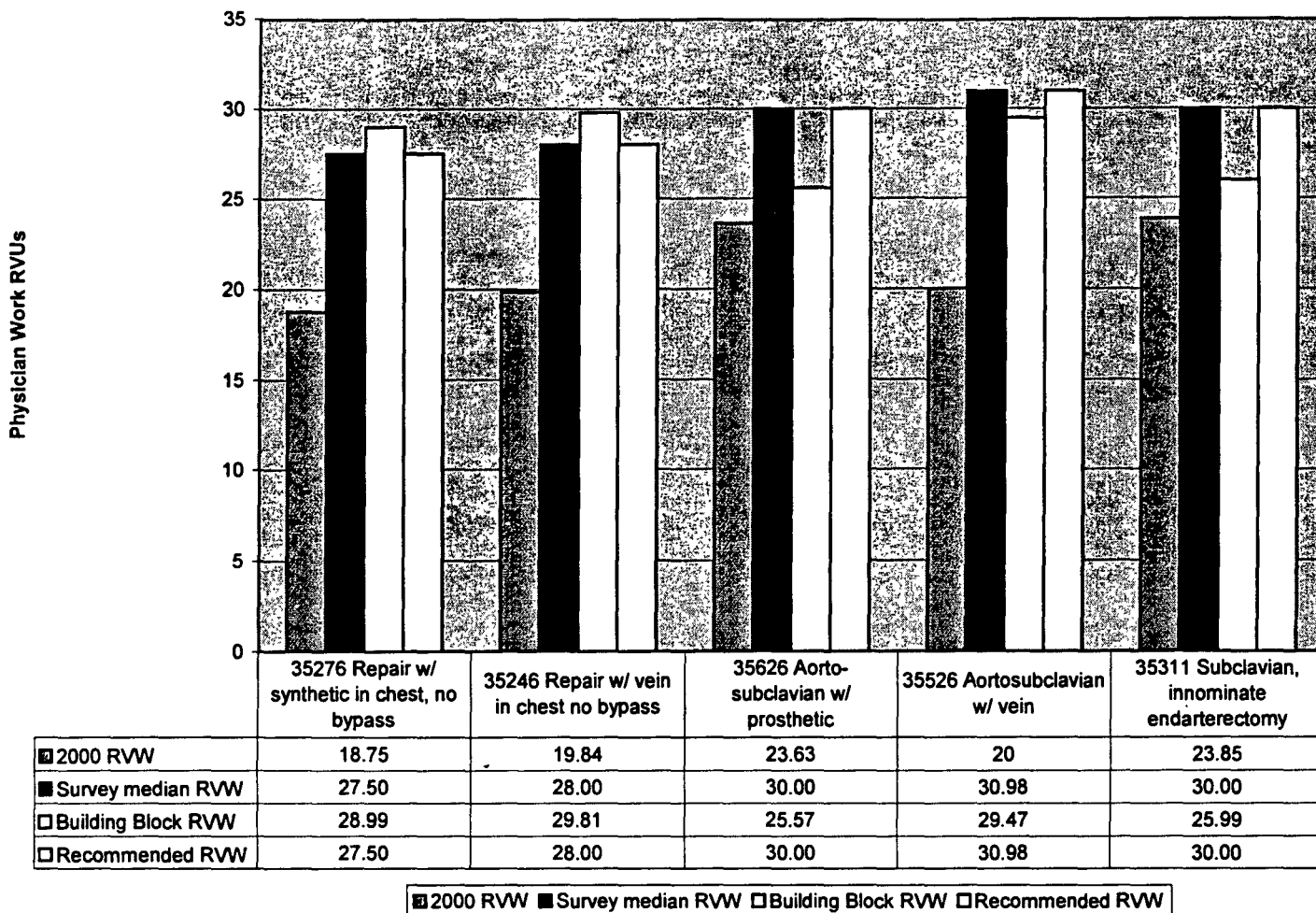
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Family 15 Reconstructions for Chronic Venous Disease



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Family 16 Repairs, Bypass Grafts, Endarterectomies in the Chest



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RVW Summary Recommendations in CPT Code Order

The following section contains individual summary recommendations for each of the codes submitted to the five-year review by the Society for Vascular Surgery and the American Association for Vascular Surgery.



CPT 34101

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

CPT Code: 34101

Global Period: 090

RUC Rec. RVW: 10.00

SVS Rec. RVW: 11.50

Median Survey RVW: 11.50

Building Block RVW: 10.79

2000 RVW: 9.97

CPT Descriptor: Embolectomy or thrombectomy, with or without catheter, axillary, brachial, innominate, subclavian artery, by arm incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old female arrives in the ED with a severely painful arm and numbness of her hand. Symptom onset was sudden and occurred 3 hours prior to arrival. Exam reveals a cold and pulseless limb. Cardiac rhythm is irregular, and ECG confirms atrial fibrillation not present on a study performed one month earlier. Pre-service work includes emergent review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. An emergent embolectomy is performed. Post-service work includes immediate postoperative care starting after skin closure, plus all subsequent related in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in arm
- Dissect soft tissue to find artery
- Encircle artery with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery
- Open artery with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close arteriotomy with extra-fine suture (typically 6-0 polypropylene)
- Listen with Doppler to assure restitution of flow to arm and hand
- Achieve hemostasis
- Irrigate wound

- Close soft-tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, blood flow to end-organs, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiogram performed prior to passage of balloon catheters

CPT 34101 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 113

Response Rate: 30 (27%)

.27

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	7.00	10.00	11.50	13.00	18.70
Pre-Service			75		
Intra-Service Time	30	60	60	75	120

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	68	99232x1, 99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.13	090	35875	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);

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

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

	Survey CPT 34101 (n=30)	Ref CPT 35875 (n=10)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	75	70
Intra-service time	60	60
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	68
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.38	3.44
Intra-service	3.14	3.44
Post-service	2.90	3.11

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.20
Urgency of medical decision making	4.37	3.78

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.27	3.70
Physical effort required	2.90	3.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.80	4.10
Outcome depends on the skill and judgment of physician	3.77	4.20
Estimated risk of malpractice suit with poor outcome	4.00	3.80

CPT 34101 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC survey

CPT Code 34101

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	60	0.075	4.50
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.37
Total RVW by Building Block Method =			10.79

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CPT 34101 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Sometimes

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

3,095	general surgery	4	cma, anesthesia assistant
1,480	vascular surgery	4	nephrology
960	thoracic surgery	4	nuclear medicine
354	diagnostic radiology	3	colorectal surgery
204	cardiac surgery	3	surgical oncology
116	clinic or group practice (not gppp)	2	emergency medicine
70	cardiology	2	hand surgery
46	internal medicine	2	plastic & reconstructive surgery
43	peripheral vascular disease	1	ASC
39	interventional radiology	1	dermatology
18	general practice	1	orthopaedic surgery
13	family practice	1	osteopathic manipulative therapy

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions: (first number is survey; second number is consensus committee)

Has the work of performing this service changed in the past 5 years?

1 0 Yes
4 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
1 0 I do not agree

Patients requiring this service are now:

1 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
1 0 no change

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

CPT Code: 34111	Global Period: 090	RUC Rec. RVW:	10.00
		SVS Rec. RVW:	10.50
		Median Survey RVW:	10.50
		Building Block RVW:	10.79
		2000 RVW:	8.07

CPT Descriptor: Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision.

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established. This mini-survey was included along with a full RUC survey for a very similar service, CPT 34101 (embolectomy or thrombectomy, with or without catheter, axillary, brachial, innominate, subclavian artery, by arm incision).

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in arm
- Dissect soft tissue to find artery
- Encircle artery with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery
- Open artery with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close arteriotomy with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow to hand
- Achieve hemostasis
- Irrigate wound
- Close soft-tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, blood flow to end-organs, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiogram performed prior to passage of balloon catheters
- Fasciotomies, if required

CPT 34111 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 114 **Response Rate:** 56 (50%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.00	10.00	10.50	13.00	18.70
Pre-Service Time			60		
Intra-Service Time			60		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	68	99232x1 99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

CPT 34111 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 34111

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			0.92
Intra-service	60	0.075	4.50
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.37
Total RVW by Building Block Method =			10.79

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CPT 34111 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

350	general surgery	5	hand surgery
203	vascular surgery	5	peripheral vascular disease
92	diagnostic radiology	4	cardiology
92	thoracic surgery	3	colorectal surgery
26	cardiac surgery	2	pathology
20	interventional radiology	2	pulmonary disease
13	clinic or group practice (not gppp)	1	critical care (intensivists)
7	orthopaedic surgery	1	emergency medicine
7	plastic & reconstructive surgery	1	family practice
5	general practice		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

4	0	Yes
25	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
4	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
2	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
1	0	from inpatient to outpatient
3	0	no change

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

CPT Code: 34151	Global Period: 090	RUC Rec. RVW: 25.00
		SVS Rec. RVW: 28.00
		Median Survey RVW: 28.00
		Building Block RVW: 22.78 (Using survey median data)
		Building Block RVW: 27.28 (Using actual skin-to-skin intra)
		2000 RVW: 16.86

CPT Descriptor: Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery by abdominal incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 80-year-old female with new onset atrial fibrillation has a two-hour history of excruciating abdominal pain. Emergent angiography reveals an embolus occluding her superior mesenteric artery. Pre-service work includes immediate review of all preoperative studies, expedited informed consent from patient, brief discussion with family, anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent embolectomy is performed. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in abdomen
- Explore abdomen to assess bowel viability and examine all organs for pathology
- Dissect soft tissue to find artery
- Encircle artery with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery
- Open artery with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed

- Close arteriotomy with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow to end-organs
- Achieve hemostasis
- Irrigate wound & close fascia
- Irrigate subcutaneous tissue & close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, blood flow to end-organs, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiogram performed prior to passage of balloon catheters
- Resection of gangrenous bowel
- Performance of ileostomy, colostomy, Hartmann's pouch, etc.

CPT 34151 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 98 **Response Rate:** 30 (31%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	20.01	25.00	28.00	29.38	35.00
Pre-Service Time			75		
Intra-Service Time	90	133	150	180	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	136	99232x2 99231x4
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1 99212x2

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

	Survey CPT 34151 (n=30)	Ref CPT 35081 (n=17)
TIME ESTIMATES (MEDIAN)		
Pre-service time	75	90
Intra-service time	150	160
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	136	136
Discharge management time	36	36
Total office visit time	53	61

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

Pre-service	4.57	3.71
Intra-service	4.40	4.53
Post-service	4.00	3.65

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.50	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	3.82
Urgency of medical decision making	5.00	3.31

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.57	4.24
Physical effort required	4.27	4.12

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.83	4.00
Outcome depends on the skill and judgment of physician	4.70	4.29
Estimated risk of malpractice suit with poor outcome	3.83	3.71

CPT 34151 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: We used the following Building Block Methods to justify the survey data. This is a rarely performed service that has not changed in work over the past five years. We believe this service was never valued appropriately in the original Harvard studies. This is a very complex operation that is almost always performed emergently on elderly patients with advanced comorbidities.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 34151

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.022	0.00
Same day evaluation	40	0.022	0.90
Scrub, prep	30	0.008	0.24
Pre-service total			1.14
Intra-service	150	0.090	13.50
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.14
Total RVW by Building Block Method =			22.78

Building Block Method Using Actual Skin-to-Skin Time.

This is a rarely performed service for which the survey respondents estimated an intra-service time of 150 minutes. We were suspicious that this estimate is low, and we reviewed our database of 5,000 operations conducted by 31 vascular surgeons during 1999. From this data we culled only two cases of 34151, and the median intra-service time was 200 minutes. The following Building Block table was calculated exactly as above but with the substitution of 200 minutes for intra-service time.

Building Block Method

Intra-service Intensity is from SVS/AAVS Intensity Survey

Intra-service time is from actual skin-to-skin data

All Other time and visit data from full RUC survey

CPT Code 34151

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	40	0.0224	0.90
Scrub, prep	30	0.0081	0.24
Pre-service total			1.14
Intra-service	200	0.090	18.00
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.14
Total RVW by Building Block Method =			27.28

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CPT 34151 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

260	general surgery	4	peripheral vascular disease
104	vascular surgery	2	general practice
45	thoracic surgery	2	urology
26	clinic or group practice (not gppp)	1	anesthesiology
7	cardiac surgery	1	hematology/oncology
5	cardiology	1	plastic & reconstructive surgery
5	diagnostic radiology	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 34201	Global Period: 090	RUC Rec. RVW:	10.03
		SVS Rec. RVW:	11.50
		Median Survey RVW:	11.50
		Building Block RVW:	12.89
		2000 RVW:	9.13

CPT Descriptor: Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 65-year-old female arrives in the ED with a severely painful leg, numbness of her foot, and inability to wiggle her toes. Symptom onset was sudden and occurred 3 hours prior to arrival. Exam reveals a cold and pulseless limb. Cardiac rhythm is irregular, and ECG confirms atrial fibrillation not present on a study performed one month earlier. Pre-service work includes emergent review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. An emergent balloon-catheter embolectomy is performed. Post-service work includes immediate postoperative care starting after skin closure, all subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in leg
- Dissect soft tissue to find artery
- Encircle artery with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery
- Open artery with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close arteriotomy with extra-fine suture (typically 6-0 polypropylene)
- Listen with Doppler to assure restitution of flow to leg and foot
- Reverse anticoagulation and achieve hemostasis
- Irrigate wound
- Close soft-tissue

- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, blood flow to end-organs, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiogram performed prior to passage of balloon catheters
- Fasciotomies if required

CPT 34201 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 93 **Response Rate:** 30 (32%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	10.03	11.50	16.00	19.00
Pre-Service Time			75		
Intra-Service Time	45	60	75	90	180

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232X1 99231X3
Discharge Day Mgmt	36	99238
Office Visits	38	99213X1 99212X1

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CPT 34201 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.13	090	35875	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);

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

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

	Survey CPT 34201 (n=30)	Ref CPT 35875 (n=14)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	75	65
Intra-service time	75	78
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	68
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.61	3.29
Intra-service	3.50	3.31
Post-service	3.04	2.69

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.21
Urgency of medical decision making	4.43	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.40	3.62
Physical effort required	3.23	3.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.97	3.57
Outcome depends on the skill and judgment of physician	3.80	3.71
Estimated risk of malpractice suit with poor outcome	3.90	3.64

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CPT 34201 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: This service has not changed substantially over the last five years. We are submitting it to the five-year review process because we believe it was not valued appropriately during the original Harvard studies. The following building block approach adds validity to the RUC survey data.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 34201

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	45	0.022	1.01
Scrub, prep	30	0.008	0.24
Pre-service total			1.25
Intra-service	75	0.075	5.63
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.01
Total RVW by Building Block Method =			12.89

CPT 34201 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

4,058	general surgery	7	surgical oncology
2,250	vascular surgery	6	emergency medicine
1,411	thoracic surgery	6	plastic & reconstructive surgery
458	cardiac surgery	5	nuclear medicine
319	clinic or group practice (not gppp)	4	anesthesiology
125	cardiology	4	pulmonary disease
66	peripheral vascular disease	3	obstetrics/gynecology
55	diagnostic radiology	2	hand surgery
34	general practice	2	orthopaedic surgery
19	internal medicine	2	pathology
17	family practice	2	urology
15	interventional radiology		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
7 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 34203	Global Period: 090	RUC Rec. RVW:	16.50
		SVS Rec. RVW:	16.50
		Median Survey RVW:	16.50
		Building Block RVW:	16.45
			(Using median survey data)
		Building Block RVW:	18.54
			(Using actual skin-to-skin intra)
		2000 RVW:	12.21

CPT Descriptor: Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old male arrives in the ED with a severely painful distal calf, numbness of his foot, and inability to wiggle his toes. Symptom onset was sudden and occurred 3 hours prior to arrival. Exam reveals palpable femoral and popliteal pulses, but no ankle or foot pulses. His foot is pale and cold with decreased sensation and motion. Cardiac rhythm is irregular, and ECG confirms atrial fibrillation not present on a study performed one month earlier. Pre-service work includes emergent review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. An emergent balloon-catheter embolectomy is performed through a below-knee incision. Post-service work includes immediate postoperative care starting after skin closure, all subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in leg
- Dissect soft tissue to find artery
- Encircle artery with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery

- Open artery with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close arteriotomy with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow to leg and foot
- Reverse anticoagulation and achieve hemostasis
- Irrigate wound & Close soft-tissue & skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & patient (following emergence from anesthesia)
- Late post-operative check on day of surgery
- Daily attention to wounds, blood flow to end-organs, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiogram performed prior to passage of balloon catheters
- Fasciotomies if required

CPT 34203 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 164 **Response Rate:** 34 (21%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.50	15.00	16.50	18.00	28.39
Pre-Service Time			75		
Intra-Service Time	45	88	108	150	200

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1 99231x3
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 34203 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
17.00	090	35876	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 34203 (n=34)	Ref CPT 35876 (n=7)
Pre-service time	75	90
Intra-service time	108	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	87
Discharge management time	36	36
Total office visit time	61	61

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

Pre-service	3.85	3.86
Intra-service	3.88	4.43
Post-service	3.21	3.29

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.82	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	3.86
Urgency of medical decision making	4.58	4.29

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.91	4.14
Physical effort required	3.55	3.71

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.97	4.00
Outcome depends on the skill and judgment of physician	4.12	4.43
Estimated risk of malpractice suit with poor outcome	3.82	4.00

CPT 34203 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed substantially over the last five years. Rather, we believe it was never valued appropriately during the extrapolations of the original Harvard studies. The following Building Block Method lends credence to our RUC survey data.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 34203

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	45	0.022	1.01
Scrub, prep	30	0.008	0.24
Pre-service total			1.25
Intra-service	108	0.079	8.53
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.66
Total RVW by Building Block Method =			16.45

The following building block analysis was calculated using actual skin-to-skin intra-service time of 134.5 minutes (n=6) culled from our database of 5,000 vascular surgery procedures performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-time is actual skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code 34203

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	45	0.0224	1.01
Scrub, prep	30	0.0081	0.24
Pre-service total			1.25
Intra-service	134.5	0.079	10.63
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.66
Total RVW by Building Block Method =			18.54

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CPT 34203 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

916	general surgery	6	plastic & reconstructive surgery
737	vascular surgery	4	emergency medicine
257	thoracic surgery	4	internal medicine
82	clinic or group practice (not gppp)	3	hand surgery
63	cardiac surgery	2	family practice
40	cardiology	1	addiction medicine
24	peripheral vascular disease	1	orthopaedic surgery
23	diagnostic radiology		
10	interventional radiology	8	general practice

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
8 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 34401	Global Period: 090	RUC Rec. RVW:	25.00
		SVS Rec. RVW:	28.00
		Median Survey RVW:	28.00
		Building Block RVW:	22.78
		(Using median survey data)	
		2000 RVW:	12.86

CPT Descriptor: Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service. 1998 frequency for this survey was <1,000. Based on our five-year review plan, a RUC-approved mini-survey was performed rather than a complete RUC survey. In the mini-survey RVW was estimated based on CPT descriptor rather than clinical vignette, and no clinical vignette has been established.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in abdomen
- Explore abdomen and examine all organs for pathology
- Mobilize bowel and dissect soft tissue to find vena cava
- Dissect soft tissue around cava
- Ligate and divide small venous branches
- Encircle cava with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to cava
- Open cava with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close cavotomy with extra-fine suture (typically 6-0 polypropylene)
- Listen with Doppler to assure restitution of flow
- Reverse anticoagulation and achieve hemostasis
- Irrigate wound
- Close abdominal fascia

- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram performed prior to passage of balloon catheters
- Placement of vena cava filter
- Performance of distal arteriovenous fistula to enhance caval patency

CPT 34401 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 98 **Response Rate:** 27 (28%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	22.00	28.00	28.00	35.00
Pre-Service Time			70		
Intra-Service Time			150		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	136	99232x2 99231x4			
Discharge Day Mgmt	36	99238			
Office Visits	53	99213x1 99212x2			

CPT 34401 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed substantially over the past five years. Rather we believe this service was never valued appropriately during the original Harvard / Hsiao studies. The following building block approach substantiates the mini-survey data.

Building Block Method

Intra-service Intensity from SVS/AAVS Intensity Survey
 Other intensity factors from original Harvard / Stone formula
 All time and visit data from mini-survey / Consensus Panel

CPT Code 34401

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	40	0.0224	0.90
Scrub, prep	30	0.0081	0.24
Pre-service total			1.14
Intra-service	150	0.090	13.50
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.14
Total RVW by Building Block Method =			22.78

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CPT 34401 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

38	general surgery	5	clinic or group practice (not gppp)
27	vascular surgery	1	cardiology
12	urology	1	general practice
9	diagnostic radiology	1	interventional radiology
8	thoracic surgery	1	pulmonary disease
6	cardiac surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions: (first number is survey; second number is consensus committee)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 34421	Global Period: 090	RUC Rec. RVW:	12.00
		SVS Rec. RVW:	15.00
		Median Survey RVW:	15.00
		Building Block RVW:	15.81
		2000 RVW:	9.93

CPT Descriptor: Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service. 1998 Medicare frequency for this survey was <1,000. A RUC-approved mini-survey was used to evaluate this service. No vignette was established.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in leg
- Dissect soft tissue to find femoral vein
- Carefully dissect soft tissue surrounding femoral vein
- Ligate and divide small venous branches
- Encircle femoral vein and major branches with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps
- Open vein with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close venotomy with extra-fine suture (typically 6-0 polypropylene)
- Listen with Doppler to assure restitution of flow
- Reverse anticoagulation and achieve hemostasis
- Irrigate wound
- Close soft tissue around vein
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram performed prior to passage of balloon catheters
- Placement of vena cava filter
- Performance of distal arteriovenous fistula to enhance venous patency

CPT 34421 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 164 **Response Rate:** 52 (32%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	12.00	15.00	18.00	25.00
Pre-Service Time			70		
Intra-Service Time			95		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	117	99232x2 99231x3			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

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CPT 34421 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service is the same or has become slightly more complex over the last 5 years (see data below). We believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 34421

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	40	0.0224	0.90
Scrub, prep	30	0.0081	0.24
Pre-service total			1.14
Intra-service	95	0.080	7.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.07
Total RVW by Building Block Method =			15.81

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Five-Year Review Specific Questions:

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:
[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

103	vascular surgery	7	peripheral vascular disease
80	general surgery	5	cardiology
63	thoracic surgery	4	internal medicine
46	diagnostic radiology	2	family practice
27	interventional radiology	1	orthopaedic surgery
11	clinic or group practice (not gppp)	1	pediatric medicine
8	cardiac surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions:
(first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
33	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
3	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
3	0	no change

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

CPT Code: 34451	Global Period: 090	RUC Rec. RVW:	27.00
		SVS Rec. RVW:	28.00
		Median Survey RVW:	28.00
		Building Block RVW:	25.12
		2000 RVW:	14.44

CPT Descriptor: Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service. 1998 frequency for this survey was <1,000. Based on our five-year review plan, a RUC-approved mini-survey was performed rather than a complete RUC survey. No clinical vignette has been established.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in abdomen
- Explore abdomen and examine all organs for pathology
- Mobilize bowel and dissect soft tissue to find vena cava
- Carefully dissect soft tissue surrounding cava
- Ligate and divide small venous branches
- Encircle cava with soft rubber loops
- Skin incision in leg
- Dissect soft tissue to find femoral vein
- Carefully dissect soft tissue surrounding femoral vein
- Encircle vein with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to cava
- Open cava with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close cavotomy with extra-fine suture (typically 6-O polypropylene)
- Apply vascular clamps to femoral vein
- Pass balloon catheters proximally and distally until all clot has been removed

- Close venotomy with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow
- Reverse anticoagulation and achieve hemostasis
- Irrigate abdominal cavity
- Close abdominal fascia
- Irrigate subcutaneous tissue
- Close abdominal skin
- Close soft tissue in leg
- Irrigate subcutaneous tissue & close skin at leg incision

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram performed prior to passage of balloon catheters, if performed
- Placement of vena cava filter, if performed
- Performance of distal arteriovenous fistula to enhance caval patency, if performed

CPT 34451 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): SVS – AAVS

Sample Size: 98

Response Rate: 26 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.00	25.00	28.00	30.00	35.00
Pre-Service			70		
Intra-Service			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	136	99232x2 99231x4			
Discharge Day Mgmt	36	99238			
Office Visits	53	99212x1 99212x2			

CPT 34451 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this very rarely performed service has not changed substantially over the past five years. Rather, we believe it was not valued appropriately during the original Harvard / Hsiao studies. The following building block approach lends credence to our mini-survey data and supports the requested RVW.

Building Block Method

Intra-service Intensity is median value of SVS/AAVS Intensity Survey
 Other intensity factors from original Harvard / Stone formula
 All time and visit data from mini-survey / Consensus Panel

CPT Code 34451

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	40	0.0224	0.90
Scrub, prep	30	0.0081	0.24
Pre-service total			1.14
Intra-service	180	0.088	15.84
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.14
Total RVW by Building Block Method =			25.12

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CPT 34451 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

24	general surgery	1	anesthesiology
7	vascular surgery	1	cardiac surgery
6	thoracic surgery	1	cardiology
3	interventional radiology	1	diagnostic radiology
2	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 34490	Global Period: 090	RUC Rec. RVW:	9.86
		SVS Rec. RVW:	10.50
		Median Survey RVW:	10.50
		Building Block RVW:	13.76
		2000 RVW:	7.60

CPT Descriptor: Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old woman complains of a massively painful swollen left upper extremity. Noninvasive studies confirm axillary and subclavian venous thrombosis. Her arm becomes increasingly symptomatic on heparin, and she has a contraindication to thrombolytic therapy. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's medical comorbidities with anesthesia, patient positioning, scrub, prep, and drape. At operation an axillary and subclavian venous thrombectomy is performed through an arm incision. Post-service work includes post-operative in-hospital care plus related outpatient care for 90 days.

Description of Pre-Service Work:

Since this is typically an emergent service, Pre-Service Work usually begins on the day or night of surgery after the decision to operate. Pre-service work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dressing for OR, ensuring all necessary equipment is present, positioning the patient, and performing scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in arm
- Dissect soft tissue to locate vein
- Carefully dissect soft tissue from sides of vein
- Ligate and divide small venous branches
- Encircle vein and major branches with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps
- Open vein with fine scalpel
- Pass balloon catheters proximally and distally until all clot has been removed
- Close venotomy with extra-fine suture (typically 6-0 polypropylene)
- Listen with Doppler to assure restitution of flow
- Reverse anticoagulation and achieve hemostasis
- Irrigate wound

- Close soft tissue around vein
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram performed prior to passage of balloon catheters
- Placement of vena cava filter
- Performance of distal arteriovenous fistula to enhance venous patency

CPT 34490 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 92 **Response Rate:** 30 (33%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	10.00	10.50	12.00	25.00
Pre-Service Time			80		
Intra-Service Time	45	60	80	98	180

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1 99231x3
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 34490 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.13	090	35875	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula)

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 34490 (n=30)	Ref CPT 35875 (n=18)
Pre-service time	80	95
Intra-service time	80	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	68
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.62	3.38
Intra-service	3.69	3.56
Post-service	3.15	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	3.39
Urgency of medical decision making	3.83	3.83

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.59	3.44
Physical effort required	3.28	3.22

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.76	4.00
Outcome depends on the skill and judgment of physician	3.90	3.89
Estimated risk of malpractice suit with poor outcome	3.93	3.83

CPT 34490 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this very rarely performed service has not changed substantially over the past five years. Rather, we believe it was not valued appropriately during the original Harvard / Hsiao studies. The following building block approach lends credence to our survey data and supports the requested RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 34490

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.022	0.67
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			1.59
Intra-service	80	0.077	6.16
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.01
Total RVW by Building Block Method =			13.76

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CPT 34490 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods –80 (assistant), -55 (post-op only), -56 (pre-op only)].

332	general surgery	5	peripheral vascular disease
311	vascular surgery	5	urology
253	thoracic surgery	3	crna, anesthesia assistant
212	diagnostic radiology	3	hematology/oncology
108	interventional radiology	1	anesthesiology
50	clinic or group practice (not gppp)	1	hand surgery
37	cardiac surgery	1	plastic & reconstructive surgery
8	general practice	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
26	7	No

This service represents new technology that has become more familiar (i.e., less work).

1	0	I agree
2	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
3	0	no change

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

CPT Code: 34501	Global Period: 090	RUC Rec. RVW:	16.00
		SVS Rec. RVW:	16.00
		Median Survey RVW:	16.00
		Building Block RVW:	16.35
		(Using median survey data)	
		2000 RVW:	10.93

CPT Descriptor: Valvuloplasty, femoral vein

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service. 1998 Medicare frequency for this survey was <1,000. Based on our five-year review plan, a RUC-approved mini-survey was performed rather than a complete RUC survey. In the mini-survey RVW was estimated based on CPT descriptor rather than clinical vignette, and no clinical vignette has been established.

Description of Pre-Service Work:

Pre-Service Work usually begins the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in thigh
- Dissect soft tissue to find femoral vein
- Carefully dissect soft tissue surrounding femoral vein at valve site
- Ligate and divide small venous branches
- Encircle femoral vein and major branches with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps
- Open vein with fine scalpel
- Repair vein valve using extra-fine suture (typically 7-O polypropylene)
- Close venotomy with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow
- Possible reverse anticoagulation
- Achieve hemostasis
- Irrigate wound
- Close soft tissue around vein
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram performed prior to venotomy
- Placement of vena cava filter
- Performance of distal arteriovenous fistula to enhance venous patency

CPT 34501 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 142

Response Rate: 53 (37%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	12.75	16.00	20.00	28.00
Pre-Service Time			90		
Intra-Service Time			120		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	49	99232x1 99231x1			
Discharge Day Mgmt	36	99238			
Office Visits	53	99213x1 99212x2			

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CPT 34501 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service may have become more complex over the last 5 years (see questions below). In addition we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is Median Value from SVS/AAVS Intensity Survey

Other intensity values from original Harvard / Stone formula

All time and visit data from Mini-survey/Consensus panel

CPT Code 34501

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	120	0.080	9.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.16
Total RVW by Building Block Method =			16.35

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CPT 34501 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

38	thoracic surgery	2	clinic or group practice (not gppp)
21	general surgery	1	neurology
16	vascular surgery		
5	cardiac surgery		
3	cardiology		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

6	0	Yes
30	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
6	0	I do not agree

Patients requiring this service are now:

5	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
6	0	no change

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

CPT Code: 34510	Global Period: 090	RUC Rec. RVW:	18.95
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	19.99
		2000 RVW:	13.25

CPT Descriptor: Venous valve transposition, any vein donor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 30-year-old male is disabled by chronic leg swelling and recalcitrant venous ulceration due to chronic venous valvular insufficiency. Noninvasive and venographic work-up reveals patent deep veins with severe reflux through incompetent venous valves. Pre-service work includes review of all preoperative studies, review of risk/benefit analysis with patient and family, final discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Typical intra-service work is harvest of an axillary vein valve and subsequent implantation in the popliteal venous system. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-Service Work usually begins the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision behind knee
- Dissect soft tissue to find popliteal vein
- Carefully dissect soft tissue surrounding popliteal vein at valve site
- Ligate and divide small venous branches
- Encircle popliteal vein and major branches with soft rubber loops
- Skin incision at axillary vein harvest site
- Dissect soft tissue to find axillary vein
- Carefully dissect soft tissue from sides of vein
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps at axillary vein valve harvest site
- Excise segment of vein that contains valve with fine scalpel
- Reanastomose transected axillary vein using extra-fine suture (typically 7-0 polypropylene)
- Apply vascular clamps to popliteal vein at valve insertion site
- Divide popliteal vein

- Sew axillary vein segment into place with extra-fine suture (typically 6-O polypropylene)
- Listen with Doppler to assure restitution of flow
- Possibly reverse anticoagulation
- Achieve hemostasis & Irrigate wounds
- Close soft tissue at both sites
- Irrigate subcutaneous tissue & Close skin at both sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, patency of reconstruction, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram, if performed prior to venotomy
- Performance of distal arteriovenous fistula to enhance venous patency, if performed

CPT 34510 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): SVS – AAVS

Sample Size: 142

Response Rate: 30 (21%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	18.95	20.00	22.00	27.00
Pre-Service Time			95		
Intra-Service Time	40	120	150	180	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	68	99232X1 99231X2
Discharge Day Mgmt	36	99238
Office Visits	53	99213X1 99212X2

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CPT 34510 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
18.00	090	35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition

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

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

	Survey CPT 34510 (n=30)	Ref CPT 35881 (n=12)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	95	90
Intra-service time	150	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	49
Discharge management time	36	36
Total office visit time	53	38

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

Pre-service	3.68	3.27
Intra-service	3.71	3.27
Post-service	3.18	2.91

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.03	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.33
Urgency of medical decision making	2.72	3.17

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.17	3.83
Physical effort required	3.38	3.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.66	3.67
Outcome depends on the skill and judgment of physician	4.14	3.92
Estimated risk of malpractice suit with poor outcome	3.34	3.33

CPT 34510 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service is unchanged or may have become more complex over the last 5 years (see Five-year Review Questions below). In addition we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 34510

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.022	0.67
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			1.59
Intra-service	150	0.084	12.60
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.80
Total RVW by Building Block Method =			19.99

CPT 34510 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

17	cardiac surgery	3	vascular surgery
5	general surgery	1	anesthesiology
4	thoracic surgery	1	cardiology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
6	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
1	0	I do not agree

Patients requiring this service are now:

1	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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

CPT Code: 34520	Global Period: 090	RUC Rec. RVW:	17.95
		SVS Rec. RVW:	19.00
		Median Survey RVW:	19.00
		Building Block RVW:	19.76
		2000 RVW:	13.74

CPT Descriptor: Cross-over vein graft to venous system

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey**

This is a rarely performed service. 1998 Medicare frequency for this survey was <1,000. Based on our five-year review plan, a RUC-approved mini-survey was performed rather than a complete RUC survey. In the mini-survey the RVW was estimated based on CPT descriptor rather than clinical vignette, and no clinical vignette has been established.

Description of Pre-Service Work:

Pre-Service Work usually begins the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in both groins, extending to knee on saphenous vein harvest side
- Dissect soft tissue to find saphenous vein on harvest side
- Carefully dissect soft tissue surrounding full length of saphenous vein in thigh
- Ligate and divide all saphenous vein branches
- Dissect soft tissue to find femoral vein on opposite side
- Carefully dissect soft tissue surrounding a short segment of femoral vein
- Encircle femoral vein and major branches with soft rubber loops
- Create a subcutaneous tunnel between the two groin incisions
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Ligate and divide saphenous vein at knee level
- Pass divided end of saphenous vein through tunnel to opposite groin
- Apply vascular clamps to femoral vein
- Open femoral vein with fine scalpel
- Anastomose free end of saphenous vein to venotomy in femoral vein
- Remove clamps
- Listen with Doppler to assure restitution of flow
- Possibly reverse anticoagulation
- Achieve hemostasis

- Irrigate wounds
- Close soft tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, patency of reconstruction, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram prior to venotomy, if performed
- Performance of distal arteriovenous fistula to enhance venous patency, if performed

CPT 34520 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 142 **Response Rate:** 54 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.50	15.75	19.00	21.00	30.00
Pre-Service Time			90		
Intra-Service Time			143		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	38	99232X1 99231X2
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 34520 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service is unchanged or possibly has become more complex over the last five years (see Five-year Review Questions below). In addition we believe this service was not valued appropriately in the original Harvard / Hsiao studies. The following Building Block method helps justify our requested RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 34520

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.022	0.67
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			1.59
Intra-service	143	0.085	12.16
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.02
Total RVW by Building Block Method =			19.76

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CPT 34520 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

26	general surgery	5	clinic or group practice (not gppp)
17	cardiology	4	independently-billing clinical lab
14	vascular surgery	2	anesthesiology
6	family practice	2	otolaryngology
6	internal medicine	2	rheumatology
6	plastic & reconstructive surgery	1	orthopaedic surgery
6	thoracic surgery	1	pediatric medicine
5	cardiac surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3 0 Yes
32 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
3 0 I do not agree

Patients requiring this service are now:

2 0 more complex (more work)
0 0 less complex (less work)
1 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 34530	Global Period: 090	RUC Rec. RVW:	16.64
		SVS Rec. RVW:	17.25
		Median Survey RVW:	17.25
		Building Block RVW:	17.64
		2000 RVW:	17.61

CPT Descriptor: Saphenopopliteal vein anastomosis

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey**

This is a rarely performed service. 1998 Medicare frequency for this survey was <1,000. A RUC-approved mini-survey was performed rather than a full RUC survey. In the mini-survey the RVW was estimated based on CPT descriptor. No clinical vignette was established.

Description of Pre-Service Work:

Pre-Service Work usually begins on the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision from groin to below knee
- Dissect soft tissue in groin to find saphenous vein
- Carefully dissect soft tissue surrounding full length of saphenous vein in thigh
- Ligate and divide all saphenous vein branches
- Dissect soft tissue to find popliteal vein
- Carefully dissect soft tissue surrounding patent segment of popliteal vein
- Encircle popliteal vein and major branches with soft rubber loops
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Ligate and divide saphenous vein below knee
- Pass divided end of saphenous vein through dissected tissue to popliteal vein
- Apply vascular clamps to popliteal vein
- Incise popliteal vein with fine scalpel
- Anastomose free end of saphenous vein to opening in popliteal vein
- Remove clamps
- Listen with Doppler to assure restitution of flow
- Possibly reverse anticoagulation
- Achieve hemostasis
- Irrigate wounds
- Close soft tissue

- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressing
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, anticoagulation, patency of reconstruction, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic venogram prior to venotomy, if performed
- Creation of distal arteriovenous fistula to enhance venous patency, if performed

CPT 34530 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 142 **Response Rate:** 52 (37%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	15.25	17.25	20.00	30.00
Pre-Service Time			90		
Intra-Service Time			120		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	68	99232X1 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	76	99213X2 99212X2			

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CPT 34530 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service is unchanged or may have become more complex over the last 5 years (see Five-year Review Questions below). In addition we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 34530

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.022	0.67
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			1.59
Intra-service	120	0.080	9.60
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.45
Total RVW by Building Block Method =			17.64

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CPT 34530 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

12	vascular surgery	6	thoracic surgery
6	general surgery	2	internal medicine
		1	orthopaedic surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
32	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
3	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35011	Global Period: 090	RUC Rec. RVW:	18.00
		SVS Rec. RVW:	18.50
		Median Survey RVW:	18.50
		Building Block RVW:	15.50
		(Using survey median data)	
	2000 RVW:	11.65	

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 65-year-old electrician presents with an enlarging mass in the medial aspect of her left arm midway between axilla and antecubital fossa. One year earlier she sustained a high-voltage injury from grasping a live wire. Physical exam reveals a 4 cm diameter pulsatile mass, and an aneurysm is confirmed by colorflow duplex ultrasound. Pre-service work includes review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's comorbidities with anesthesia, positioning the patient, scrub, prep, and drape. At operation the normal arteries above and below the aneurysm are dissected and controlled. The aneurysm is repaired using saphenous vein harvested from the thigh. Post-service work includes post-op in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-Service Work usually begins the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in arm & Dissect soft tissue to locate aneurysm, inflow artery, outflow artery
- Carefully dissect soft tissue from sides of aneurysm & arteries
- Ligate and divide small arterial branches
- Encircle inflow and outflow arteries and major branches with soft rubber loops
- Incise skin over saphenous vein & Dissect soft tissue to locate saphenous vein
- Carefully dissect soft tissue from sides of vein & Ligate and divide all saphenous vein branches
- Ligate, divide, and excise saphenous vein after exposure of adequate conduit length
- Prepare saphenous vein for use as conduit, test for leaks
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation

- Apply vascular clamps to artery proximal and distal to aneurysm
- Open aneurysm with scalpel
- Perform proximal artery to saphenous vein anastomosis with fine vascular suture
- Tailor saphenous vein to appropriate length
- Perform distal saphenous vein to artery anastomosis with fine vascular suture
- Flush system to remove air and debris & Remove vascular clamps to reinstitute flow
- Listen with Doppler to assure restitution of flow & Confirm flow to forearm and hand
- Reverse anticoagulation and achieve hemostasis
- Irrigate both wounds & Close soft tissue at aneurysm repair site
- Close soft tissue at vein harvest site & Close skin at both sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35011 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 85 **Response Rate:** 30 (35%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12.00	18.00	18.50	21.76	30.00
Pre-Service Time			90		
Intra-Service Time	60	90	120	135	225

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	38	99231X2
Discharge Day Mgmt	36	99238
Office Visits	38	99213X1 99212X1

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CPT 35011 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

	Survey CPT 35011 (n=30)	Ref CPT 35556 (n=11)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	90	90
Intra-service time	120	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	38	87
Discharge management time	36	36
Total office visit time	38	61

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

Pre-service	3.03	3.45
Intra-service	3.45	3.55
Post-service	2.69	2.91

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.07	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.64
Urgency of medical decision making	2.93	3.27

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.72	3.91
Physical effort required	3.03	3.55

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.76	3.91
Outcome depends on the skill and judgment of physician	3.79	4.18
Estimated risk of malpractice suit with poor outcome	4.21	3.64

CPT 35011 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed substantially over the last five years. Rather we believe the service was valued inappropriately during the original Harvard / Hsiao studies. The following Building Block Method helps justify our RUC survey data and our RVW request.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35011

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.022	0.67
Same day evaluation	30	0.022	0.67
Scrub, prep	30	0.008	0.24
Pre-service total			1.59
Intra-service	120	0.080	9.60
Post-service			
Immediate post	30	0.022	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.31
Total RVW by Building Block Method =			15.50

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CPT 35011 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

721	general surgery	5	peripheral vascular disease
356	vascular surgery	4	nephrology
243	thoracic surgery	2	family practice
60	cardiac surgery	2	hand surgery
20	clinic or group practice (not gppp)	2	hematology/oncology
18	cardiology	2	nuclear medicine
11	general practice	1	anesthesiology
10	diagnostic radiology	1	critical care (intensivists)
6	urology	1	pediatric medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35013	Global Period: 090	RUC Rec. RVW:	22.00
		SVS Rec. RVW:	22.00
		Median Survey RVW:	22.00
		Building Block RVW:	19.14
		2000 RVW:	17.40

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service, and it was evaluated by RUC-approved mini-survey. No clinical vignette was established.

Description of Pre-Service Work:

Pre-Service Work usually begins on the day or night of the operative procedure because this is typically an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in arm & Dissect soft tissue to locate aneurysm, inflow artery, outflow artery
- Carefully dissect soft tissue from sides of aneurysm & arteries
- Ligate and divide small arterial branches
- Encircle inflow and outflow arteries and major branches with soft rubber loops
- Incise skin over saphenous vein
- Dissect soft tissue to locate saphenous vein
- Carefully dissect soft tissue from sides of vein
- Ligate and divide all saphenous vein branches
- Ligate, divide, and excise saphenous vein after exposure of adequate conduit length
- Prepare saphenous vein for use as conduit, test for leaks
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery proximal and distal to aneurysm
- Open aneurysm with scalpel
- Perform proximal artery to saphenous vein anastomosis with fine vascular suture
- Tailor saphenous vein to appropriate length
- Perform distal saphenous vein to artery anastomosis with fine vascular suture

- Flush system to remove air and debris
- Remove vascular clamps to reinstitute flow
- Listen with Doppler to assure restitution of flow
- Confirm flow to forearm and hand
- Reverse anticoagulation and achieve hemostasis
- Irrigate both wounds & Close soft tissue at aneurysm repair site
- Close soft tissue at vein harvest site & Close skin at both sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic arteriogram prior to aneurysm repair, if performed
- Forearm fasciotomy, if required
- Thrombectomy of inflow or outflow arteries, if required

CPT 35013 SURVEY DATA

Presenter: Gary R. Seabrook, MD

Specialty: SVS/AAVS

Sample Size: 85

Response Rate: 30 (35%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12.00	20.00	22.00	25.00	50.00
Pre-Service Time			90		
Intra-Service Time			133		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	68	99232X1 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213X2 99212X1			

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CPT 35013 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this rarely performed service has not changed in the last five years. Rather, we believe it was not valued correctly during the original Harvard / Hsiao studies. The following Building Block Method helps validate our mini-survey data and the requested RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / consensus

CPT Code 35013

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	132.5	0.087	11.53
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.02
Total RVW by Building Block Method =			19.14

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CPT 35013 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

107	general surgery	4	peripheral vascular disease
46	vascular surgery	2	cardiology
29	thoracic surgery	1	crna, anesthesia assistant
5	anesthesiology	1	general practice
5	cardiac surgery	1	nephrology
4	clinic or group practice (not gppp)	1	obstetrics/gynecology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35045	Global Period: 090	RUC Rec. RVW:	17.57
		SVS Rec. RVW:	18.00
		Median Survey RVW:	18.00
		Building Block RVW:	14.65
		2000 RVW:	11.26

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, radial or ulnar artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-Service Work usually begins the day before the operative procedure. Pre-Service Work may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Skin incision in forearm
- Dissect soft tissue to locate aneurysm, inflow artery, outflow artery
- Carefully dissect soft tissue from sides of aneurysm & arteries
- Ligate and divide small arterial branches
- Encircle inflow and outflow arteries and major branches with soft rubber loops
- Incise skin over saphenous vein
- Dissect soft tissue to locate saphenous vein
- Carefully dissect soft tissue from sides of vein
- Ligate and divide all saphenous vein branches
- Ligate, divide, and excise saphenous vein after exposure of adequate conduit length
- Prepare saphenous vein for use as conduit, test for leaks
- Administer systemic anticoagulation (e.g. heparin) and wait for circulation
- Apply vascular clamps to artery proximal and distal to aneurysm
- Open aneurysm with scalpel
- Perform proximal artery to saphenous vein anastomosis with fine vascular suture
- Tailor saphenous vein to appropriate length
- Perform distal saphenous vein to artery anastomosis with fine vascular suture

- Flush system to remove air and debris
- Remove vascular clamps to restore flow
- Listen with Doppler to assure restitution of flow & Confirm flow to hand
- Reverse anticoagulation and achieve hemostasis & Irrigate both wounds
- Close soft tissue at aneurysm repair site & Close soft tissue at vein harvest site
- Close skin at both sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Late post-operative check on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic arteriogram prior to aneurysm repair, if performed

CPT 35045 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 85 **Response Rate:** 30 (35%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	16.00	18.00	20.00	29.50
Pre-Service Time			90		
Intra-Service Time			120		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	19	99231X1
Discharge Day Mgmt	36	99238
Office Visits	30.5	99213X1 99212X .5

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CPT 35045 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last five years. Rather, we believe it was not valued appropriately during the original Harvard / Hsiao studies. The following Building Block method adds credence to our RUC mini-survey and supports the requested RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35045

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	120	0.080	9.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	.5	0.43	0.22
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			3.46
Total RVW by Building Block Method =			14.65

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CPT 35045 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

212	general surgery	5	cardiology
81	vascular surgery	3	peripheral vascular disease
40	thoracic surgery	2	general practice
19	hand surgery	1	emergency medicine
16	orthopaedic surgery	1	family practice
14	clinic or group practice (not gppp)	1	nephrology
12	plastic & reconstructive surgery	1	otolaryngology
5	cardiac surgery	1	pediatric medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35082	Global Period: 090	RUC Rec. RVW:	38.50
		SVS Rec. RVW:	38.50
		Median Survey RVW:	38.50
		Building Block RVW:	38.23
		2000 RVW:	36.35

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male with CAD and COPD arrives by ambulance with a one-hour history of excruciating abdominal and back pain. His blood pressure is 70/40, heart rate is 140, and he has a distended abdomen with a tender pulsatile mass. Pre-service work includes immediate review of all preoperative studies, expedited informed consent from patient, brief discussion with family, anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of ruptured infrarenal abdominal aortic aneurysm is performed by placement of a tube graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-Service Work usually begins on the day or night of the operative procedure because this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal incision
- Rapidly mobilize left lobe of liver
- Rapidly divide crus of diaphragm overlying upper abdominal aorta
- Rapidly apply vascular clamp to upper abdominal aorta
- Rapidly mobilize small bowel overlying infrarenal aneurysm
- Rapidly incise aneurysm and remove bulk thrombus/plaque
- Rapidly insert balloon catheters to control back-bleeding from iliac arteries
- Rapidly prepare infrarenal aorta for proximal graft anastomosis
- Rapidly perform proximal anastomosis of tube graft to infrarenal aorta
- Rapidly test for anastomotic leaks
- Rapidly apply additional sutures as needed to achieve anastomotic hemostasis
- Rapidly place cross-clamp on body of prosthetic graft

- Rapidly remove diaphragmatic aortic cross-clamp to reperfuse kidneys and bowel
- Endarterectomize aneurysm site searching for back-bleeding lumbar arteries
- Suture-ligate back-bleeding lumbar arteries
- Prepare aorta at bifurcation for distal anastomosis
- Cut aortic graft to appropriate length
- Anastomose distal graft to distal aorta
- Flush system to remove air and debris
- Test distal anastomosis for leaks
- Add sutures as needed to achieve hemostasis
- Remove vascular clamp slowly to reinstitute flow while avoiding hypotension
- Listen with Doppler to assure restitution of flow to iliac arteries
- Confirm flow to femorals by feeling for pulses
- Listen with Doppler to assure flow to bowel
- Suture ligate back-bleeding inferior mesenteric artery
- Correct coagulopathy with plasma, platelets, cryoprecipitate etc., as required
- Close aneurysm shell over new aortic graft
- Return bowels to normal position
- Irrigate abdomen
- Final check for hemostasis
- Close fascia
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity embolectomy, if required
- Lower extremity revascularization, if required
- Inferior mesenteric revascularization, if required

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CPT 35082 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 100 **Response Rate:** 30 (30%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	33.00	35.00	38.50	45.00	65.00
Pre-Service Time			60		
Intra-Service Time	90	150	180	240	450

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	60	
Critical Care	120	99291x2
Other Hospital	188	99233x1 99232x3 99231x3
Discharge Day Mgmt	36	99238
Office Visits	76	99214x1 99213x1 99212x1

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CPT 35082 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
35.40	090	35091	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35082 (n=30)	Ref CPT 35091 (n=15)
Pre-service time	60	95
Intra-service time	180	240
Immediate Post-service time	60	45
Total critical care time	120	120
Total other hospital visit time	188	136
Discharge management time	36	36
Total office visit time	76	84

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.24	4.21
Intra-service	4.90	4.64
Post-service	4.69	3.93

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	4.33
Urgency of medical decision making	4.90	3.27

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.87	4.87
Physical effort required	4.87	4.53

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.90	4.53
Outcome depends on the skill and judgment of physician	4.83	4.73
Estimated risk of malpractice suit with poor outcome	3.20	4.00

CPT 35082 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35082

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	30	0.022	0.67
Scrub, prep	20	0.008	0.16
Pre-service total			0.83
Intra-service	180	0.100	18.00
Post-service			
Immediate post	60	0.022	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	3	0.64	1.92
99232	3	1.06	3.18
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			19.39
Total RVW by Building Block Method =			38.23

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CPT 35082 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,673	general surgery	3	emergency medicine
798	vascular surgery	3	gastroenterology
488	thoracic surgery	2	family practice
298	anesthesiology	2	orthopaedic surgery
162	cardiac surgery	1	maxillofacial surgery
125	clinic or group practice (not gppp)	1	osteopathic manipulative therapy
60	cardiology	1	pathology
40	peripheral vascular disease	1	plastic & reconstructive surgery
13	general practice	1	pulmonary disease
5	internal medicine		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35092	Global Period: 090	RUC Rec. RVW:	45.00
		SVS Rec. RVW:	45.00
		Median Survey RVW:	45.00
		Building Block RVW:	62.91
		2000 RVW:	38.39

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-Service Work usually begins on the day or night of the operative procedure because this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapid abdominal or retroperitoneal incision
- Rapidly mobilize soft tissue and/or left liver lobe to gain access to aorta at diaphragm
- Rapidly divide crus of diaphragm overlying upper abdominal aorta
- Rapidly apply vascular clamp to upper abdominal aorta
- Rapidly mobilize bowel, organs, soft tissue overlying aneurysm
- Rapidly incise aneurysm and remove bulk thrombus/plaque
- Rapidly insert balloon catheters to control back-bleeding from iliac arteries
- Rapidly prepare aorta for proximal graft anastomosis
- Rapidly perform proximal anastomosis of tubular prosthetic graft to infrarenal aorta
- Rapidly test for anastomotic leaks & apply additional sutures as needed to achieve hemostasis
- Rapidly reimplant renal, SMA, celiac arteries as required
- Rapidly place cross-clamp on body of prosthesis
- Rapidly remove diaphragmatic aortic cross-clamp to reperfuse kidneys and bowel
- Endarterectomize aneurysm site searching for back-bleeding lumbar arteries
- Suture-ligate back-bleeding lumbar arteries
- Prepare aortic bifurcation for distal anastomosis
- Cut aortic graft to appropriate length & Anastomose distal graft to distal aorta
- Flush system to remove air and debris & Test distal anastomosis for leaks

- Place additional sutures as required to achieve hemostasis
- Remove vascular clamp slowly to reinstitute flow while avoiding hypotension
- Listen with Doppler to assure restitution of flow to iliac arteries
- Confirm flow to femorals by feeling for pulses
- Listen with Doppler to assure flow to bowel
- Suture-ligate back-bleeding inferior mesenteric artery
- Correct coagulopathy with plasma, platelets, cryoprecipitate etc., as required
- Close aneurysm shell over new aortic graft
- Return viscera to normal position & Irrigate abdomen
- Final check for hemostasis & Close fascia
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival & Write post-op orders and notes
- Dictate operative note & Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary & Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity embolectomy OR revascularization, if required
- Inferior mesenteric revascularization, if required
- Extensive bypass construction to renal or visceral arteries, if required

CPT 35092 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS, AAVS

Sample Size: 100

Response Rate: 30 (30%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	35.00	42.50	45.00	53.50	65.00
Pre-Service			60		
Intra-Service			260		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	60	
Critical Care	300	99291X5
Other Hospital	251	99233X3 99232X3 99231X2
Discharge Day Mgmt	36	99238
Office Visits	76	99214X1 99213X1 99212X1

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CPT 35092 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this complex service has not changed over the past five years. Rather, we believe this service was not valued appropriately during the original Harvard / Hsiao studies. The following Building Block Analysis easily justifies our survey median value and our RVW recommendation. This building block analysis also lends credence to our concern that surgeons undervalue E/M services when considering global RVWs in RUC surveys.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35092

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	40	0.022	0.90
Scrub, prep	20	0.008	0.16
Pre-service total			1.06
Intra-service	260	0.108	28.08
Post-service			
Immediate post	60	0.022	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	5	4.00	20.00
99231	2	0.64	1.28
99232	3	1.06	3.18
99233	3	1.51	4.53
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			33.77
Total RVW by Building Block Method =			62.91

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CPT 35092 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

176	general surgery	2	family practice
121	vascular surgery	2	peripheral vascular disease
47	thoracic surgery	1	emergency medicine
22	cardiac surgery	1	hand surgery
21	clinic or group practice (not gppp)	1	internal medicine
4	cardiology		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35103	Global Period: 090	RUC Rec. RVW: 40.50	
		SVS Recommended RVW: 40.50	
		Median Survey RVW: 40.50	
		Building Block RVW: 37.69	
		(Using survey median data)	
		Building Block RVW: 46.74	
		(Using actual skin-to-skin intra time)	
		2000 RVW: 33.57	

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male with CAD and COPD arrives by ambulance with a one-hour history of excruciating abdominal and back pain. His blood pressure is 70/40, heart rate is 140, and his abdomen is distended with a tender pulsatile mass. Pre-service work includes immediate review of all preoperative studies, expedited informed consent from patient, brief discussion with family, anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of ruptured infrarenal abdominal aortic aneurysm involving the iliac vessels is performed by placement of a bifurcated graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-Service Work usually begins on the day or night of the operative procedure because this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapid abdominal incision
- Rapidly mobilize left lobe of liver
- Rapidly divide crus of diaphragm overlying upper abdominal aorta
- Rapidly apply vascular clamp to upper abdominal aorta
- Rapidly mobilize small bowel overlying infrarenal aneurysm

- Rapidly incise aneurysm and remove bulk thrombus/plaque
- Rapidly insert balloon catheters to control back-bleeding from iliac arteries
- Rapidly prepare infrarenal aorta for proximal graft anastomosis
- Rapidly perform proximal anastomosis of bifurcated graft to infrarenal aorta
- Rapidly test for anastomotic leaks
- Rapidly apply additional sutures as needed to achieve anastomotic hemostasis
- Rapidly place cross-clamp on body of prosthetic graft
- Rapidly remove diaphragmatic aortic cross-clamp to reperfuse kidneys and bowel
- Endarterectomize aneurysm site searching for back-bleeding lumbar arteries
- Suture-ligate back-bleeding lumbar arteries
- Dissect soft tissue over common iliac arteries enough to expose normal distal artery
- Move balloon catheters as needed for hemostasis during distal anastomosis
- Cut right limb of graft to appropriate length
- Anastomose distal graft limb to normal iliac artery beyond aneurysm
- Flush system to remove air and debris
- Test distal anastomosis for leaks
- Add sutures as needed to achieve hemostasis
- Remove vascular clamp slowly to reinstitute flow while avoiding hypotension
- Listen with Doppler to assure restitution of flow to right iliac arteries
- Confirm flow to right femoral by feeling for pulse
- Cut left limb of graft to appropriate length
- Anastomose distal graft limb to normal iliac artery beyond aneurysm
- Flush system to remove air and debris
- Test distal anastomosis for leaks
- Add sutures as needed to achieve hemostasis
- Remove vascular clamp slowly to reinstitute flow while avoiding hypotension
- Listen with Doppler to assure restitution of flow to left iliac arteries
- Confirm flow to left femoral by feeling for pulse
- Listen with Doppler to assure flow to bowel
- Suture-ligate back-bleeding inferior mesenteric artery
- Correct coagulopathy with plasma, platelets, cryoprecipitate etc., as required
- Close aneurysm shell over new aortic graft
- Return bowels to normal position
- Irrigate abdomen
- Final check for hemostasis
- Close fascia
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes

- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity embolectomy, if required
- Lower extremity revascularization, if required
- Inferior mesenteric revascularization, if required
- Extensive hypogastric revascularization, if required

CPT 35103 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 30 (32%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	30.50	35.00	40.50	45.00	60.87
Pre-Service Time			60		
Intra-Service Time	30	158	180	240	450

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	60	
Critical Care	120	99291x2
Other Hospital	166	99232x3 99231x4
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35103 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35103 (n=30)	Ref CPT 35102 (n=13)
Pre-service time	60	90
Intra-service time	180	200
Immediate Post-service time	60	30
Total critical care time	120	0
Total other hospital visit time	166	158
Discharge management time	36	36
Total office visit time	61	38

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.43	4.08
Intra-service	4.96	4.15
Post-service	4.89	3.92

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.97	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	4.15
Urgency of medical decision making	4.83	3.46

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.87	4.62
Physical effort required	4.93	4.15

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.90	4.00
Outcome depends on the skill and judgment of physician	4.77	4.31
Estimated risk of malpractice suit with poor outcome	3.23	3.77

CPT 35103 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service may have become more complex over the past five years (see Five-Year Review Questions below). In addition, we believe it was never valued appropriately during the original Harvard / Hsiao studies, nor was it surveyed during the first five-year review. The following Building Block analyses help justify our RUC survey data and our RVW recommendation. The first uses median survey times while the second uses real skin-to-skin surgery time from our vascular surgery database.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35103

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.022	0.00
Same day evaluation	30	0.022	0.67
Scrub, prep	25	0.008	0.20
Pre-service total			0.87
Intra-service	180	0.104	18.72
Post-service			
Immediate post	60	0.022	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	4	0.64	2.56
99232	3	1.06	3.18
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			18.09
Total RVW by Building Block Method =			37.69

Recalculation of Building Block Method using actual skin-to-skin time of 267 minute (n=9) culled from database of 5,000 vascular surgery operations performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-time is actual skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code 35103

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	267	0.104	27.77
Post-service			
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	4	0.64	2.56
99232	3	1.06	3.18
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			17.29
Total RVW by Building Block Method =			46.74

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CPT 35103 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

496	general surgery	2	colorectal surgery
330	vascular surgery	2	diagnostic radiology
124	thoracic surgery	1	crna, anesthesia assistant
53	cardiac surgery	1	hand surgery
50	clinic or group practice (not gppp)	1	internal medicine
13	peripheral vascular disease	1	nuclear medicine
11	cardiology	1	osteopathic manipulative therapy
5	pulmonary disease	1	plastic & reconstructive surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1 0 Yes
2 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
1 0 I do not agree

Patients requiring this service are now:

1 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
1 0 no change

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

CPT Code: 35111	Global Period: 090	RUC Rec. RVW:	25.00
		SVS Rec. RVW:	27.00
		Median Survey RVW:	27.00
		Building Block RVW:	21.20
		2000 RVW:	16.43

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, splenic artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal incision
- Routine abdominal exploration
- Mobilize soft tissue and left liver lobe to gain access to aorta at diaphragm
- Divide crus of diaphragm overlying upper abdominal aorta
- Dissect soft tissue to find celiac artery origin
- Carefully dissect soft tissue from around celiac
- Dissect soft tissue to find splenic aneurysm
- Carefully dissect soft tissue around normal proximal and distal splenic artery
- Apply vascular clamps proximal and distal to aneurysm
- Harvest saphenous vein from lower extremity if autogenous conduit is indicated
- Incise or excise aneurysm
- Anastomose autogenous or prosthetic graft to proximal and distal artery, if indicated
- Flush system to remove air and debris
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow, if indicated

- Return viscera to normal position
- Irrigate abdomen
- Final check for hemostasis
- Close fascia
- Irrigate subcutaneous tissue
- Close skin
- Irrigate and close saphenous vein harvest site if present

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Splenectomy, if required

CPT 35111 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 25 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.00	24.00	27.00	30.00	42.02
Pre-Service Time			90		
Intra-Service Time			150		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	98	99232X2 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	53	99213X1 99212X2			

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CPT 35111 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this survey has not changed in the last five years. Rather, we believe that it was not valued appropriately during the initial Harvard / Hsiao studies. The following BBM helps justify an RVW greater than the current value.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / consensus panel

CPT Code 35111

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.085	12.75
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.86
Total RVW by Building Block Method =			21.20

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CPT 35111 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

26	general surgery	2	clinic or group practice (not gppp)
14	vascular surgery	1	peripheral vascular disease
6	thoracic surgery	1	surgical oncology
2	cardiac surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35112	Global Period: 090	RUC Rec. RVW:	30.00
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	34.44
		2000 RVW:	18.69

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery because this is an emergent service. Pre-Service Work begins after the decision to operate and may include rapid procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapid abdominal incision
- Rapidly mobilize soft tissue and left liver lobe to gain access to aorta at diaphragm
- Rapidly divide crus of diaphragm overlying upper abdominal aorta
- Rapidly apply aortic cross-clamp if exsanguinating hemorrhage is present
- Rapidly dissect soft tissue to find celiac artery origin
- Rapidly dissect soft tissue from around celiac
- Rapidly dissect soft tissue to find splenic aneurysm
- Rapidly dissect soft tissue around normal proximal and distal splenic artery
- Rapidly apply vascular clamps proximal and distal to aneurysm
- Remove aortic cross-clamp, if previously applied
- Harvest saphenous vein from lower extremity if autogenous conduit required
- Incise or excise aneurysm
- Anastomose autogenous or prosthetic graft to proximal and distal artery, if indicated
- Flush system to remove air and debris
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow, if indicated
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate, as required

- Return viscera to normal position
- Irrigate abdomen
- Final check for hemostasis
- Close fascia
- Irrigate subcutaneous tissue
- Close skin
- Irrigate and close saphenous vein harvest site if present

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Splenectomy, if required

CPT 35112 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 25 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.00	28.00	30.00	35.00	84.03
Pre-Service Time			90		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	60				
Critical Care	120	99291X2			
Other Hospital	98	99232X2 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213X2 99212X1			

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CPT 35112 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last five years. Rather, we believe that it was not valued appropriately during the initial Harvard / Hsiao studies. The following Building Block Analysis easily supports our survey median and requested RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35112

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.095	17.10
Post-service			
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			15.75
Total RVW by Building Block Method =			34.44

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CPT 35112 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

15	general surgery
3	thoracic surgery
2	vascular surgery
1	clinic or group practice (not gppp)
1	general practice
1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35121	Global Period: 090	RUC Rec. RVW:	30.00
		SVS Rec. RVW:	32.00
		Median Survey RVW:	32.00
		Building Block RVW:	26.83
		2000 RVW:	25.99

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal incision
 - Routine abdominal exploration
 - Mobilize soft tissue and left liver lobe to gain access to aorta at diaphragm, if required
 - Divide crus of diaphragm overlying upper abdominal aorta
 - Dissect soft tissue to find celiac, hepatic, renal, or mesenteric artery origin
 - Carefully dissect soft tissue from around artery to gain proximal control
 - Dissect soft tissue to find aneurysm
 - Carefully dissect soft tissue around normal proximal and distal artery
 - Harvest saphenous vein from lower extremity if autogenous graft required
 - Apply vascular clamps proximal and distal to aneurysm
 - Incise or excise aneurysm
 - Anastomose autogenous or prosthetic graft to proximal and distal artery if indicated
 - Flush system to remove air and debris & remove vascular clamps
 - Apply additional sutures as needed to achieve hemostasis
 - Listen with Doppler to assure restitution of flow, if indicated
 - Return viscera to normal position & irrigate abdomen
 - Final check for hemostasis
 - Close fascia & irrigate subcutaneous tissue
-

- Close skin at abdominal incision
- Irrigate and close saphenous vein harvest site if present

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes & dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Splenectomy, bowel resection, or liver resection, if required

CPT 35121 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 25 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.00	30.00	32.00	35.00	84.03
Pre-Service Time			90		
Intra-Service Time			190		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	136	99232X2 99231X4
Discharge Day Mgmt	36	99238
Office Visits	53	99213X1 99212X2

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CPT 35121 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe it was not valued appropriately during the initial Harvard / Hsiao studies. The following building block analysis helps support our mini-survey data and our recommended RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / consensus panel

CPT Code 35121

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	190	0.090	17.10
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.14
Total RVW by Building Block Method =			26.83

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CPT 35121 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

89	general surgery	5	clinic or group practice (not gppp)
87	vascular surgery	2	urology
21	thoracic surgery	1	critical care (intensivists)
11	cardiac surgery	1	crna, anesthesia assistant
6	cardiology	1	emergency medicine
6	plastic & reconstructive surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35122	Global Period: 090	RUC Rec. RVW:	35.00
		SVS Rec. RVW:	35.00
		Median Survey RVW:	35.00
		Building Block RVW:	40.40
		2000 RVW:	33.45

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery because this is an emergent service. Pre-Service Work begins after the decision to operate and may include rapid procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapid abdominal incision
- Rapidly mobilize soft tissue and left liver lobe to gain access to aorta at diaphragm
- Rapidly divide crus of diaphragm overlying upper abdominal aorta
- Rapidly apply aortic cross-clamp if exsanguinating hemorrhage is present
- Rapidly dissect soft tissue to find celiac, hepatic, renal, or mesenteric artery origin
- Rapidly dissect soft tissue from sides of artery and encircle with rubber loop, as required
- Rapidly dissect soft tissue to find aneurysm
- Rapidly dissect soft tissue around normal proximal and distal artery
- Rapidly apply vascular clamps proximal and distal to aneurysm
- Remove aortic cross-clamp, if previously applied
- Harvest saphenous vein from lower extremity if autogenous conduit indicated
- Incise or excise aneurysm
- Anastomose autogenous or prosthetic graft to proximal and distal artery, if indicated
- Flush system to remove air and debris & Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow, if indicated
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate, as required

- Return viscera to normal position & Irrigate abdomen
- Final check for hemostasis & Close fascia
- Irrigate subcutaneous tissue & Close skin at abdominal incision
- Irrigate and close saphenous vein harvest site, if present

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Bowel resection, if required
- Liver resection, if required

CPT 35122 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 25 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	23.00	30.00	35.00	40.00	112.04
Pre-Service Time			90		
Intra-Service Time			220		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	60	
Critical Care	120	99291X2
Other Hospital	128	99232X3 99231X2
Discharge Day Mgmt	36	99238
Office Visits	61	99213X2 99212X1

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CPT 35122 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last five years. Rather, we believe it was not valued appropriately during the initial Harvard / Hsiao studies. The following Building Block Analysis readily justifies our mini-survey data and requested RVW.

This analysis also supports out contention that surgeons who fill out RUC surveys tend to undervalue post-operative care in acutely ill individuals.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35122

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	220	0.100	22.00
Post-service			
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	2	0.64	1.28
99232	3	1.06	3.18
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			16.81
Total RVW by Building Block Method =			40.40

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CPT 35122 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

17	general surgery	1	cardiology
6	vascular surgery	1	clinic or group practice (not gppp)
4	thoracic surgery	1	gastroenterology
2	cardiac surgery	1	urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35131	Global Period: 090	RUC Rec. RVW:	25.00
		SVS Rec. RVW:	27.50
		Median Survey RVW:	27.50
		Building Block RVW:	22.81
		(Using survey median values)	
		Building Block RVW:	27.40
		(Using actual skin-to-skin intra time)	
		2000 RVW:	18.55

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 70-year-old male complains of a swollen left lower extremity. Noninvasive studies rule out DVT in the left leg, but Doppler signals suggest a more central obstruction to venous return. An abdominal and pelvic CT scan reveals a 5-cm isolated common iliac artery aneurysm compressing the iliac vein. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's medical comorbidities with anesthesia, patient positioning, scrub, prep, and drape. At operation the iliac aneurysm is repaired using a Dacron conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal or retroperitoneal incision
- Routine abdominal exploration
- Incise retroperitoneum if abdominal approach
- Dissect soft tissue to find aneurysm, plus proximal and distal normal arteries
- Carefully dissect soft tissue from around proximal and distal arteries
- Carefully dissect soft tissue around aneurysm
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation

- Apply vascular clamps proximal and distal to aneurysm
- Incise aneurysm
- Remove bulky thrombus/plaque
- Endarterectomize aneurysm searching for back-bleeding branches
- Suture-ligate back-bleeding branches
- Anastomose prosthetic graft to proximal artery
- Apply vascular clamp beyond anastomosis
- Open proximal artery inflow clamp and look for leaks
- Apply additional vascular sutures to achieve hemostasis
- Cut graft to appropriate length
- Anastomose graft to outflow artery
- Flush system to remove air and debris
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow
- Feel femoral pulse to assure restitution of flow to leg
- Reverse anticoagulant (e.g. protamine)
- Return viscera to normal position
- Irrigate abdomen
- Final check for hemostasis
- Close fascia
- Irrigate subcutaneous tissue
- Close skin at abdominal incision

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Hypogastric or pelvic revascularization with bypass, if required
- Lower extremity revascularization, if required
- Lower extremity embolectomy/thrombectomy, if required

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CPT 35131 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 30 (32%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	20.50	26.00	27.50	28.01	31.00
Pre-Service Time			105		
Intra-Service Time	120	133	150	180	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	40	
Critical Care	0	
Other Hospital	117	99232x2 99231x3
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1 99212x2

CPT 35131 KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

	Survey CPT 35131 (n=30)	Ref CPT 35081 (n=21)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	105	90
Intra-service time	150	180
Immediate Post-service time	40	43
Total critical care time	0	0
Total other hospital visit time	117	106
Discharge management time	36	36
Total office visit time	53	53

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

Pre-service	3.97	4.05
Intra-service	4.31	4.40
Post-service	3.79	3.95

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.69	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.28	4.30
Urgency of medical decision making	3.69	3.65

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.52	4.50
Physical effort required	4.34	4.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.41	4.45
Outcome depends on the skill and judgment of physician	4.45	4.50
Estimated risk of malpractice suit with poor outcome	4.07	4.00

CPT 35131 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe this procedure was not valued accurately during the initial Harvard / Hsiao studies. The following two building block analyses support our survey median value and recommended RVW. The second of these two supports our contention that surgeons tend to under-estimate intra-service skin-to-skin time.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35131

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.090	13.50
Post-service			
Immediate post	40	0.0224	0.90
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.73
Total RVW by Building Block Method =			22.81

Recalculated Building Block Method using actual skin-to-skin time of 201 minutes (n=2) culled from our database of 5,000 vascular surgery operations performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is actual skin-to-skin time from SVS/AAVS database

All other time and visit data from RUC survey

CPT Code 35131

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	201	0.090	18.09
Post-service			
Immediate post	40	0.0224	0.90
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.73
Total RVW by Building Block Method =			27.40

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CPT 35131 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

444	general surgery	2	diagnostic radiology
353	vascular surgery	2	obstetrics/gynecology
191	thoracic surgery	1	family practice
66	cardiac surgery	1	hematology/oncology
24	clinic or group practice (not gppp)	1	interventional radiology
19	cardiology	1	nuclear medicine
8	peripheral vascular disease	1	otolaryngology
4	plastic & reconstructive surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35132	Global Period: 090	RUC Rec. RVW:	30.00
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	34.36
		2000 RVW:	21.95

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapid abdominal or retroperitoneal incision
- Rapidly incise retroperitoneum if abdominal approach
- Rapidly dissect aorta or proximal common iliac to gain vascular control
- Rapidly apply aortic or iliac cross-clamp
- Rapidly dissect soft tissue and hematoma to find proximal and distal normal arteries
- Rapidly apply vascular clamps to all inflow and outflow arteries to control back-bleeding
- Carefully dissect soft tissue and hematoma around aneurysm
- Administer intravenous anticoagulant (e.g. heparin) if indicated and wait for circulation
- Incise aneurysm & Remove bulky thrombus/plaque
- Endarterectomize aneurysm searching for back-bleeding branches
- Suture-ligate back-bleeding branches
- Anastomose prosthetic graft to proximal artery
- Apply vascular clamp beyond anastomosis
- Open proximal artery inflow clamp and look for leaks
- Apply additional vascular sutures to achieve hemostasis
- Cut graft to appropriate length & Anastomose graft to outflow artery
- Flush system to remove air and debris & Remove vascular clamps

- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow
- Feel femoral pulse to assure restitution of flow to leg
- Reverse anticoagulant with protamine if patient was heparinized
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate as indicated
- Return viscera to normal position & Irrigate abdomen
- Final check for hemostasis & Close fascia
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival & Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Extensive hypogastric or pelvic revascularization, if required
- Lower extremity revascularization, if required
- Lower extremity embolectomy/thrombectomy, if required

CPT 35132 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS/AAVS

Sample Size: 94

Response Rate: 25 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	28.00	30.00	30.00	35.00	84.03
Pre-Service Time			55		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	60				
Critical Care	120	99291X2			
Other Hospital	98	99232X2 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213X2 99212X1			

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CPT 35132 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last five years. Rather, we believe it was not valued appropriately during the original Harvard / Hsiao studies. The following Building Block analysis readily supports our mini-survey median value and recommended RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35132

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	180	0.099	17.73
Post-service			
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	2	4.00	8.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			15.75
Total RVW by Building Block Method =			34.36

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CPT 35132 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery:

Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

87	general surgery	5	cardiology
47	vascular surgery	1	family practice
28	thoracic surgery	1	gastroenterology
9	clinic or group practice (not gppp)	1	general practice
5	cardiac surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35141	Global Period: 090	RUC Rec. RVW:	20.00
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	19.71
		2000 RVW:	14.46

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 78-year-old man complains of a large uncomfortable bulge in his left groin. He underwent an aortobifemoral bypass graft 20 years earlier. Exam reveals an 8-cm. pulsatile mass under the femoral incision of the prior operation. There is no tenderness or erythema. By CT scan it appears that the old graft limb has pulled away from the femoral artery resulting in a false aneurysm. The aortic and right femoral anastomoses of the graft are normal. Pre-service work includes review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's cardiac history with anesthesia, positioning the patient, scrub, prep, and drape. At operation the graft limb and native arteries are dissected and controlled. The anastomosis is reconstructed using a short segment of synthetic conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin in groin over aneurysm
- Dissect soft tissue to find inflow artery or graft, plus outflow arteries
- Carefully dissect soft tissue from around proximal and distal arteries
- Encircle inflow and outflow arteries or graft limb with soft rubber loops
- Carefully dissect soft tissue around aneurysm
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation
- Apply vascular clamps proximal and distal to aneurysm
- Incise aneurysm & Remove bulky thrombus/plaque
- Endarterectomize aneurysm searching for back-bleeding branches
- Suture-ligate back-bleeding branches

- Anastomose prosthetic graft to proximal artery or pre-existing inflow graft limb
- Open proximal artery inflow clamp and look for leaks
- Apply additional vascular sutures to achieve hemostasis
- Cut graft to appropriate length & Anastomose graft to outflow artery
- Flush system to remove air and debris & Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Listen with Doppler to assure restitution of flow
- Feel ankle/foot pulses to assure restitution of flow to calf and foot
- Reverse anticoagulant (e.g. protamine) & Irrigate wound
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity revascularization with bypass or embolectomy/thrombectomy, if required

CPT 35141 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 70

Response Rate: 30 (43%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	13.00	19.05	20.00	23.75	30.76
Pre-Service Time			90		
Intra-Service Time	60	120	150	180	270

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	68	99232x1 99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

CPT 35141 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35141 (n=30)	Ref CPT 35656 (n=16)
Pre-service time	90	90
Intra-service time	150	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	87
Discharge management time	36	36
Total office visit time	38	53
<i>INTENSITY/COMPLEXITY MEASURES (mean)</i>		
TIME SEGMENTS		
Pre-service	3.30	3.00
Intra-service	3.67	3.19
Post-service	2.73	2.69
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.13
Urgency of medical decision making	3.43	2.81
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.97	3.13
Physical effort required	3.63	3.06
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.83	3.25
Outcome depends on the skill and judgment of physician	4.00	3.50
Estimated risk of malpractice suit with poor outcome	3.63	3.69

CPT 35141 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe it was not valued accurately in the original Harvard / Hsiao studies. The following Building Block Analysis results in virtually the same value as our RUC survey median, thereby justifying our recommended RVW.

Building Block Method

Intra-service Intensity is median value from SVS/AAVS Intensity Survey

Other Intensities are from original Harvard Stone formula

All times and visits are from RUC survey data

CPT Code 35141

	Time	Intensity		RVU (=time x intensity)
Pre-service				
Day prior evaluation	30	0.0224		0.67
Same day evaluation	30	0.0224		0.67
Scrub, prep	30	0.0081		0.24
Pre-service total				1.59
Intra-service	150	0.085		12.75
Post-service				
Immediate post	30	0.0224		0.67
Subsequent visits			Visit n	E/M RVU
99291			0	4.00
99231			2	0.64
99232			1	1.06
99233			0	1.51
99238			1	1.28
99211			0	0.17
99212			1	0.43
99213			1	0.65
99214			0	1.08
99215			0	1.73
Post-service total				5.37
Total RVW by Building Block Method				19.71

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CPT 35141 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

2,183	general surgery	5	internal medicine
1,781	vascular surgery	4	hematology/oncology
1,124	thoracic surgery	4	pulmonary disease
482	cardiac surgery	3	nuclear medicine
207	clinic or group practice (not gppp)	2	emergency medicine
135	cardiology	2	hand surgery
61	peripheral vascular disease	2	surgical oncology
15	diagnostic radiology	1	colorectal surgery
13	general practice	1	gastroenterology
9	family practice	1	orthopaedic surgery
9	plastic & reconstructive surgery	1	psychiatry
7	interventional radiology	1	radiation oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35142	Global Period: 090	RUC Rec. RVW:	23.30
		SVS Rec. RVW:	25.00
		Median Survey RVW:	25.00
		Building Block RVW:	25.79
		2000 RVW:	15.86

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent procedure. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin in groin proximal to and over aneurysm
- Rapidly dissect soft tissue to find inflow artery or inflow graft limb
- Rapidly dissect soft tissue from around proximal arteries
- Rapidly encircle inflow artery or graft limb with soft rubber loop
- Rapidly apply vascular clamp to inflow to control hemorrhage
- Administer intravenous anticoagulant (e.g. heparin) if indicated
- Rapidly dissect soft tissue over aneurysm
- Incise aneurysm & Remove bulky thrombus/plaque
- Insert balloon occluding catheters to control back-bleeding branches
- Anastomose prosthetic graft to proximal artery or pre-existing inflow graft limb
- Apply vascular clamp beyond anastomosis
- Open proximal artery inflow clamp and look for leaks
- Apply additional vascular sutures to achieve hemostasis
- Cut graft to appropriate length & Anastomose graft to outflow artery
- Flush system to remove air and debris & Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis

- Listen with Doppler to assure restitution of flow
- Feel ankle/foot pulses to assure restitution of flow to calf and foot
- Reverse anticoagulant (e.g. protamine) & Irrigate wound
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive care unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity revascularization with bypass, if required
- Lower extremity embolectomy/thrombectomy, if required

CPT 35142 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 70 **Response Rate:** 29 (41%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	17.00	22.00	25.00	28.50	35.00
Pre-Service Time			90		
Intra-Service Time			150		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	45				
Critical Care	60	99291X1			
Other Hospital	87	99232X1 99231X3			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213X2 99212X1			

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CPT 35142 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not valued accurately during the original Harvard / Hsiao extrapolations. The following Building Block Analysis falls squarely at the mini-survey median RVW and supports our recommended RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35142

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.088	13.20
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	4.00	4.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			11.00
Total RVW by Building Block Method =			25.79

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CPT 35142 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code: We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

219	general surgery	5	peripheral vascular disease
159	vascular surgery	4	pulmonary disease
81	thoracic surgery	2	general practice
24	cardiac surgery	1	endocrinology
18	clinic or group practice (not gppp)	1	hematology/oncology
14	cardiology		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35151	Global Period: 090	RUC Rec. RVW:	22.64
		SVS Rec. RVW:	23.00
		Median Survey RVW:	23.00
		Building Block RVW:	20.78
		(Using survey median data)	
		Building Block RVW:	22.69
		(Using real skin-to-skin intra time)	
		2000 RVW:	17.00

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, popliteal artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 68-year-old man presenting with acute severe ischemia of the right lower extremity undergoes successful thrombolytic therapy and is found to have a popliteal artery aneurysm that caused the sudden thrombosis. Popliteal aneurysm repair is recommended to prevent re-thrombosis. Pre-service work includes review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's comorbidities with anesthesia, positioning the patient, scrub, prep, and drape. At operation the normal arteries above and below the knee are dissected and controlled. The aneurysm is excluded and a graft is placed. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin above and below knee
- Dissect soft tissue to find inflow and outflow arteries
- Carefully dissect soft tissue from around proximal and distal arteries
- Encircle inflow and outflow arteries with soft rubber loops
- Carefully dissect soft tissue around aneurysm
- Create tunnel as required from inflow to outflow arteries
- Incise skin as required to harvest saphenous vein for conduit

- Carefully dissect soft tissue from saphenous vein
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein conduit and remove
- Test saphenous vein for leaks and repair with superfine vascular suture as needed
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation
- Apply vascular clamps proximal and distal to aneurysm
- Incise inflow artery
- Anastomose saphenous vein conduit to inflow artery
- Remove inflow clamp to test anastomosis
- Apply additional sutures as needed to achieve hemostasis
- Anastomose saphenous vein conduit to distal artery
- Flush conduit to remove air and debris
- Open clamp and look for leaks
- Apply additional vascular sutures to achieve hemostasis
- Listen with Doppler to assure restitution of flow
- Feel ankle/foot pulses to assure restitution of flow to calf and foot
- Suture ligate all inflow and outflow arteries to completely isolate aneurysm from circulation
- Reverse anticoagulant (e.g. protamine)
- Irrigate wound
- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Lower extremity embolectomy/thrombectomy, if required
- Extensive lower extremity revascularization, if required
- Foot or toe amputation, if required
- Administration of intra-operative thrombolytic therapy, if required

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CPT 35151 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 91 **Response Rate:** 31 (34%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.53	21.76	23.00	26.96	30.76
Pre-Service Time			100		
Intra-Service Time	90	120	150	180	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1 99231x3
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1 99212x2

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35151 (n=31)	Ref CPT 35556 (n=22)
Pre-service time	100	90
Intra-service time	150	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	87
Discharge management time	36	36
Total office visit time	53	53

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

Pre-service	3.45	3.50
Intra-service	3.84	3.82
Post-service	3.16	3.14

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.68
Urgency of medical decision making	3.68	3.18

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.91
Physical effort required	3.68	3.64

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.87	3.82
Outcome depends on the skill and judgment of physician	4.19	4.23
Estimated risk of malpractice suit with poor outcome	4.10	3.77

CPT 35151 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe that this procedure was not valued accurately in the original Harvard / Hsiao studies. The following two Building Block Analyses support our RUC survey median value and recommended RVW. The first table uses data from the RUC survey. The table on the following page uses real skin-to-skin intra-time culled from our vascular surgery database.

Building Block Method

Intra-service Intensity is median value of SVS/AAVS Intensity Survey

Other Intensity values are from original Harvard Stone formula

All times and visits are from RUC survey

CPT Code 35151

	Time	Intensity		RVU
				(=time x intensity)
Pre-service				
Day prior evaluation	30	0.0224		0.67
Same day evaluation	30	0.0224		0.67
Scrub, prep	30	0.0081		0.24
Pre-service total				1.59
Intra-service	150	0.085		12.75
Post-service				
Immediate post	30	0.0224		0.67
Subsequent visits			Visit n	E/M RVU
				(=n x E/M RVU)
99291			0	4.00
99231			3	0.64
99232			1	1.06
99233			0	1.51
99238			1	1.28
99211			0	0.17
99212			2	0.43
99213			1	0.65
99214			0	1.08
99215			0	1.73
Post-service total				6.44
Total RVW by Building Block Method				20.78

Building Block Analysis Recalculated using real skin-to-skin Intra-time of 172.5 minutes (n=6) culled from our database of 5,000 vascular surgery procedures performed by 31 surgeons during 1999.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is real skin-to-skin time from SVS/AAVS database

All other time and visit data from RUC survey

CPT Code 35151

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	172.5	0.085	14.66
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.44
Total RVW by Building Block Method =			22.69

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CPT 35151 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

403	general surgery	3	internal medicine
339	vascular surgery	2	general practice
134	thoracic surgery	1	family practice
35	cardiac surgery	1	nuclear medicine
33	clinic or group practice (not gppp)	1	obstetrics/gynecology
17	cardiology	1	surgical oncology
9	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35152	Global Period: 090	RUC Rec. RVW:	25.62
		SVS Rec. RVW:	27.00
		Median Survey RVW:	27.00
		Building Block RVW:	26.72
		2000 RVW:	16.70

CPT Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin in groin & dissect soft tissue to find common femoral artery
- Rapidly dissect soft tissue from around artery & anticoagulate patient
- Rapidly clamp common femoral artery to control hemorrhage
- Incise skin above and below knee & Dissect soft tissue to find aneurysm
- Identify all arteries feeding into and out of aneurysm
- Ligate and divide all of these arteries & Wash hematoma out of popliteal cavity
- Encircle normal inflow and outflow arteries with soft rubber loops
- Create tunnel as required from inflow to outflow arteries
- Incise skin as required to harvest saphenous vein for conduit
- Carefully dissect soft tissue from saphenous vein
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein conduit and remove
- Test saphenous vein for leaks and repair with superfine vascular suture as needed
- Apply vascular clamps to inflow and outflow arteries
- Remove vascular clamp from common femoral artery & Incise inflow artery
- Anastomose saphenous vein conduit to inflow artery
- Remove inflow clamp to test anastomosis
- Apply additional sutures as needed to achieve hemostasis
- Anastomose saphenous vein conduit to distal outflow artery

- Flush conduit to remove air and debris
- Open clamp and look for leaks & Apply additional vascular sutures to achieve hemostasis
- Listen with Doppler to assure restoration of flow
- Feel ankle/foot pulses to assure restitution of flow to calf and foot
- Reverse anticoagulant (e.g. protamine) & Irrigate wound
- Final check for hemostasis & Close all soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin at all sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrive to PACU or ICU
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic arteriogram, if required
- Lower extremity embolectomy/thrombectomy, if required
- Extensive lower extremity revascularization, if required
- Foot or toe amputation, if required
- Administration of intra-operative thrombolytic therapy, if required

CPT 35152 SURVEY DATA **Presenter(s):** Gary R. Seabrook, MD **Specialty:** SVS / AAVS

Sample Size: 91 **Response Rate:** 32 (35%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.37	25.00	27.00	30.00	40.00
Pre-Service Time			90		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	0	
Other Hospital	139	99233X1 99232X2 99231X2
Discharge Day Mgmt	36	99238
Office Visits	61	99213X2 99212X1

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CPT 35152 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe it was not valued accurately during the original Harvard / Hsiao project. The following Building Block Analysis computes a value that is essentially equal to the median RVW of our mini-survey.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35152

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.090	16.20
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.93
Total RVW by Building Block Method =			26.72

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CPT 35152 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code: We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

18	vascular surgery	3	cardiology
14	general surgery	1	clinic or group practice (not gppp)
9	thoracic surgery	1	diagnostic radiology
3	cardiac surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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CPT 35182

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

CPT Code: 35182	Global Period: 090	RUC Rec. RVW:	30.00
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	28.70
		2000 RVW:	17.74

CPT Descriptor: Repair, congenital arteriovenous fistula; thorax and abdomen

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a very rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. For congenital AV fistulae, there is no such thing as a "typical case". Since each case represents a unique problem only the general steps will be outlined

- Abdominal and thoracic incision
- Routine abdominal and thoracic exploration
- Divide diaphragm as needed for exposure
- Dissect to identify all feeding arteries and outflow veins
- Carefully dissect soft tissue from around these arteries and veins
- Apply vascular clamps to all vessels
- Ligate and divide all vessels
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Return viscera to normal position
- Irrigate abdomen and thorax
- Reconstruct diaphragm
- Final check for hemostasis
- Close chest
- Close abdomen
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Any arterial or venous reconstructions needed to revascularize specific organs or limbs following excision of AV fistula

CPT 35182 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 95 **Response Rate:** 17 (18%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.00	22.50	30.00	32.00	45.00
Pre-Service Time			88		
Intra-Service Time			200		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	109	99233x1 99232x1 99231x2
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35182 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this incredibly unusual procedure may have become more complex over the last 5 years according to survey respondents (see Five-year Review Questions below). In addition, we believe it was not valued accurately during the initial Harvard / Hsiao studies. The following Building Block analysis confirms that the median mini-survey value of 30 is appropriate.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35182

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	28	0.0081	0.23
Pre-service total			1.57
Intra-service	200	0.098	19.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.53
Total RVW by Building Block Method =			28.70

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CPT 35182 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

5	thoracic surgery	1	peripheral vascular disease
4	general surgery	1	surgical oncology
1	cardiac surgery	1	vascular surgery
1	general practice		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

6	0	Yes
17	7	No

This service represents new technology that has become more familiar (i.e., less work).

2	0	I agree
4	0	I do not agree

Patients requiring this service are now:

5	0	<u>more</u> complex (more work)
1	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
6	0	no change

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

CPT Code: 35184	Global Period: 090	RUC Rec. RVW:	18.00
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	19.27
		2000 RVW:	12.25

CPT Descriptor: Repair, congenital arteriovenous fistula; extremities

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. For congenital AV fistulae, there is no such thing as a "typical case". Since each case represents a unique problem only the general steps will be outlined

- Skin incision of sufficient length to expose all feeding arteries and draining veins
- Dissect soft tissue to find feeding arteries and outflow veins
- Carefully dissect soft tissue from around these arteries and veins
- Apply vascular clamps to all vessels
- Divide AV fistula
- Ligate any noncritical feeding arteries and draining veins
- Locally repair any critical arteries and veins
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Use Doppler to confirm blood flow to more distal portions of extremity
- Irrigate wound
- Final check for hemostasis
- Close soft tissues in layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Arterial or venous bypass reconstruction needed to revascularize limb after fistula repair

CPT 35184 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 116 **Response Rate:** 44 (38%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	18.00	20.00	25.00	38.00
Pre-Service Time			88		
Intra-Service Time			150		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	49	99232X1 99231X1			
Discharge Day Mgmt	36	99238			
Office Visits	45.5	99213X1 99212X1.5			

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CPT 35184 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has become **more complex** over the last 5 years because straightforward fistulae are treated with percutaneous angioplasty. We also believe this unusual procedure was not valued accurately during the original Harvard / Hsiao studies. The following Building Block Analysis strongly supports our mini-survey median value as an appropriate recommendation for a new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35184

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	28	0.0081	0.23
Pre-service total			1.57
Intra-service	150	0.085	12.75
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1.5	0.43	0.65
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.95
Total RVW by Building Block Method =			19.27

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CPT 35184 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

73	general surgery	4	general practice
30	vascular surgery	3	clinic or group practice (not gppp)
21	thoracic surgery	3	peripheral vascular disease
6	cardiac surgery	1	orthopaedic surgery
4	cardiology		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

6	7	Yes
17	0	No

This service represents new technology that has become more familiar (i.e., less work).

2	0	I agree
4	0	I do not agree

Patients requiring this service are now:

5	7	<u>more</u> complex (more work)
1	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
6	0	no change

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

CPT Code: 35189	Global Period: 090	RUC Rec. RVW:	28.00
		SVS Rec. RVW:	28.00
		Median Survey RVW:	28.00
		Building Block RVW:	26.34
		2000 RVW:	18.43

CPT Descriptor: Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. For congenital AV fistulae, there is no such thing as a "typical case". Since each case represents a unique problem only the general steps will be outlined

- Abdominal and thoracic incision
- Routine abdominal and thoracic exploration
- Divide diaphragm as needed for exposure
- Dissect to identify all feeding arteries and outflow veins
- Carefully dissect soft tissue from around these arteries and veins
- Apply vascular clamps to all vessels
- Divide AV fistula
- Ligate all non-critical feeding arteries and draining veins
- Locally repair all major feeding arteries and draining veins
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Return viscera to normal position
- Irrigate abdomen and thorax
- Reconstruct diaphragm
- Final check for hemostasis
- Close chest
- Close abdomen
- Irrigate subcutaneous tissue

- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Arterial or venous bypass repairs needed to revascularize specific organs or limbs following AV fistula resection

CPT 35189 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 95 **Response Rate:** 18 (19%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	24.00	28.00	30.00	40.00
Pre-Service Time			88		
Intra-Service Time			165		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	130	99233x1 99232x2 99231x1.5
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35189 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service is unchanged or may have become more complex over the last 5 years (see Five-year Review Questions below). In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35189

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	28	0.0081	0.23
Pre-service total			1.57
Intra-service	165	0.100	16.50
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1.5	0.64	0.96
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.27
Total RVW by Building Block Method =			26.34

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CPT 35189 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

23	general surgery	6	cardiology
19	vascular surgery	5	clinic or group practice (not gppp)
12	thoracic surgery	2	anesthesiology
7	cardiac surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2 0 Yes
21 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
2 0 I do not agree

Patients requiring this service are now:

2 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
2 0 no change

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

CPT Code: 35190	Global Period: 090	RUC Rec. RVW:	12.75
		SVS Rec. RVW:	16.00
		Median Survey RVW:	16.00
		Building Block RVW:	13.17
		2000 RVW:	12.75

CPT Descriptor: Repair, acquired or traumatic arteriovenous fistula; extremities

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old female presents with dyspnea and a swollen right lower extremity one-year after undergoing a cardiac catheterization. There is a palpable thrill in her right groin. Duplex ultrasound reveals a high volume arteriovenous fistula between her common femoral artery and vein. Pre-service work includes review of all preoperative studies, informed consent from patient, discussions with family, anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Intra-service work is open surgical repair of the fistula. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. For acquired AV fistulae the vignette represents the most common case, but these can be widely variable in complexity depending on the mode and location of the injury. The following steps represent the general approach to an acquired AV fistula of the extremity:

- Skin incision of sufficient length to expose all feeding arteries and draining veins
- Dissect soft tissue to find feeding arteries and outflow veins
- Carefully dissect soft tissue from around these arteries and veins
- Administer systemic anticoagulant and wait for circulation
- Apply vascular clamps to all vessels
- Divide fistula
- Locally repair involved arteries and veins
- Remove vascular clamps
- Apply additional sutures as needed to achieve hemostasis
- Use Doppler to confirm blood flow to more distal portions of extremity
- Irrigate wound

- Final check for hemostasis
- Close soft tissues in layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Arterial or venous bypass graft construction needed to revascularize limb following excision

CPT 35190 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 116

Response Rate: 30 (26%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.50	11.60	16.00	18.60	27.92
Pre-Service Time			85		
Intra-Service Time	45	79	90	120	270
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	38	99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.00	090	35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35190 (n=30)	Ref CPT 35879 (n=5)
Pre-service time	85	90
Intra-service time	90	90
Immediate Post-service time	30	40
Total critical care time	0	0
Total other hospital visit time	38	19
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.38	3.20
Intra-service	3.48	3.80
Post-service	2.93	2.60

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.24	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.40
Urgency of medical decision making	2.97	3.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.45	3.80
Physical effort required	3.14	3.20

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.24	3.60
Outcome depends on the skill and judgment of physician	3.45	4.00
Estimated risk of malpractice suit with poor outcome	2.97	3.00

CPT 35190 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe this unusual procedure was not valued accurately during the original Harvard / Hsiao studies. The following Building Block Analysis lends credence to our RUC survey data and helps justify our recommended RVW.

Building Block Method

Intra-service Intensity is median value from SVS/AAVS Intensity Survey

Other Intensities are from original Harvard Stone Equation

All times and visits are from RUC survey

CPT Code 35190

	Time	Intensity		RVU
				(=time x intensity)
Pre-service				
Day prior evaluation	30	0.0224		0.67
Same day evaluation	30	0.0224		0.67
Scrub, prep	28	0.0081		0.23
Pre-service total				1.57
Intra-service	90	0.081		7.29
Post-service				
Immediate post	30	0.0224		0.67
Subsequent visits			Visit n	E/M RVU
				(=n x E/M RVU)
99291			0	4.00
99231			2	0.64
99232			0	1.06
99233			0	1.51
99238			1	1.28
99211			0	0.17
99212			1	0.43
99213			1	0.65
99214			0	1.08
99215			0	1.73
Post-service total				4.31
Total RVW by Building Block Method				13.17

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CPT 35190 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: E No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,040	general surgery	2	urology
555	vascular surgery	1	colorectal surgery
262	thoracic surgery	1	emergency medicine
82	cardiac surgery	1	family practice
69	clinic or group practice (not gppp)	1	hand surgery
31	cardiology	2	general practice
25	peripheral vascular disease	1	nephrology
13	diagnostic radiology	1	nuclear medicine
4	plastic & reconstructive surgery	1	pathology
3	anesthesiology	1	pediatric medicine
3	orthopaedic surgery	1	pulmonary disease
2	crna, anesthesia assistant		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
5	7	No

This service represents new technology that has become more familiar (i.e., less work).

1	0	I agree
0	0	I do not agree

Patients requiring this service are now:

1	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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

CPT Code: 35206

Global Period: 090

RUC Rec. RVW:	13.25
SVS Rec. RVW:	16.00
Median Survey RVW:	16.00
Building Block RVW:	12.27
2000 RVW:	9.25

CPT Descriptor: Repair blood vessel, direct; upper extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old woman is stabbed in the left upper arm by a purse-snatcher. She arrives in the ED hypotensive, tachycardic and with no palpable antecubital or wrist pulses. ED physicians perform a rapid initial assessment, place large bore IVs, and control hemorrhage with direct pressure. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent direct repair of a lacerated brachial artery is performed. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along medial aspect of arm starting at axilla
- Rapidly dissect soft tissue to find brachial artery
- Avoid injury to nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp brachial artery near axilla to obtain proximal control
- Clamp brachial artery beyond injury to obtain distal control
- Repair brachial artery by application of fine vascular suture
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair

- Reverse anticoagulant with protamine & Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes
- Dictate operative note & Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35206 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 67 **Response Rate:** 30 (45%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.50	13.25	16.00	17.75	24.00
Pre-Service Time			50		
Intra-Service Time	45	64	90	90	120

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	38	99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.00	090	35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35206 (n=30)	Ref CPT 35879 (n=12)
Pre-service time	50	95
Intra-service time	90	90
Immediate Post-service time	25	18
Total critical care time	0	0
Total other hospital visit time	38	38
Discharge management time	36	36
Total office visit time	38	30

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.82	3.18
Intra-service	3.86	3.67
Post-service	3.03	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.93	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	3.25
Urgency of medical decision making	4.57	2.92

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.83	4.00
Physical effort required	3.30	3.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.93	3.50
Outcome depends on the skill and judgment of physician	3.97	3.83
Estimated risk of malpractice suit with poor outcome	4.23	3.42

CPT 35206 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe that this procedure was not evaluated accurately during the original Harvard / Hsiao studies. The following Building Block Method helps justify our RUC survey median value.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35206

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
 Intra-service	 90	 0.080	 7.20
 Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.20
 Total RVW by Building Block Method =			 12.27

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CPT 35206 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data is available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

952	general surgery	5	general practice
440	vascular surgery	3	surgical oncology
285	thoracic surgery	3	urology
76	plastic & reconstructive surgery	2	internal medicine
64	orthopaedic surgery	2	nephrology
59	cardiac surgery	2	nuclear medicine
46	cardiology	1	colorectal surgery
45	clinic or group practice (not gppp)	1	diagnostic radiology
25	peripheral vascular disease	1	emergency medicine
16	hand surgery	1	endocrinology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now::

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35221	Global Period: 090	RUC Rec. RVW:	24.39
		SVS Rec. RVW:	28.01
		Median Survey RVW:	28.01
		Building Block RVW:	24.39
		2000 RVW:	16.42

CPT Descriptor: Repair blood vessel, direct; intra-abdominal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old woman is shot in the abdomen by a carjacker. She arrives in the ED in shock. ED physicians intubate the patient, place large-bore IVs, and perform a rapid initial assessment. Pre-service work includes immediate review of preoperative studies, brief discussion with anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent direct repair of a gunshot wound to the infrarenal abdominal aorta is performed. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform laparotomy incision & explore abdomen to find site of hemorrhage
- Manually compress aorta if patient has exsanguinating hemorrhage
- Avoid injury to viscera & Rapidly dissect soft tissue from around aorta
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp aorta above injury to obtain proximal control
- Rapidly clamp aorta beyond injury to obtain distal control
- Rapidly repair aorta by application of fine vascular suture
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate

- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35221 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 114 **Response Rate:** 30 (26%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	27.00	28.01	31.00	38.00
Pre-Service Time			53		
Intra-Service Time	60	120	125	180	270

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	0	
Critical Care	60	99291X1
Other Hospital	139	99233X1 99232X2 99231X2
Discharge Day Mgmt	36	99238
Office Visits	38	99213X1 99212X1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

	Survey CPT 35221 (n=30)	Ref CPT 35081 (n=20)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	53	95
Intra-service time	125	155
Immediate Post-service time	45	45
Total critical care time	60	0
Total other hospital visit time	139	158
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	4.36	3.95
Intra-service	4.75	4.25
Post-service	4.18	3.95

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.61	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.34	4.10
Urgency of medical decision making	4.79	3.25

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.52	4.40
Physical effort required	4.59	4.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.93	4.21
Outcome depends on the skill and judgment of physician	4.79	4.50
Estimated risk of malpractice suit with poor outcome	3.72	3.95

CPT 35221 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe this high-complexity emergency service was not valued accurately during the original Harvard / Hsiao studies. The following Building Block Analysis supports an RVW greater than current, but it fails to fully support our survey median value of 28.01. We **strongly** believe the respondents in this survey **under-estimated** intra-service time (125 minutes). We found this to be the case in several of the following repair artery codes for which we have accurate, real skin-to-skin time in our vascular surgery database. Unfortunately, this service is so rare that there are none of these cases among the 5,000 procedures in our database.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35221

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	23	0.0081	0.19
Pre-service total			0.86
Intra-service	125	0.090	11.25
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	4.00	4.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			12.28
Total RVW by Building Block Method =			24.39

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CPT 35221 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

410	general surgery	4	obstetrics/gynecology
159	vascular surgery	3	critical care (intensivists)
69	thoracic surgery	3	surgical oncology
28	cardiac surgery	2	general practice
22	clinic or group practice (not gppp)	2	orthopaedic surgery
12	peripheral vascular disease	1	anesthesiology
8	urology	1	colorectal surgery
5	cardiology	1	emergency medicine
5	internal medicine	1	hand surgery
1	maxillofacial surgery	1	pediatric medicine
1	neurosurgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35226	Global Period: 090	RUC Rec. RVW:	14.50
		SVS Rec. RVW:	16.50
		Median Survey RVW:	16.50
		Building Block RVW:	13.65
		(based on survey median intra)	
		Building Block RVW:	15.41
		(based on real skin-to-skin time)	
		2000 RVW:	9.06

CPT Descriptor: Repair blood vessel, direct; lower extremity

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 70-year-old woman is stabbed in the thigh by a purse-snatcher. She arrives in the ED hypotensive, tachycardic and with no palpable popliteal or ankle pulses. ED physicians perform a rapid initial assessment, place large bore IVs, and control hemorrhage with direct pressure. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent direct repair of a lacerated femoral artery is performed. Post-service work includes immediate postop care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform thigh incision proximal to and adjacent to wound
- Rapidly dissect soft tissue to find normal proximal artery for proximal control
- Place proximal vascular clamp if patient has exsanguinating hemorrhage
- Rapidly explore site of trauma to find injured artery
- Manually compress artery if patient has active hemorrhage
- Avoid injury to nerves
- Rapidly dissect soft tissue from around artery proximal and distal to site of injury
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly apply vascular clamps proximal and distal to injured artery
- Rapidly repair artery by application of fine vascular suture
- Remove clamps & Apply additional sutures as needed to control hemorrhage

- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Fasciotomies if required

CPT 35226 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 170

Response Rate: 30 (18%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	14.50	16.50	19.88	27.00
Pre-Service Time			60		
Intra-Service Time	50	86	100	120	180
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	49	99232X1 99231X1			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213X1 99212X1			

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KEY REFERENCE SERVICE(S):

'00 RVW Global CPT Descriptor
16.00 090 35879 Revision, lower extremity arterial bypass, without thrombectomy, open;
with vein patch angioplasty

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

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

	Survey CPT 35226 (n=30)	Ref CPT 35879 (n=9)
TIME ESTIMATES (MEDIAN)		
Pre-service time	60	90
Intra-service time	100	75
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	49	68
Discharge management time	20	23
Total office visit time	38	30

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.80	3.11
Intra-service	3.73	3.33
Post-service	2.93	2.67

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.97	3.11
Urgency of medical decision making	4.53	2.67

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.67	3.56
Physical effort required	3.67	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.17	3.22
Outcome depends on the skill and judgment of physician	4.03	3.89
Estimated risk of malpractice suit with poor outcome	3.87	2.89

CPT 35226 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe this procedure was not valued accurately during the original Harvard / Hsiao studies. The following two Building Block Analyses justify the survey median. The first uses survey median data while the second uses real skin-to-skin intra-service data from our vascular surgery database. The second survey supports our contention that surgeons typically underestimate surgery skin-to-skin time when asked to complete RUC surveys.

Additional Note: More than 75% of claims for this service are submitted by cardiology. We believe this code represents an open surgical procedure. The procedures that cardiologists are using this code for are unlikely to be open. With addition of the above-noted vignette to the RUC (and HCFA) database, it may become necessary for cardiology to submit a new CPT code that reflects the procedure for which their specialty is using 35226.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35226

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	100	0.080	8.00
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.73
Total RVW by Building Block Method =			13.65

Building Block Analysis Recalculated using actual median Skin-to-Skin Intra Time of 122 minutes (n=16) culled from our database of 5,000 vascular surgery procedures performed by 31 vascular surgeons during 1999.

Building Block Method Using SVS/AAVS Survey Median IWPUT for Intra-service Work

CPT Code 35226

	Time	Intensity		RVU
				(=time x intensity)
Pre-service				
Day prior evaluation	0	0.0224		0.00
Same day evaluation	30	0.0224		0.67
Scrub, prep	30	0.0081		0.24
Pre-service total				0.92
Intra-service	122	0.080		9.76
Post-service				
Immediate post	30	0.0224		0.67
Subsequent visits			Visit n	E/M RVU
				(=n x E/M RVU)
99291			0	4.00
99231			1	0.64
99232			1	1.06
99233			0	1.51
99238			1	1.28
99211			0	0.17
99212			1	0.43
99213			1	0.65
99214			0	1.08
99215			0	1.73
Post-service total				4.73
Total RVW by Building Block Method				15.41

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CPT 35226 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

5,463	cardiology**	8	emergency medicine
1,091	general surgery	6	anesthesiology
993	vascular surgery	3	urology
931	diagnostic radiology	2	gastroenterology
764	thoracic surgery	2	general practice
418	clinic or group practice (not gppp)	2	hand surgery
327	internal medicine	1	colorectal surgery
318	cardiac surgery	1	crna, anesthesia assistant
69	interventional radiology	1	family practice
51	peripheral vascular disease	1	obstetrics/gynecology
20	plastic & reconstructive surgery	1	ophthalmology
11	orthopaedic surgery	1	podiatry

**Cardiology frequency with modifiers

35226	2,229
35226-50	5
35226-51	1,003
35226-52	2,217
35226-54	4
35226-62	6
35226-80	14

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

CPT 35226 Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions:
(first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
11	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
3	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
1	0	from inpatient to outpatient
2	0	no change

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

CPT Code: 35231	Global Period: 090	RUC Rec. RVW:	20.00
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	17.08
		2000 RVW:	12.00

CPT Descriptor: Repair blood vessel with vein graft; neck

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Rapidly dissect soft tissue from around arteries
- Avoid injury to cranial nerves
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp common carotid artery to obtain proximal control
- Clamp distal common carotid to obtain distal control
- Clamp internal and external carotids only if necessary to obtain distal control
- Rapidly incise skin of thigh for saphenous vein harvest
- Rapidly dissect soft tissue to find saphenous vein
- Rapidly clear soft tissue from around saphenous vein for adequate length
- Rapidly ligate and divide all saphenous vein branches
- Rapidly ligate and divide ends of saphenous vein and remove from thigh
- Rapidly test saphenous vein conduit for leaks
- Rapidly repair leaks with 7-0 vascular suture
- Rapidly suture vein conduit in place across injury site with 6-0 suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage

- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35231 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176 **Response Rate:** 27 (15%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	16.00	18.18	20.00	22.30	30.00
Pre-Service Time			60		
Intra-Service Time			120		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	71	99233x1 99232x1			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

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CPT 35231 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. We believe that it was not valued accurately during the initial Harvard / Hsiao studies. The following Building Block Table justifies an RVW substantially higher than the current value.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code

35231	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.088	10.56
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.60
Total RVW by Building Block Method =			17.08

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CPT 35231 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

32	plastic & reconstructive surgery	3	hand surgery
28	general surgery	1	cardiology
28	vascular surgery	1	general practice
16	thoracic surgery	1	neurosurgery
8	otolaryngology	1	orthopaedic surgery
4	cardiac surgery	1	peripheral vascular disease
4	clinic or group practice (not gppp)	1	pulmonary disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35236	Global Period: 090	RUC Rec. RVW:	17.11
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	16.49
		(based on survey median data)	
		Building Block RVW:	18.02
		(based on real intra-service time)	
		2000 RVW:	10.54

CPT Descriptor: Repair blood vessel with vein graft; upper extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 30-year-old woman presents to the ED with a gunshot wound to the left upper extremity. She has an axillary pulse, but no antecubital or wrist pulses. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of a transected brachial artery is performed using a vein graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along medial aspect of arm starting at axilla
- Rapidly dissect soft tissue to find brachial artery
- Avoid injury to nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp brachial artery near axilla to obtain proximal control
- Clamp brachial artery beyond injury to obtain distal control
- Rapidly incise skin of thigh for saphenous vein harvest
- Rapidly dissect soft tissue to find saphenous vein
- Rapidly clear soft tissue from around saphenous vein for adequate length
- Rapidly ligate and divide all saphenous vein branches

- Rapidly ligate and divide ends of saphenous vein and remove from thigh
- Rapidly test saphenous vein conduit for leaks & repair leaks with 7-0 vascular suture
- Rapidly suture vein conduit in place across injury site with 6-0 suture
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Fasciotomies, if required

CPT 35236 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 118

Response Rate: 30 (25%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	13.00	18.00	20.00	22.00	26.92
Pre-Service Time			60		
Intra-Service Time	60	120	120	150	210
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	68	99232x1 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
18.00	090	35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition

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

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

	Survey CPT 35236 (n=30)	Ref CPT 35881 (n=13)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	60	95
Intra-service time	120	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	49
Discharge management time	20	25
Total office visit time	38	38

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

Pre-service	3.83	2.92
Intra-service	3.86	3.23
Post-service	3.00	3.08

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.38
Urgency of medical decision making	4.47	2.85

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.17	3.77
Physical effort required	3.63	3.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.33	3.23
Outcome depends on the skill and judgment of physician	4.37	3.85
Estimated risk of malpractice suit with poor outcome	4.33	3.46

CPT 35236 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the past 5 years. Instead, we believe that this procedure was not evaluated accurately during the original Harvard / Hsiao extrapolations. The following Building Block Analyses support our median survey recommendation. The first uses time and visit data from the survey. The second substitutes accurate intra-service time from our vascular surgery database.

Building Block Method

Intra-service Intensity is the median value from the SVS/AAVA Intensity Survey

All other Intensities from the original Harvard Stone formula

All times and visits are from RUC survey

CPT Code 35236

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.085	10.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits			Visit n E/M RVU (=n x E/M RVU)
99291			0 4.00 0
99231			2 0.64 1.28
99232			1 1.06 1.06
99233			0 1.51 0
99238			1 1.28 1.28
99211			0 0.17 0
99212			1 0.43 0.43
99213			1 0.65 0.65
99214			0 1.08 0
99215			0 1.73 0
Post-service total			5.37
Total RVW by Building Block Method			16.49

Building Block recalculated using actual median skin-to-skin intra time of 138 minutes (n=8) culled from a 5,000 case database of 31 vascular surgeons.

Building Block Method

Intra-service intensity is median value for this service from SVS/AAVS Intensity Survey

Other Intensities from original Harvard Stone formula

Intra-service time is real skin-to-skin time from vascular database

All other times and visits from RUC survey

CPT Code 35236

	Time	Intensity		RVU
Pre-service				(=time x intensity)
Day prior evaluation	0	0.0224		0.00
Same day evaluation	30	0.0224		0.67
Scrub, prep	30	0.0081		0.24
Pre-service total				0.92
Intra-service	138	0.085		11.73
Post-service				
Immediate post	30	0.0224		0.67
Subsequent visits			Visit n	E/M RVU
				(=n x E/M RVU)
99291			0	4.00
99231			2	0.64
99232			1	1.06
99233			0	1.51
99238			1	1.28
99211			0	0.17
99212			1	0.43
99213			1	0.65
99214			0	1.08
99215			0	1.73
Post-service total				5.37
Total RVW by Building Block Method				18.02

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CPT 35236 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

402	general surgery	17	hand surgery
238	vascular surgery	13	cardiology
116	thoracic surgery	12	peripheral vascular disease
40	plastic & reconstructive surgery	4	urology
38	cardiac surgery	3	nuclear medicine
24	orthopaedic surgery	1	diagnostic radiology
21	clinic or group practice (not gppp)	1	general practice

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
9	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35246	Global Period: 090	RUC Rec. RVW:	26.45
		SVS Rec. RVW:	28.00
		Median Survey RVW:	28.00
		Building Block RVW:	29.81
		2000 RVW:	19.84

CPT Descriptor: Repair blood vessel with vein graft; intrathoracic, without bypass

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform thoracotomy
- Rapidly dissect soft tissue to find injured artery
- Avoid injury to lung, heart
- Rapidly dissect soft tissue from around artery
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp artery proximal and distal to injury
- Rapidly incise skin of thigh for saphenous vein harvest
- Rapidly dissect soft tissue to find saphenous vein
- Rapidly clear soft tissue from around saphenous vein for adequate length
- Rapidly ligate and divide all saphenous vein branches
- Rapidly ligate and divide ends of saphenous vein and remove from thigh
- Rapidly test saphenous vein conduit for leaks
- Rapidly repair leaks with 7-0 vascular suture
- Rapidly suture vein conduit in place across injury site with 6-0 suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow

- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate chest to wash out hematoma
- Final check for hemostasis
- Reapproximate ribs & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35246 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 95 **Response Rate:** 37 (39%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	21.50	25.00	28.00	30.00	42.00
Pre-Service Time			90		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	60	99291x1
Other Hospital	90	99233x1 99232x1 99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35246 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the past 5 years. Rather, we believe it was not valued accurately during the original Harvard / Hsiao extrapolations. The following Building Block Method substantiates the validity of our mini-survey median value, which is also our RVW recommendation.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35246

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.098	17.64
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	4.00	4.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			10.58
Total RVW by Building Block Method =			29.81

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CPT 35246 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

7	general surgery	2	plastic & reconstructive surgery
6	cardiac surgery	1	cardiology
6	thoracic surgery	1	surgical oncology
4	diagnostic radiology	1	urology
3	vascular surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
22	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
1	0	I do not agree

Patients requiring this service are now:

1	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35251	Global Period: 090	RUC Rec. RVW:	30.20
		SVS Rec. RVW:	31.00
		Median Survey RVW:	31.00
		Building Block RVW:	25.55
		2000 RVW:	17.49

CPT Descriptor: Repair blood vessel with vein graft; intra-abdominal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform laparotomy incision
- Rapidly explore abdomen to find site of hemorrhage
- Manually compress aorta if patient has exsanguinating hemorrhage
- Avoid injury to viscera
- Rapidly dissect soft tissue from around injured artery
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp injured artery proximal and distal to injury
- Rapidly incise skin of thigh for saphenous vein harvest
- Rapidly dissect soft tissue to find saphenous vein
- Rapidly clear soft tissue from around saphenous vein for adequate length
- Rapidly ligate and divide all saphenous vein branches
- Rapidly ligate and divide ends of saphenous vein and remove from thigh
- Rapidly test saphenous vein conduit for leaks
- Rapidly repair leaks with 7-0 vascular suture
- Rapidly suture vein conduit in place across injury site with 6-0 suture
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow

- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, graft patency, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35251 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): SVS/AAVS

Sample Size: 114

Response Rate: 27 (24%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	29.00	31.00	32.00	48.00
Pre-Service Time			70		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	139	99233x1 99232x2 99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35251 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

The work of this service has not changed in the last 5 years. Rather, we believe it was not assessed accurately during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps validate a substantial increase in RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35251

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	40	0.0224	0.90
Scrub, prep	30	0.0081	0.24
Pre-service total			1.14
Intra-service	180	0.092	16.47
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.94
Total RVW by Building Block Method =			25.55

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CPT 35251 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

73	general surgery	2	cardiac surgery
23	vascular surgery	2	plastic & reconstructive surgery
8	clinic or group practice (not gppp)	1	gynecology/oncology
7	surgical oncology	1	urology
6	thoracic surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35256	Global Period: 090	RUC Rec. RVW:	18.36
		SVS Rec. RVW:	21.76
		Median Survey RVW:	21.76
		Building Block RVW:	16.50
		(Using survey median data)	
		Building Block RVW:	21.85
		(Using real skin-to-skin intra time)	
		2000 RVW:	11.38

CPT Descriptor: Repair blood vessel with vein graft, lower extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 30-year-old woman presents to the ED with a gunshot wound to the thigh. She has a femoral pulse, but no popliteal or ankle pulses. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of a disrupted femoral artery is performed using a vein graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform thigh incision proximal to and adjacent to wound
- Rapidly dissect soft tissue to find normal proximal artery for proximal control
- Place proximal vascular clamp if patient has exsanguinating hemorrhage
- Rapidly explore site of trauma to find injured artery
- Manually compress artery if patient has active hemorrhage
- Avoid injury to nerves
- Rapidly dissect soft tissue from around artery proximal and distal to site of injury
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly apply vascular clamps proximal and distal to injured artery
- Rapidly incise skin of thigh for saphenous vein harvest
- Rapidly dissect soft tissue to find saphenous vein

- Rapidly clear soft tissue from around saphenous vein for adequate length
- Rapidly ligate and divide all saphenous vein branches
- Rapidly ligate and divide ends of saphenous vein and remove from thigh
- Rapidly test saphenous vein conduit for leaks
- Rapidly repair leaks with 7-0 vascular suture
- Rapidly suture vein conduit in place across injury site with 6-0 suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma
- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and note & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Fasciotomies, if required

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CPT 35256 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 190 **Response Rate:** 31 (16%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	16.00	19.25	21.76	22.00	30.00
Pre-Service Time			60		
Intra-Service Time	75	120	120	150	210

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	57	99231x3
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1 99212x1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

	Survey CPT 35256 ^a (n=31)	Ref CPT 35556 (n=20)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	60	95
Intra-service time	120	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	57	87
Discharge management time	36	36
Total office visit time	53	53

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

Pre-service	4.00	3.40
Intra-service	4.13	3.60
Post-service	3.39	3.05

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.70
Urgency of medical decision making	4.45	3.15

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	3.95
Physical effort required	3.97	3.60

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.32	3.58
Outcome depends on the skill and judgment of physician	4.32	4.15
Estimated risk of malpractice suit with poor outcome	4.13	3.45

CPT 35256 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed appreciably over the last 5 years. Rather, we believe this procedure was not valued accurately during the original Harvard / Hsiao studies. The following two Building Block analyses serve to validate the survey median survey value as an appropriate RVW recommendation. The first analysis uses RUC survey times and visits. The second substitutes accurate real skin-to-skin intra-service time. The second value substantiates our suspicion that surgeons tend to under-estimate skin-to-skin time on RUC surveys.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35256

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.085	10.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.38
Total RVW by Building Block Method =			16.50

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Building Block recalculated using actual skin-to-skin intra-service time of 183 minutes (n=7) culled from a database of 5,000 vascular operations performed by 31 surgeons.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey
 Other Intensity factors from the original Harvard / Stone formula
 Intra-service time is real skin-to-skin time from vascular surgery database
 All other time and visit data from RUC survey

CPT Code 35256

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	183	0.085	15.56
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.000	0
99231	3	0.64	1.92
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			5.38
Total RVW by Building Block Method			21.85

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CPT 35256 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

644	vascular surgery	4	general practice
583	general surgery	3	nuclear medicine
225	thoracic surgery	3	urology
111	clinic or group practice (not gppp)	1	anesthesiology
46	cardiac surgery	1	critical care (intensivists)
33	peripheral vascular disease	1	cma, anesthesia assistant
17	cardiology	1	orthopaedic surgery
16	plastic & reconstructive surgery	1	pulmonary disease
4	family practice		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
6	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35261	Global Period: 090	RUC Rec. RVW:	17.80
		SVS Rec. RVW:	19.00
		Median Survey RVW:	19.00
		Building Block RVW:	16.72
		2000 RVW:	11.63

CPT Descriptor: Repair blood vessel with graft other than vein; neck

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Rapidly dissect soft tissue from around arteries
- Avoid injury to cranial nerves
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp common carotid artery to obtain proximal control
- Clamp distal common carotid to obtain distal control
- Clamp internal and external carotids only if necessary to obtain distal control
- Excise injured segment of artery
- Choose appropriately sized synthetic conduit
- Perform proximal and distal artery-conduit anastomoses with 5-0 vascular suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma

- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not Included in this Service:

- Diagnostic angiography, if performed

CPT 35261 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176 **Response Rate:** 27 (15%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	16.00	18.00	19.00	21.50	18.00
Pre-Service Time			60		
Intra-Service Time			120		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	71	99233x1 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35261 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed in the last 5 years. Rather, we believe it was not valued accurately during the original Harvard / Hsiao extrapolations. The following Building Block analysis justifies an RVW greater than the current value.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35261

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.085	10.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.60
Total RVW by Building Block Method =			16.72

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CPT 35261 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

51	general surgery	3	neurosurgery
34	vascular surgery	1	cardiology
15	thoracic surgery	1	peripheral vascular disease
12	cardiac surgery	1	plastic & reconstructive surgery
4	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35266	Global Period: 090	RUC Rec. RVW:	14.91
		SVS Rec. RVW:	18.00
		Median Survey RVW:	18.00
		Building Block RVW:	13.67
		2000 RVW:	10.30

CPT Descriptor: Repair blood vessel with graft other than vein; upper extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 80-year-old woman presents to the ED with an ischemic left upper extremity following blunt trauma to the shoulder and arm. She has a high axillary pulse, but no antecubital or wrist pulses. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of a transected brachial artery is performed using a short segment of synthetic graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along medial aspect of arm starting at axilla
- Rapidly dissect soft tissue to find brachial artery
- Avoid injury to nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp brachial artery near axilla to obtain proximal control
- Clamp brachial artery beyond injury to obtain distal control
- Excise injured segment of artery
- Choose appropriately sized synthetic conduit
- Perform proximal and distal artery-conduit anastomoses with 5-0 vascular suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage

- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily hospital visits, based on patient requirements
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Fasciotomies, if required
- Diagnostic angiography, if required

CPT 35266 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 140

Response Rate: 31 (22%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12.00	16.25	18.00	18.45	30.00
Pre-Service Time			60		
Intra-Service Time	60	90	90	120	150
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	68	99232x1 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
18.00	090	35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition

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

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

	Survey CPT 35266 (n=31)	Ref CPT 35881 (n=9)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	60	90
Intra-service time	90	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	68
Discharge management time	36	36
Total office visit time	38	30

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

Pre-service	3.84	3.67
Intra-service	3.68	3.22
Post-service	2.77	2.78

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.13	3.11
Urgency of medical decision making	4.42	2.67

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.74	3.33
Physical effort required	3.16	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.87	3.22
Outcome depends on the skill and judgment of physician	3.83	3.56
Estimated risk of malpractice suit with poor outcome	3.90	3.56

CPT 35266 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the past 5 years. We believe that this procedure was not valued accurately during the original Harvard / Hsiao extrapolations. The following Building Block analysis justifies an RVW significantly higher than the current value. Of note, we believe the intra-service time is unreasonably low, but we have no hard data to apply here. It may be important to note that the RUC database intra-service time for reference service 35881 is 150 minutes, not the 120 minutes assumed by the 9 respondents who chose that service as reference.

Building Block Method

Intra-service Intensity is median value for that service from SVS/AAVS Intensity Survey

Other Intensity factors are from original Harvard Stone formula

All times and visits are from RUC survey

CPT Code 35266

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	90	0.082	7.38
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			5.37
Total RVW by Building Block Method			13.67

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CPT 35266 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

424	general surgery	10	peripheral vascular disease
354	vascular surgery	2	hand surgery
144	thoracic surgery	1	emergency medicine
32	cardiology	1	family practice
11	cardiac surgery	1	general practice
11	clinic or group practice (not gppp)	1	medical oncology
11	urology	1	plastic & reconstructive surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
3 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35276	Global Period: 090	RUC Rec. RVW:	24.25
		SVS Rec. RVW:	27.50
		Median Survey RVW:	27.50
		Building Block RVW:	28.99
		2000 RVW:	18.75

CPT Descriptor: Repair blood vessel with graft other than vein; intrathoracic, without bypass

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform thoracotomy
- Rapidly dissect soft tissue to find injured artery
- Avoid injury to lung, heart
- Rapidly dissect soft tissue from around artery
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp artery proximal and distal to injury
- Excise injured segment of artery
- Choose appropriately sized synthetic conduit
- Perform proximal and distal artery-conduit anastomoses with vascular suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate chest to wash out hematoma
- Final check for hemostasis
- Reapproximate ribs & Close soft tissue in multiple layers

- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35276 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 82 **Response Rate:** 36 (44%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	20.50	24.25	27.50	30.00	37.00
Pre-Service Time			90		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	60	99291x1
Other Hospital	68	99232x1 99231x2
Discharge Day Mgmt	36	99238
Office Visits	49.5	99213x1.5 99212x1

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CPT 35276 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the past 5 years. Rather, we believe it was not valued accurately during the original Harvard / Hsiao studies. The following Building Block analysis exactly justifies our mini-survey median RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35276

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.097	17.37
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	4.00	4.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1.5	0.65	0.98
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			9.63
Total RVW by Building Block Method =			28.99

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CPT 35276 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

12	thoracic surgery
5	cardiac surgery
2	cardiology
2	vascular surgery
1	general surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
22	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
1	0	I do not agree

Patients requiring this service are now:

1	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35281	Global Period: 090	RUC Rec. RVW:	28.00
		SVS Rec. RVW:	28.01
		Median Survey RVW:	28.01
		Building Block RVW:	28.65
		2000 RVW:	16.48

CPT Descriptor: Repair blood vessel with graft other than vein; intra-abdominal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform laparotomy incision
- Rapidly explore abdomen to find site of hemorrhage
- Manually compress aorta if patient has exsanguinating hemorrhage
- Avoid injury to viscera
- Rapidly dissect soft tissue from around injured artery
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp injured artery proximal and distal to injury
- Excise injured segment of artery
- Choose appropriately sized synthetic conduit
- Perform proximal and distal artery-conduit anastomoses with vascular suture
- Flush system to remove air and debris
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma

- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35281 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 114 **Response Rate:** 38 (33%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.50	27.00	28.01	30.00	44.00
Pre-Service Time			85		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	40	
Critical Care	60	99291 x 1
Other Hospital	98	99232 x 2, 99231 x 2
Discharge Day Mgmt	36	99238
Office Visits	61	99213 x 2, 99212 x 1

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CPT 35281 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median mini-survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35281

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	25	0.0081	0.20
Pre-service total			1.55
Intra-service	180	0.090	16.20
Post-service			
Immediate post	40	0.0224	0.90
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	3.60	3.60
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			10.91
Total RVW by Building Block Method =			28.65

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CPT 35281 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

67	general surgery	1	diagnostic radiology
35	vascular surgery	1	cardiology
11	thoracic surgery	1	plastic & reconstructive surgery
9	clinic or group practice (not gppp)	1	surgical oncology
6	cardiac surgery	1	urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2	0	Yes
24	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
2	0	I do not agree

Patients requiring this service are now:

2	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
2	0	no change

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

CPT Code: 35286	Global Period: 090	RUC Rec. RVW:	16.16
		SVS Rec. RVW:	19.53
		Median Survey RVW:	19.53
		Building Block RVW:	14.17
		(Using median survey data)	
		Building Block RVW:	15.83
		(Using real skin-to-skin intra time)	
		2000 RVW:	11.87

CPT Descriptor: Repair blood vessel with graft other than vein; lower extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 80-year-old woman presents to the ED with an ischemic lower extremity following blunt trauma. She has a groin pulse, but no popliteal or ankle pulses. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent repair of a transected femoral artery is performed using a segment of synthetic graft. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergent service. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform thigh incision proximal to and adjacent to wound
- Rapidly dissect soft tissue to find normal proximal artery for proximal control
- Place proximal vascular clamp if patient has exsanguinating hemorrhage
- Rapidly explore site of trauma to find injured artery
- Manually compress artery if patient has active hemorrhage
- Avoid injury to nerves
- Rapidly dissect soft tissue from around artery proximal and distal to site of injury
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly apply vascular clamps proximal and distal to injured artery
- Excise injured segment of artery & Choose appropriately sized synthetic conduit
- Perform proximal and distal artery-conduit anastomoses with vascular suture

- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Fasciotomies, if required

CPT 35286 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 155

Response Rate: 30 (19%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	18.25	19.53	21.75	30.00
Pre-Service Time			60		
Intra-Service Time	53	90	100	120	120

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	57	99231X3
Discharge Day Mgmt	36	99238
Office Visits	38	99213X2 99212X1

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KEY REFERENCE SERVICE(S):

'00 RVW Global CPT Descriptor
 19.53 090 35656 Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35286 (n=30)	Ref CPT 35656 (n=18)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	60	90
Intra-service time	100	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	57	87
Discharge management time	25	23
Total office visit time	38	53

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

Pre-service	3.90	3.72
Intra-service	3.90	3.83
Post-service	3.24	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.61
Urgency of medical decision making	4.37	2.83

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.03	4.22
Physical effort required	3.73	3.83

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.33	3.94
Outcome depends on the skill and judgment of physician	4.30	4.39
Estimated risk of malpractice suit with poor outcome	3.83	3.61

CPT 35286 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database. The second analysis supports our belief that surgeons tend to under-estimate skin-to-skin times.

Building Block Method

Intra-service Intensity is median value for this service from SVS/AAVS Intensity Survey

Other Intensities are those used in original Harvard Stone formula

All times and visits from RUC survey

CPT Code 35286

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	100	0.083	8.30
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	3	0.64	1.92
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.95
Total RVW by Building Block Method			14.17

Building Block recalculated using actual skin-to-skin time of 120 minutes (n=7) from a database of 5,000 vascular surgery operations performed by 31 surgeons.

Building Block Method

Intra-service Intensity is median value for this service from SVS/AAVS Intensity Survey

Other Intensities are those used in original Harvard Stone formula

Intra-service time is real skin-to-skin time from vascular surgery database

All other times and visits from RUC survey

CPT Code 35286

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.083	9.96
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	3	0.64	1.92
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.95
Total RVW by Building Block Method			15.83

Additional Note: Actual intra-service time for reference service 35656 is 150 minutes in the RUC database and 137.5 minutes in the vascular surgery skin-to-skin database for 33 operations.

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CPT 35286 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

533	general surgery	3	general practice
442	vascular surgery	2	orthopaedic surgery
226	thoracic surgery	1	anesthesiology
77	cardiac surgery	1	certified clinical nurse specialist
63	cardiology	1	endocrinology
51	clinic or group practice (not gppp)	1	internal medicine
28	diagnostic radiology	1	interventional radiology
17	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
11	7	No

This service represents new technology that has become more familiar (i.e., less work).

1	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
1	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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

CPT Code: 35311	Global Period: 090	RUC Rec. RVW:	27.00
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	25.99
		2000 RVW:	23.85

CPT Descriptor: Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform thoracotomy or median sternotomy
- Dissect soft tissue to find diseased artery
- Avoid injury to lung, heart, phrenic nerves
- Dissect soft tissue from around artery
- Gain proximal and distal control
- Administer systemic anticoagulant and wait for circulation
- Clamp artery proximal and distal to diseased segment
- Incise artery longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris
- Close arteriotomy with fine vascular suture & Flush system once more to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate chest & Final check for hemostasis
- Reapproximate ribs & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35311 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 82

Response Rate: 28 (34%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	20.00	27.00	30.00	30.91	38.00
Pre-Service Time			90		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	120	99233x1	99232x2	99231x1	
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1	99212x1		

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CPT 35311 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps substantiate the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35311

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.095	17.10
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.30
Total RVW by Building Block Method =			25.99

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CPT 35311 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

20	cardiac surgery	5	vascular surgery
10	thoracic surgery	2	cardiology
9	general surgery	2	clinic or group practice (not gppp)

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35321	Global Period: 090	RUC Rec. RVW:	16.00
		SVS Rec. RVW:	18.00
		Median Survey RVW:	18.00
		Building Block RVW:	13.90
		Using survey median intra time	
		2000 RVW:	11.97

CPT Descriptor: Thromboendarterectomy, with or without patch graft; axillary-brachial

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old right-handed male smoker has disabling right arm pain with exercise. No pulses are palpable at the right brachial, radial, or ulnar positions. An aortogram reveals a critical stenosis of the distal axillary and brachial arteries. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, then position patient, prep and drape. Endarterectomy is performed through an axillary and arm incision. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin of chest and/or arm proximal, across, and distal to region of arterial disease
- Dissect soft tissue to find artery
- Avoid injury to nerves
- Dissect soft tissue from around artery
- Gain proximal and distal control
- Administer systemic anticoagulant and wait for circulation
- Clamp artery proximal and distal to diseased segment
- Incise artery longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris & Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris & Remove clamps

- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate wound & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35321 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 100 **Response Rate:** 38 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12.00	16.00	18.00	18.50	28.01
Pre-Service Time			90		
Intra-Service Time	45	90	100	120	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	38	99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
18.70	090	35301	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision

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

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

	Survey CPT 35321 (n=38)	Ref CPT 35301 (n=15)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	90	95
Intra-service time	100	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	38	19
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.39	4.00
Intra-service	3.63	4.47
Post-service	3.00	3.60

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.35	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.80
Urgency of medical decision making	3.21	3.73

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	4.47
Physical effort required	3.37	3.53

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.74	4.80
Outcome depends on the skill and judgment of physician	4.16	4.67
Estimated risk of malpractice suit with poor outcome	3.89	4.53

CPT 35321 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps substantiate the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code

35321	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	100	0.080	8.00
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.31
Total RVW by Building Block Method			13.90

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CPT 35321 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

553	general surgery	8	peripheral vascular disease
297	thoracic surgery	7	urology
170	vascular surgery	3	general practice
13	clinic or group practice (not gppp)	2	hand surgery
9	cardiac surgery	1	colorectal surgery
9	cardiology	1	critical care (intensivists)
1	family practice		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
9	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35331	Global Period: 090	RUC Rec. RVW: 26.20
		SVS Rec. RVW: 28.01
		Median Survey RVW: 28.01
		Building Block RVW: 25.82 (Using survey median data)
		2000 RVW: 23.52

CPT Descriptor: Thromboendarterectomy, with or without patch graft; abdominal aorta

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65 year-old female cigarette-smoker has disabling bilateral leg pain after walking 50 feet. She has no femoral pulses. Arteriography reveals atherosclerotic plaque causing a near-complete occlusion of her infrarenal abdominal aorta while the remainder of her arteries has minimal disease. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. Aortic endarterectomy is performed. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & Explore abdomen
- Mobilize bowel from over aorta
- Incise retroperitoneum to expose aorta
- Dissect soft tissue from around aorta
- Avoid injury to vena cava
- Gain proximal and distal aortic control
- Administer systemic anticoagulant and wait for circulation
- Clamp aorta proximal and distal to diseased segment
- Incise aorta longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris & Close arteriotomy with fine vascular suture

- Flush system once more to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate abdomen
- Final check for hemostasis & Close laparotomy
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35331 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 60 **Response Rate:** 31 (52%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	26.00	28.00	28.01	29.25	38.50
Pre-Service Time			95		
Intra-Service Time	120	150	180	210	270

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	136	99232x2 99231x4
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1 99212x2

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

	Survey CPT 35331 (n=31)	Ref CPT 35081 (n=23)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	95	95
Intra-service time	180	180
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	136	136
Discharge management time	36	36
Total office visit time	53	53

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.28	4.18
Intra-service	4.55	4.50
Post-service	3.79	3.68

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.09
Urgency of medical decision making	3.37	3.48

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.67	4.39
Physical effort required	4.40	4.30

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.53	4.48
Outcome depends on the skill and judgment of physician	4.63	4.48
Estimated risk of malpractice suit with poor outcome	4.20	3.96

CPT 35331 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35331

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	25	0.0224	0.56
Scrub, prep	30	0.0081	0.24
Pre-service total			1.48
Intra-service	180	0.090	16.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			8.14
Total RVW by Building Block Method			25.82

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CPT 35331 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

92	general surgery	6	cardiology
78	vascular surgery	2	gastroenterology
44	thoracic surgery	2	peripheral vascular disease
8	cardiac surgery	1	pulmonary disease
8	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35351	Global Period: 090	RUC Rec. RVW:	23.00
		SVS Rec. RVW:	26.00
		Median Survey RVW:	26.00
		Building Block RVW:	22.39
		2000 RVW:	20.11

CPT Descriptor: Thromboendarterectomy, with or without patch graft; iliac

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy
- Explore abdomen
- Mobilize bowel from over distal aorta and iliac arteries
- Incise retroperitoneum to expose distal aorta and iliacs
- Dissect soft tissue from around distal aorta and iliacs
- Avoid injury to vena cava and iliac veins
- Gain proximal and distal vascular control
- Administer systemic anticoagulant and wait for circulation
- Place vascular clamps proximal and distal to diseased segment
- Incise iliac artery longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris
- Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine

- Irrigate abdomen
- Final check for hemostasis & Close laparotomy
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35351 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 60 **Response Rate:** 32 (53%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	22.25	26.00	27.03	32.50
Pre-Service Time			90		
Intra-Service Time			150		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35351 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates a value close to the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35351

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.090	13.50
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.30
Total RVW by Building Block Method =			22.39

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CPT 35351 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

334	general surgery	9	cardiology
288	vascular surgery	5	general practice
125	thoracic surgery	5	urology
27	cardiac surgery	2	family practice
22	clinic or group practice (not gppp)	1	internal medicine
12	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35355	Global Period: 090	RUC Rec. RVW:	18.50
		SVS Rec. RVW:	19.77
		Median Survey RVW:	19.77
		Building Block RVW:	19.24
		2000 RVW:	16.09

CPT Descriptor: Thromboendarterectomy, with or without patch graft; iliofemoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male smoker has disabling right calf pain with ambulation. No pulses are palpable at the right femoral, popliteal, DP or PT positions. An aortogram reveals diffuse atherosclerosis with complete occlusion of the distal external iliac and entire common femoral artery. The more proximal iliac, the superficial femoral, and the profunda femoris arteries are not severely diseased. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, then position, prep and drape patient. Endarterectomy of the common femoral and external iliac arteries is performed through a groin incision. This includes manipulation of the inguinal ligament to gain access to the distal external iliac artery plus any subsequent repair of the ligament. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin of pelvis and groin proximal, across, and distal to region of arterial disease
- Dissect soft tissue to find artery
- Avoid injury to nerves
- Clear soft tissue from around artery & Gain proximal and distal arterial control
- Administer systemic anticoagulant and wait for circulation
- Clamp artery proximal and distal to diseased segment
- Incise artery longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media

- Irrigate to remove debris & Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate wound & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35355 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 85 **Response Rate:** 30 (35%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	17.00	18.50	19.77	21.38	30.76
Pre-Service Time			90		
Intra-Service Time	90	120	120	165	220

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	117	99232X2 99231X3
Discharge Day Mgmt	36	99238
Office Visits	38	99213X1 99212X1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

	Survey CPT 35355 (n=30)	Ref CPT 35556 (n=14)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	90	90
Intra-service time	120	145
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	117	87
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.57	3.43
Intra-service	3.93	3.79
Post-service	3.07	2.85

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.77	3.64
Urgency of medical decision making	3.20	3.21

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.07	3.86
Physical effort required	3.80	3.79

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.60	3.64
Outcome depends on the skill and judgment of physician	4.17	3.93
Estimated risk of malpractice suit with poor outcome	3.70	3.64

CPT 35355 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35355

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
Pre-service total			1.36
Intra-service	120	0.090	10.80
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.07
Total RVW by Building Block Method =			19.24

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CPT 35355 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

531	general surgery	3	endocrinology
390	vascular surgery	3	general practice
187	thoracic surgery	3	internal medicine
40	clinic or group practice (not gppp)	2	colorectal surgery
36	cardiac surgery	2	pulmonary disease
30	cardiology	1	family practice
12	peripheral vascular disease	1	obstetrics/gynecology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35361	Global Period: 090	RUC Rec. RVW:	28.20
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	30.13
		2000 RVW:	23.59

CPT Descriptor: Thromboendarterectomy, with or without patch graft; combined aortoiliac

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy
- Explore abdomen
- Mobilize bowel from over aorta and iliac arteries
- Incise retroperitoneum to expose aorta and iliacs
- Clear soft tissue from aorta and iliacs
- Avoid injury to vena cava and iliac veins
- Gain proximal and distal vascular control
- Administer systemic anticoagulant and wait for circulation
- Place vascular clamps proximal and distal to diseased segment
- Incise aorta and iliac artery longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris & Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis
- Close laparotomy

- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35361 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 60 **Response Rate:** 32 (53%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.70	29.00	30.00	30.77	45.50
Pre-Service Time			90		
Intra-Service Time			210		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	139	99233x1 99232x2 99231x2
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35361 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35361

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	210	0.095	19.95
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.59
Total RVW by Building Block Method =			30.13

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CPT 35361 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

47	general surgery	3	clinic or group practice (not gppp)
37	vascular surgery	2	cardiology
16	thoracic surgery	2	peripheral vascular disease
5	cardiac surgery	1	neurosurgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35363	Global Period: 090	RUC Rec. RVW:	30.20
		SVS Rec. RVW:	32.00
		Median Survey RVW:	32.00
		Building Block RVW:	33.62
		2000 RVW:	24.66

CPT Descriptor: Thromboendarterectomy, with or without patch graft; combined aortoiliofemoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy and groin incisions & Explore abdomen
- Mobilize bowel from over aorta and iliac arteries
- Incise retroperitoneum to expose aorta and iliacs
- Clear soft tissue from aorta and iliacs
- Avoid injury to vena cava and iliac veins
- Gain proximal and distal vascular control
- Dissect soft tissue in groin(s) to find femoral artery
- Clear soft tissue from surface of femoral artery
- Administer systemic anticoagulant and wait for circulation
- Place vascular clamps proximal and distal to diseased segment
- Incise aorta, iliac, and femoral arteries longitudinally across diseased segment
- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris
- Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine

- Irrigate abdomen & Final check for hemostasis
- Close laparotomy
- Irrigate subcutaneous tissue & Close skin
- Irrigate groin incisions & Close soft tissue and skin in groin(s)

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35363 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 60 **Response Rate:** 32 (53%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.70	30.00	32.00	33.25	60.50
Pre-Service Time			90		
Intra-Service Time			240		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	158	99233x1 99232x2 99231x3
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35363 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35363

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	240	0.095	22.80
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			9.23
Total RVW by Building Block Method =			33.62

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CPT 35363 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

35	general surgery	3	cardiology
19	thoracic surgery	3	peripheral vascular disease
19	vascular surgery	2	cardiac surgery
5	clinic or group practice (not gppp)	1	general practice

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35371	Global Period: 090	RUC Rec. RVW:	14.72
		SVS Rec. RVW:	18.00
		Median Survey RVW:	18.00
		Building Block RVW:	13.83
		(Using median survey data)	
		Building Block RVW:	14.31
		(Using actual skin-to-skin intra time)	
		2000 RVW:	11.64

CPT Descriptor: Thromboendarterectomy, with or without patch graft; common femoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male smoker has disabling right calf pain with ambulation. No pulses are palpable at the right femoral, popliteal, DP or PT positions. An aortogram reveals diffuse atherosclerosis with complete occlusion of the common femoral artery. The iliac, superficial femoral, and profunda femoris arteries are not severely diseased. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, then position patient, prep and drape. Endarterectomy of the common femoral artery is performed through a groin incision. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin in groin & Dissect soft tissue to find common femoral artery
- Avoid injury to nerves
- Clear soft tissue from around artery
- Gain proximal and distal arterial control
- Administer systemic anticoagulant and wait for circulation
- Clamp artery proximal and distal to diseased segment
- Incise artery longitudinally across diseased segment

- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris & Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate wound
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35371 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 98

Response Rate: 30 (31%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	11.50	17.00	18.00	18.70	21.25
Pre-Service Time			75		
Intra-Service Time	60	90	103	120	200

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	38	99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35371 (n=30)	Ref CPT 35656 (n=7)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	75	90
Intra-service time	103	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	38	106
Discharge management time	36	36
Total office visit time	38	61

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

Pre-service	3.28	4.00
Intra-service	3.48	4.18
Post-service	2.93	3.36

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.47	4.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	4.27
Urgency of medical decision making	2.97	3.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.80	4.27
Physical effort required	3.33	3.73

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.57	4.09
Outcome depends on the skill and judgment of physician	3.97	4.55
Estimated risk of malpractice suit with poor outcome	3.43	3.73

CPT 35371 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service may have increased in complexity over the last 5 years based on response to the Five-year Review Question (see below). In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database. The second analysis supports our belief that surgeons tend to under-estimate skin-to-skin times.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35371

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	20	0.0224	0.45
Scrub, prep	20	0.0081	0.16
Pre-service total			1.28
Intra-service	103	0.080	8.24
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.31
Total RVW by Building Block Method			13.83

Recalculated Building Block Method using actual intra-service time of 109 minutes (n=19) culled from a database of 5,000 vascular surgery operations performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is real skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code

35371	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	20	0.0224	0.45
Scrub, prep	20	0.0081	0.16
Pre-service total			1.28
Intra-service	109	0.080	8.72
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.31
Total RVW by Building Block Method			14.31

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CPT 35371 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,991	general surgery	5	family practice
1,585	vascular surgery	5	internal medicine
584	thoracic surgery	4	pulmonary disease
176	clinic or group practice (not gppp)	3	emergency medicine
147	cardiac surgery	3	plastic & reconstructive surgery
95	peripheral vascular disease	3	urology
85	cardiology	2	gastroenterology
12	general practice	1	hand surgery
6	diagnostic radiology	1	hematology/oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2 0 Yes
7 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
2 0 I do not agree

Patients requiring this service are now:
2 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:
0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
2 0 no change

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

CPT Code: 35372	Global Period: 090	RUC Rec. RVW:	18.00
		SVS Rec. RVW:	18.50
		Median Survey RVW:	18.50
		Building Block RVW:	15.63
		(Using median survey data)	
		Building Block RVW:	18.09
		(Using real skin-to-skin intra time)	
		2000 RVW:	13.56

CPT Descriptor: Thromboendarterectomy, with or without patch graft; deep (profunda) femoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 75-year-old diabetic female smoker has severe right foot pain at rest. Her right femoral pulse is palpable, but there are no pulses at more distal locations. Doppler studies confirm critical ischemia. An aortogram reveals nearly normal iliac and common femoral arteries. Her profunda femoris is severely stenotic from its origin to the second branch point, but beyond that it is nearly normal. The superficial femoral artery is completely occluded. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. Endarterectomy of the profunda femoris is performed. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin in groin & Dissect soft tissue to find deep femoral artery
- Avoid injury to nerves
- Clear soft tissue from around artery
- Gain proximal and distal arterial control
- Administer systemic anticoagulant and wait for circulation
- Clamp artery proximal and distal to diseased segment
- Incise artery longitudinally across diseased segment

- Perform endarterectomy by excising plaque, intima, and most of media
- Irrigate to remove debris & Close arteriotomy with fine vascular suture
- Flush system once more to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate wound
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, reconstruction patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35372 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 92

Response Rate: 31 (34%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	16.00	18.00	18.50	19.27	25.00
Pre-Service Time			80		
Intra-Service Time	90	113	120*	150	200

*Assume 150 minutes for intra-service time utilizing actual time data.

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	38	99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35372 (n=31)	Ref CPT 35556 (n=7)
Pre-service time	80	90
Intra-service time	150	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	38	87
Discharge management time	36	36
Total office visit time	38	61

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

Pre-service	3.39	3.45
Intra-service	3.68	3.75
Post-service	3.10	2.91

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.64
Urgency of medical decision making	3.37	3.27

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.06	3.91
Physical effort required	3.35	3.55

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.65	3.91
Outcome depends on the skill and judgment of physician	4.16	4.18
Estimated risk of malpractice suit with poor outcome	3.45	3.64

CPT 35372 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35372

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	25	0.0224	0.56
Scrub, prep	30	0.0081	0.24
Pre-service total			1.48
Intra-service	120	0.082	9.84
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.31
Total RVW by Building Block Method			15.63

Building Block recalculated using actual skin-to-skin Intra-service time = 150 (n = 10) culled from a database of 5,000 vascular surgery operations performed in 1999 by 31 surgeons.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is actual skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code 35372

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	25	0.0224	0.56
Scrub, prep	30	0.0081	0.24
Pre-service total			1.48
Intra-service	150	0.082	12.30
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			4.31
Total RVW by Building Block Method			18.09

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CPT 35372 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,325	general surgery	2	emergency medicine
1,161	vascular surgery	2	family practice
416	thoracic surgery	2	hand surgery
128	cardiac surgery	2	hematology/oncology
125	clinic or group practice (not gppp)	1	anesthesiology
44	cardiology	1	endocrinology
28	peripheral vascular disease	1	internal medicine
6	general practice	1	maxillofacial surgery
3	pulmonary disease	1	nurse practitioner

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2	0	Yes
6	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
2	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
2	0	no change

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

CPT Code: 35511	Global Period: 090	RUC Rec. RVW:	21.20
		SVS Rec. RVW:	22.00
		Median Survey RVW:	22.00
		Building Block RVW:	19.11
		2000 RVW:	16.83

CPT Descriptor: Bypass graft, with vein; subclavian-subclavian

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just superior to clavicle bilaterally
- Dissect soft tissue to find subclavian artery on both sides
- Avoid injury to nerves
- Clear soft tissue from around arteries
- Incise skin of thigh for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks
- Repair leaks with 7-0 vascular suture
- Create subcutaneous tunnel from one subclavian artery to the other
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to subclavian artery on inflow side
- Incise artery at proximal anastomosis site
- Anastomose vein conduit to artery with 6-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Pull vein conduit through tunnel

- Apply proximal and distal arterial clamps on recipient side
- Perform arteriotomy & Cut vein conduit to appropriate length
- Perform distal anastomosis
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate incisions
- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35511 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 96 **Response Rate:** 46 (48%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12	20	22.00	24.50	32.00
Pre-Service Time			75		
Intra-Service Time			150		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	60	99232x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35511 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35511

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	150	0.085	12.75
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.04
Total RVW by Building Block Method =			19.11

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CPT 35511 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

7	general surgery	2	cardiology
7	thoracic surgery	1	cardiac surgery
7	vascular surgery		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1 0 Yes
17 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
1 0 I do not agree

Patients requiring this service are now:

1 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
1 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35518	Global Period: 090	RUC Rec. RVW:	21.20
		SVS Rec. RVW:	22.50
		Median Survey RVW:	22.50
		Building Block RVW:	19.82
		2000 RVW:	15.42

CPT Descriptor: Bypass graft, with vein; axillary-axillary

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. No clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle bilaterally
- Dissect soft tissue to find axillary artery on each side
- Avoid injury to nerves
- Clear soft tissue from around arteries
- Incise skin of thigh for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks
- Repair vein conduit leaks with 7-0 vascular suture
- Create subcutaneous tunnel from one axillary artery to the other
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to axillary artery on inflow side
- Incise artery at proximal anastomosis site
- Anastomose vein conduit to artery with 6-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Pull vein conduit through tunnel
- Apply proximal and distal arterial clamps on recipient side
- Perform arteriotomy

- Cut vein conduit to appropriate length & Perform distal anastomosis
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate incisions & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous vein harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35518 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80

Response Rate: 30 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	20.13	22.50	25.00	35.00
Pre-Service Time			75		
Intra-Service Time			140		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	109	99232x3 99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35518 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35518

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	140	0.084	11.76
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	3	1.06	3.18
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.74
Total RVW by Building Block Method =			19.82

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CPT 35518 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

85	general surgery	3	cardiac surgery
69	vascular surgery	2	cardiology
10	thoracic surgery	1	peripheral vascular disease
4	clinic or group practice (not gppp)	1	urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35521	Global Period: 090	RUC Rec. RVW:	22.20
		Median Survey RVW:	24.50
		Building Block RVW:	22.71
		2000 RVW:	16.17

CPT Descriptor: Bypass graft, with vein; axillary-femoral

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle
 - Dissect soft tissue to find axillary artery
 - Avoid injury to nerves
 - Clear soft tissue from around artery
 - Incise skin of groin over femoral artery & Dissect soft tissue to find artery
 - Clear soft tissue from surface of artery
 - Incise skin of thigh and calf for saphenous vein harvest
 - Dissect soft tissue to find saphenous vein
 - Clear soft tissue from surface of saphenous vein for adequate length
 - Ligate and divide all saphenous vein branches
 - Ligate and divide ends of saphenous vein and remove from thigh
 - Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
 - Create subcutaneous tunnel from axillary artery to femoral artery
 - Administer systemic anticoagulant and wait for circulation
 - Apply proximal and distal arterial clamp to axillary artery
 - Incise artery at proximal anastomosis site
 - Anastomose vein conduit to artery with 6-0 suture
 - Test anastomosis for leaks and apply additional sutures as required
 - Pull vein conduit through tunnel
 - Apply proximal and distal arterial clamps to femoral artery & Perform arteriotomy
-

- Cut vein conduit to appropriate length & Perform distal anastomosis with 6-0 suture
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate incisions
- Final check for hemostasis & Close soft tissue of all three incisions in multiple layers
- Irrigate subcutaneous tissue & Close skin at all three incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35521 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 80

Response Rate: 30 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	22.70	24.50	30.00	40.00
Pre-Service Time			90		
Intra-Service Time			155		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35521 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35521

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	155	0.085	13.18
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.95
Total RVW by Building Block Method =			22.71

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CPT 35521 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

53	general surgery	2	peripheral vascular disease
36	vascular surgery	1	anesthesiology
20	thoracic surgery	1	cardiology
5	clinic or group practice (not gppp)	1	diagnostic radiology
4	cardiac surgery	1	internal medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35526	Global Period: 090	RUC Rec. RVW:	29.95
		SVS Rec. RVW:	30.98
		Median Survey RVW:	30.98
		Building Block RVW:	29.47
		2000 RVW:	20.00

CPT Descriptor: Bypass graft, with vein; aortosubclavian or carotid

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform thoracotomy or median sternotomy & Dissect soft tissue to find diseased artery
- Avoid injury to lung, heart, phrenic nerves
- Dissect soft tissue to find ascending aorta
- Dissect soft tissue from around ascending aorta and target artery
- Expose sufficient length of aorta and target artery for proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place side-biting clamp on aortic arch
- Incise aorta longitudinally at proximal anastomosis site
- Anastomose vein to aortic arch with vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to subclavian or carotid artery
- Divide subclavian or carotid between clamps
- Oversee proximal subclavian or carotid with vascular suture

- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to distal end of divided subclavian or carotid
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate chest
- Final check for hemostasis & Re-approximate ribs or sternum
- Close soft tissue in multiple layers & Irrigate subcutaneous tissue
- Close skin & Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35526 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 82 **Response Rate:** 30 (37%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.00	28.00	30.98	32.00	40.00
Pre-Service Time			90		
Intra-Service Time			210		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 9231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35526 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35526

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	210	0.098	20.58
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.30
Total RVW by Building Block Method =			29.47

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CPT 35526 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

5	thoracic surgery	2	cardiology
4	cardiac surgery	2	vascular surgery
4	general surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35531	Global Period: 090	RUC Rec. RVW:	36.20
		SVS Rec. RVW:	36.00
		Median Survey RVW:	35.50
		Building Block RVW:	37.85
		2000 RVW:	25.61

CPT Descriptor: Bypass graft, with vein; aortoceliac or aortomesenteric

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & Perform routine abdominal exploration
- Mobilize left lobe of liver & Transect diaphragmatic crus over upper abdominal aorta
- Clear soft tissue from upper abdominal aorta
- Expose adequate aorta to achieve proximal and distal control
- Dissect soft tissue to find diseased celiac or mesenteric artery
- Clear soft tissue from artery for sufficient length to achieve proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks
- Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place side-biting clamp on aorta & Incise aorta longitudinally at proximal anastomosis site
- Anastomose vein conduit to aorta with vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to celiac or mesenteric artery

- Incise celiac or mesenteric artery at anastomosis site
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to celiac or mesenteric artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate abdomen
- Final check for hemostasis & Close abdominal incision
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35531 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 97

Response Rate: 29 (30%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	30.00	31.70	35.50	40.00	48.00
Pre-Service Time			90		
Intra-Service Time			240		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	60	99291x1
Other Hospital	161	99233x2 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35531 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW. In addition, we suggest a 0.5 RVU increase to 36.00 RVUs as the recommended value in order to maintain appropriate rank order with CPT 35631 to account for the extra work of vein harvest in 35531. We reduced 35631 by 0.75 RVUs and increased 35531 to create a 2.0 RVU margin to account for the vein harvest.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35531

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	240	0.095	22.80
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	1	4.00	4.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	2	1.51	3.02
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			13.06
Total RVW by Building Block Method =			37.85

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CPT 35531 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

106	vascular surgery	6	peripheral vascular disease
100	general surgery	3	cardiology
36	thoracic surgery	3	general practice
11	clinic or group practice (not gppp)	1	endocrinology
9	cardiac surgery	1	pulmonary disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35533	Global Period: 090	RUC Rec. RVW:	28.00
		SVS Rec. RVW:	28.00
		Median Survey RVW:	28.00
		Building Block RVW:	30.66
		2000 RVW:	20.52

CPT Descriptor: Bypass graft, with vein; axillary-femoral-femoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle & Dissect soft tissue to find axillary artery
- Avoid injury to nerves
- Clear soft tissue from around artery
- Incise skin of both groins over femoral artery & Dissect soft tissue to find artery
- Clear soft tissue from surface of both femoral arteries
- Incise skin of thigh and calf on both sides for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous veins and remove from thighs
- Test saphenous vein conduits for leaks & Repair leaks with 7-0 vascular suture
- Create subcutaneous tunnel from axillary artery to femoral artery
- Create subcutaneous tunnel from one femoral artery to the other
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to axillary artery
- Incise artery at proximal anastomosis site
- Anastomose vein conduit to artery with 6-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Pull vein conduit through ax-fem tunnel

- Apply proximal and distal arterial clamps to ipsilateral femoral artery
- Perform arteriotomy
- Cut vein conduit to appropriate length
- Perform distal anastomosis with 6-0 suture
- Flush system to remove air and debris
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Apply vascular clamps to distal-most end of ax-fem bypass conduit
- Incise ax-fem vein conduit between clamps
- Anastomose second vein conduit to ax-fem vein conduit with fine vascular suture
- Remove clamps and identify leaks
- Apply additional sutures as needed to control hemorrhage
- Pull vein conduit through fem-fem tunnel
- Apply proximal and distal vascular clamps to contralateral femoral artery
- Perform arteriotomy
- Anastomose fem-fem vein conduit to contralateral femoral artery with fine vascular suture
- Remove vascular clamps and identify leaks
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses bilaterally to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across all three anastomoses
- Reverse anticoagulant with protamine
- Irrigate incisions
- Final check for hemostasis
- Close soft tissue of all five incisions in multiple layers
- Irrigate subcutaneous tissue
- Close skin at all five incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

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CPT 35533 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 30 (38%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.00	25.25	28.00	30.00	50.00
Pre-Service Time			90		
Intra-Service Time			240		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

CPT 35533 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35533

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	240	0.088	21.12
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.95
Total RVW by Building Block Method =			30.66

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CPT 35533 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

72	general surgery	4	cardiac surgery
33	vascular surgery	1	cardiology
20	thoracic surgery	1	interventional radiology
9	diagnostic radiology	1	nephrology
8	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35536	Global Period: 090	RUC Rec. RVW:	31.70
		SVS Rec. RVW:	31.50
		Median Survey RVW:	31.50
		Building Block RVW:	26.79
		2000 RVW:	23.11

CPT Descriptor: Bypass graft, with vein; splenorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & Perform routine abdominal exploration
- Dissect soft tissue inferior to pancreas to find splenic artery
- Clear soft tissue from splenic artery
- Expose adequate splenic artery to achieve proximal and distal control
- Dissect soft tissue to find distal left renal artery
- Clear soft tissue from renal artery of sufficient length for proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on splenic artery
- Incise splenic artery longitudinally at proximal anastomosis site
- Anastomose vein conduit to splenic artery with vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to left renal artery & Incise left renal artery at anastomosis site
- Cut vein conduit to appropriate length & Anastomose end of vein conduit to left renal artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage

- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis & Close abdominal incision
- Irrigate subcutaneous tissue & Close skin
- Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes
- Dictate operative note & Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

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CPT 35536 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 97 **Response Rate:** 28 (29%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	26.00	29.13	31.50	38.00	45.00
Pre-Service Time			70		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0				
Other Hospital	139	99233x1 99232x2 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

CPT 35536 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35536

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	20	0.0224	0.45
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.21
Intra-service	180	0.095	17.10
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.48
Total RVW by Building Block Method =			26.79

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CPT 35536 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

32	vascular surgery
25	general surgery
5	cardiac surgery
4	thoracic surgery
2	cardiology
2	clinic or group practice (not gppp)

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35558	Global Period: 090	RUC Rec. RVW:	21.20
		SVS Rec. RVW:	22.00
		Median Survey RVW:	22.00
		Building Block RVW:	24.08
		2000 RVW:	14.04
CPT Descriptor: Bypass graft, with vein; femoral-femoral			

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

Although the RUC frequency note above is 1,106, the true 1998 Medicare frequency is <1,000 (see below). Thus, this service was evaluated by RUC-approved mini-survey. No clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin of both groins over common femoral artery
- Dissect soft tissue to find artery on each side
- Clear soft tissue from surface of both femoral arteries
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous veins and remove from thighs
- Test saphenous vein conduits for leaks & Repair leaks with 7-0 vascular suture
- Create subcutaneous tunnel from one femoral artery to the other
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to inflow femoral artery
- Incise artery at proximal anastomosis site
- Anastomose vein conduit to artery with 6-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Pull vein conduit through fem-fem tunnel
- Apply proximal and distal arterial clamps to contralateral femoral artery
- Perform arteriotomy & Cut vein conduit to appropriate length
- Perform distal anastomosis with 6-0 suture
- Flush system to remove air and debris

- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses bilaterally to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate incisions & Final check for hemostasis
- Close soft tissue of all three incisions in multiple layers
- Irrigate subcutaneous tissue & Close skin at all three incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35558 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 33 (41%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.50	21.56	22.00	23.20	30.00
Pre-Service Time			70		
Intra-Service Time			180		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35558 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the median survey value from the RUC mini-survey as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35558

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	20	0.0224	0.45
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.21
Intra-service	180	0.084	15.03
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.84
Total RVW by Building Block Method =			24.08

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CPT 35558 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

375	general surgery	3	anesthesiology
215	vascular surgery	2	family practice
122	thoracic surgery	2	general practice
46	cardiac surgery	1	diagnostic radiology
24	clinic or group practice (not gppp)	1	internal medicine
13	cardiology	1	nuclear medicine
11	peripheral vascular disease	1	urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35560

Global Period: 090

RUC Rec. RVW:	32.00
SVS Rec. RVW:	32.00
Median Survey RVW:	32.00
Building Block RVW:	29.07
2000 RVW:	23.56

CPT Descriptor: Bypass graft, with vein; aortorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize small bowel to expose infrarenal aorta
- Clear soft tissue from infrarenal abdominal aorta
- Expose adequate length of aorta to achieve proximal and distal control
- Dissect soft tissue to find renal artery
- Clear soft tissue from artery for sufficient length to achieve proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on aorta
- Incise aorta longitudinally at proximal anastomosis site
- Anastomose vein conduit to aorta with vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to renal artery

- Divide renal artery at anastomosis site
- Oversee proximal renal artery with vascular suture and remove clamp
- Apply additional sutures as needed to control hemorrhage
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to outflow end of renal artery
- Flush system to remove air and debris & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across anastomosis
- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis
- Close abdominal incision & Irrigate subcutaneous tissue
- Close skin & Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35560 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 97

Response Rate: 29 (30%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	29.00	30.76	32.00	37.00	48.00
Pre-Service Time			90		
Intra-Service Time			200		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0	1			
Other Hospital	139	99233x1 99232x2 99232x2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

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CPT 35560 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service **has changed** over the last 5 years. Most straightforward renal stenoses are now treated by percutaneous transluminal angioplasty. **Only the most difficult renals (oftentimes completely occluded arteries) are treated by using open surgical reconstruction.** The following Building Block analysis substantiates the RUC mini-survey median survey value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35560

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	200	0.095	19.00
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.48
Total RVW by Building Block Method =			29.07

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CPT 35560 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

375	general surgery	11	peripheral vascular disease
215	vascular surgery	3	anesthesiology
122	thoracic surgery	2	family practice
46	cardiac surgery	2	general practice
24	clinic or group practice (not gppp)	1	diagnostic radiology
13	cardiology	1	internal medicine
1	nuclear medicine	1	urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 7 Yes
0 0 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 7 I do not agree

Patients requiring this service are now:

0 7 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35563	Global Period: 090	RUC Rec. RVW:	24.20
		SVS Rec. RVW:	26.00
		Median Survey RVW:	26.00
		Building Block RVW:	25.36
		2000 RVW:	15.14

CPT Descriptor: Bypass graft, with vein; ilioiliac

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and iliac arteries
- Clear soft tissue from iliac arteries
- Expose adequate length of iliac arteries to achieve proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on inflow iliac artery
- Incise inflow iliac longitudinally at proximal anastomosis site
- Anastomose vein conduit to inflow iliac with vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to diseased iliac artery beyond occlusion or stenosis
- Incise diseased iliac artery at distal anastomosis site
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to diseased iliac artery

- Flush system to remove air and debris & remove clamp
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate abdomen & final check for hemostasis
- Close abdominal incision & irrigate subcutaneous tissue
- Close skin & irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & write post-op orders and notes & dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35563 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 76 **Response Rate:** 27 (36%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.65	23.00	26.00	28.00	38.00
Pre-Service Time			75		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0				
Other Hospital	120	99233x1	99232x2	99213x1	
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

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CPT 35563 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35563

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	180	0.090	16.20
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.84
Total RVW by Building Block Method =			25.36

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CPT 35563 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

10	general surgery
6	vascular surgery
3	cardiac surgery
1	thoracic surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35565	Global Period: 090	RUC Rec. RVW:	23.20
		SVS Rec. RVW:	24.60
		Median Survey RVW:	24.60
		Building Block RVW:	25.36
		2000 RVW:	15.14

CPT Descriptor: Bypass graft, with vein; iliofemoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and iliac artery
- Clear soft tissue from iliac artery
- Expose adequate length of iliac artery to achieve proximal and distal control
- Incise skin over femoral artery & Dissect soft tissue to find femoral artery
- Clear soft tissue from around femoral artery
- Expose adequate length of femoral artery to achieve proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Create tunnel from iliac artery to femoral artery
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on iliac artery
- Incise iliac longitudinally at proximal anastomosis site
- Anastomose vein conduit to inflow iliac with vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage

- Pull vein conduit through tunnel to femoral artery
- Apply proximal and distal clamps to femoral artery at distal anastomosis site
- Incise femoral iliac artery at anastomosis site
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to femoral artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis
- Close abdominal incision & Irrigate subcutaneous tissue at femoral incision
- Close soft tissue at femoral incision in multiple layers
- Close skin & Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35565 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 78

Response Rate: 28 (36%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	22.25	24.60	27.00	38.00
Pre-Service Time			75		
Intra-Service Time			180		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0				
Other Hospital	120	99233x1	99232x2	99231x1	
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

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CPT 35565 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35565

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	180	0.090	16.20
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.84
Total RVW by Building Block Method =			25.36

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CPT 35565 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

138	general surgery	9	peripheral vascular disease
128	vascular surgery	2	general practice
40	thoracic surgery	1	anesthesiology
20	clinic or group practice (not gppp)	1	cardiology
19	cardiac surgery	1	internal medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35571	Global Period: 090	RUC Rec. RVW:	24.06
		SVS Rec. RVW:	26.96
		Median Survey RVW:	26.96
		Building Block RVW:	24.87
			(using survey median data)
		2000 RVW:	18.58

CPT Descriptor: Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old diabetic female presents with dry gangrene of the left great toe. She has palpable femoral and popliteal pulses but none distally. Doppler studies reveal toe pressures <15mm Hg. Arteriography reveals normal arteries to just below the knee where there is complete occlusion of the distal popliteal and all tibials. The only target vessel is an anterior tibial that reconstitutes at the ankle and fills the dorsalis pedis. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. A bypass graft from the below-knee popliteal to the dorsalis pedis artery is performed with vein. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin below knee & Dissect popliteal space to find popliteal artery
- Clear soft tissue from popliteal artery
- Expose adequate length of popliteal artery to achieve proximal and distal control
- Incise skin over dorsalis pedis artery
- Dissect soft tissue to find dorsalis pedis artery
- Clear soft tissue from around dorsalis pedis artery
- Expose adequate length of dorsalis pedis artery to achieve proximal and distal control
- Incise skin of thigh and/or calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches

- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Create tunnel from popliteal artery to dorsalis pedis artery
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on popliteal artery
- Incise popliteal longitudinally at proximal anastomosis site
- Anastomose vein conduit to popliteal artery with fine vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Pull vein conduit through tunnel to dorsalis pedis artery
- Apply proximal and distal clamps to dorsalis pedis artery at distal anastomosis site
- Incise dorsalis pedis artery at anastomosis site
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to dorsalis pedis artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate popliteal space and DP exposure site & Final check for hemostasis
- Close popliteal space and subcutaneous tissue at DP site & Irrigate subcutaneous tissue
- Close skin at both sites & Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Distal AV fistula to enhance patency, if performed

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CPT 35571 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 96 **Response Rate:** 30 (31%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	21.76	26.50	26.96	28.00	35.50
Pre-Service Time			80		
Intra-Service Time	100	180	180	200	300

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	106	99232x1 99231x4
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
21.76	090	35556	Bypass graft, with vein; femoral-popliteal

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

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

	Survey CPT 35571 (n=30)	Ref CPT 35556 (n=22)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	80	95
Intra-service time	180	180
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	106	125
Discharge management time	36	36
Total office visit time	61	61

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

Pre-service	3.52	3.65
Intra-service	4.41	4.40
Post-service	3.44	3.60

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.86
Urgency of medical decision making	3.43	3.32

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.67	4.73
Physical effort required	4.00	4.05

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.20	4.18
Outcome depends on the skill and judgment of physician	4.53	4.59
Estimated risk of malpractice suit with poor outcome	3.50	3.64

CPT 35571 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service **has changed** over the last 5 years. As the benefits of limb salvage become increasingly apparent, surgeons have pushed the envelope in terms of performing bypass grafts to even more distal and more diseased target vessels in older and more frail individuals. In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35571

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
Pre-service total			1.36
Intra-service	180	0.090	16.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.30
Total RVW by Building Block Method =			24.87

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CPT 35571 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,833	vascular surgery	39	plastic & reconstructive surgery
1,777	general surgery	9	nuclear medicine
391	thoracic surgery	13	general practice
177	clinic or group practice (not gppp)	6	diagnostic radiology
115	cardiac surgery	6	emergency medicine
91	peripheral vascular disease	3	family practice
44	cardiology	2	internal medicine
1	urology	1	dermatology
1	orthopaedic surgery	1	hand surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 7 Yes
0 0 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 7 **more complex (more work)**
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35587	Global Period: 090	RUC Rec. RVW:	24.75
		SVS Rec. RVW:	27.75
		Median Survey RVW:	27.25
		Building Block RVW:	25.56
		2000 RVW:	19.05

CPT Descriptor: In-situ vein bypass; popliteal-tibial, peroneal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old diabetic female presents with dry gangrene of the left great toe. She has palpable femoral and popliteal pulses but none distally. Doppler studies reveal toe pressures <15mm Hg. Arteriography reveals normal arteries to just below the knee where there is complete occlusion of the distal popliteal and all tibials. The only target vessel is a posterior tibial that reconstitutes at the ankle. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. A bypass graft from the below-knee popliteal to the posterior tibial artery is performed with in-situ vein. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin below knee & Dissect popliteal space to find popliteal artery
- Clear soft tissue from popliteal artery
- Expose adequate length of popliteal artery to achieve proximal and distal control
- Incise skin over dorsalis pedis artery & Dissect soft tissue to find dorsalis pedis artery
- Clear soft tissue from around dorsalis artery
- Expose adequate length of dorsalis pedis artery to achieve proximal and distal control
- Incise skin of calf over saphenous vein & Dissect soft tissue to find saphenous vein
- Ligate and divide all saphenous vein branches & Ligate and divide ends of saphenous vein
- Pass valvulotome through saphenous vein to lyse vein valves
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation

- Place proximal and distal clamps on popliteal artery
- Incise popliteal longitudinally at proximal anastomosis site
- Anastomose vein conduit to popliteal artery with fine vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to dorsalis pedis artery at distal anastomosis site
- Incise dorsalis pedis artery at anastomosis site
- Cut vein conduit to appropriate length
- Anastomose end of vein conduit to dorsalis pedis artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine & Irrigate popliteal space and DP exposure site
- Final check for hemostasis
- Close popliteal space and subcutaneous tissue along calf and at DP site
- Irrigate subcutaneous tissue & Close skin at all sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Distal AV fistula to enhance patency, if performed

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CPT 35587 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 111 **Response Rate:** 30 (27%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.00	25.93	27.25	28.47	35.00
Pre-Service Time			93		
Intra-Service Time	110	150	180	240	270

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	106	99232x1 99231x4
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.39	090	35585	In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery

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

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

	Survey CPT 35587 (n=30)	Ref CPT 35585 (n=16)
TIME ESTIMATES (MEDIAN)		
Pre-service time	93	90
Intra-service time	180	190
Immediate Post-service time	30	38
Total critical care time	0	0
Total other hospital visit time	106	155
Discharge management time	36	36
Total office visit time	61	76

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

Pre-service	3.90	4.06
Intra-service	4.55	4.69
Post-service	3.62	3.81

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.76	4.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	4.25
Urgency of medical decision making	3.86	4.06

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.76	4.94
Physical effort required	4.10	4.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.31	4.50
Outcome depends on the skill and judgment of physician	4.72	4.88
Estimated risk of malpractice suit with poor outcome	3.34	3.25

CPT 35587 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has changed over the last 5 years. As the benefits of limb salvage become increasingly apparent, surgeons have pushed the envelope in terms of performing bypass grafts to even more distal and more diseased target vessels in older and more frail individuals. In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35587

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	35	0.0224	0.78
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.70
Intra-service	180	0.092	16.56
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	4	0.64	2.56
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.30
Total RVW by Building Block Method =			25.56

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CPT 35587 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code: We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

424	general surgery	5	plastic & reconstructive surgery
378	vascular surgery	2	diagnostic radiology
118	thoracic surgery	2	general practice
40	cardiac surgery	1	anesthesiology
38	clinic or group practice (not gppp)	1	emergency medicine
28	peripheral vascular disease	1	internal medicine
14	cardiology	v	

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

4	7	Yes
4	0	No

This service represents new technology that has become more familiar (i.e., less work).

2	0	I agree
2	0	I do not agree

Patients requiring this service are now:

4	7	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
4	0	no change

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

CPT Code: 35621	Global Period: 090	RUC Rec. RVW:	20.00
		SVS Rec. RVW:	21.50
		Median Survey RVW:	21.50
		Building Block RVW:	16.92
		2000 RVW:	14.54

CPT Descriptor: Bypass graft, with other than vein; axillary-femoral

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

An 80-year-old male with advanced congestive heart failure has critical ischemia of his left lower extremity. He underwent a right above-knee amputation years ago. Physical exam is notable for the absence of femoral pulses. An arteriogram performed by a brachial approach reveals complete occlusion of both common iliac arteries with reconstitution of the left common femoral. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's multiple medical comorbidities with anesthesia, patient positioning, scrub, prep, drape, and wait. At operation an axillary-femoral bypass is performed using a PTFE conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle & Dissect soft tissue to find axillary artery
- Avoid injury to nerves
- Clear soft tissue from around artery & Incise skin of groin over femoral artery
- Dissect soft tissue to find artery & Clear soft tissue from surface of artery
- Create subcutaneous tunnel from axillary artery to femoral artery
- Select appropriate diameter synthetic conduit
- Pull synthetic conduit through ax-fem tunnel
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to axillary artery
- Incise artery at proximal anastomosis site
- Anastomose synthetic conduit to artery with 5-0 suture

- Test anastomosis for leaks and apply additional sutures as required
- Apply proximal and distal arterial clamps to femoral artery & Perform arteriotomy
- Cut synthetic conduit to appropriate length & Perform distal anastomosis with 5-0 suture
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine & Irrigate incisions
- Final check for hemostasis & Close soft tissue of both incisions in multiple layers
- Irrigate subcutaneous tissue & Close skin at both incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

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CPT 35621 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 30 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.50	20.00	21.50	22.75	30.00
Pre-Service Time			85		
Intra-Service Time	60	93	120	148	180

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1 99231x3
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35621 (n=30)	Ref CPT 35656 (n=25)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	85	95
Intra-service time	120	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	57
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	3.80	3.36
Intra-service	3.77	3.44
Post-service	3.40	3.04

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	3.40
Urgency of medical decision making	3.80	3.28

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.87	3.64
Physical effort required	3.53	3.32

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.17	3.52
Outcome depends on the skill and judgment of physician	4.03	3.60
Estimated risk of malpractice suit with poor outcome	3.30	3.5

CPT 35621 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35621

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	120	0.083	9.96
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.37
Total RVW by Building Block Method =			16.92

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CPT 35621 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

441	vascular surgery	20	cardiology
408	general surgery	3	general practice
190	thoracic surgery	2	pulmonary disease
45	cardiac surgery	1	family practice
39	clinic or group practice (not gppp)	1	internal medicine
22	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
17	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
1	0	I do not agree

Patients requiring this service are now:

3	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35623	Global Period: 090	RUC Rec. RVW:	24.00
		Recommended RVW:	24.00
		Median Survey RVW:	24.00
		Building Block RVW:	19.60
		2000 RVW:	16.62

CPT Descriptor: Bypass graft, with other than vein; axillary-popliteal or -tibial

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle & Dissect soft tissue to find axillary artery
 - Avoid injury to nerves
 - Clear soft tissue from around artery
 - Incise skin of calf over popliteal or tibial artery & Dissect soft tissue to find artery
 - Clear soft tissue from surface of artery
 - Create subcutaneous tunnel from axillary artery to popliteal or tibial artery
 - Create counter-incisions as needed to complete tunnel
 - Select appropriate diameter synthetic conduit
 - Pull synthetic conduit through tunnel
 - Administer systemic anticoagulant and wait for circulation
 - Apply proximal and distal arterial clamp to axillary artery
 - Incise artery at proximal anastomosis site
 - Anastomose synthetic conduit to artery with 5-0 suture
 - Test anastomosis for leaks and apply additional sutures as required
 - Apply proximal and distal arterial clamps to popliteal or tibial artery
 - Perform arteriotomy & Cut synthetic conduit to appropriate length
 - Perform distal anastomosis with 6-0 suture
 - Flush system to remove air and debris
 - Remove clamps & Apply additional sutures as needed to control hemorrhage
 - Palpate distal pulses to check for restitution of blood flow
-

- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate all incisions & Final check for hemostasis
- Close soft tissue of all incisions in multiple layers
- Irrigate subcutaneous tissue & close skin at all incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary & outpatient visits as required for 90 days

CPT 35623 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 800 **Response Rate:** 29 (36%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.10	21.38	24.00	26.50	40.00
Pre-Service Time			75		
Intra-Service Time			120		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99 99238
Office Visits	61	99213x2 99212x1

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CPT 35623 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis indicates that an RVW substantially greater than the current value is indicated.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code

35623	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
 Intra-service	 120	 0.087	 10.44
 Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.84
 Total RVW by Building Block Method =			 19.60

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CPT 35623 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

34	general surgery	3	cardiac surgery
21	vascular surgery	2	cardiology
10	thoracic surgery	2	peripheral vascular disease
5	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35626	Global Period: 090	RUC Rec. RVW:	27.75
		SVS Rec. RVW:	30.00
		Median Survey RVW:	30.00
		Building Block RVW:	25.57
		(Using median survey data)	
		2000 RVW:	23.63

CPT Descriptor: Bypass graft, with other than vein; aortosubclavian or carotid

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male presents with progressive pain in his right hand that is now constant and disabling. He has no axillary, brachial, radial, or ulnar pulses. Doppler studies reveal a right brachial systolic pressure of 50 mm Hg compared to 120 mm Hg on the left side. Arteriography confirms complete occlusion of the right subclavian artery origin with reconstitution of the distal intra-thoracic segment. He has had radiation therapy to the neck and is not a candidate for carotid-subclavian bypass. Interventional radiologists were unsuccessful with attempts to open the subclavian using percutaneous techniques. An aorto-subclavian bypass is planned. Pre-service work includes review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's comorbidities with anesthesia, positioning the patient, plus scrub, prep, and drape. An aorto-subclavian bypass is performed using a synthetic graft. Post-service work includes immediate postoperative care, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform thoracotomy or median sternotomy
- Dissect soft tissue to find diseased artery
- Avoid injury to lung, heart, phrenic nerves
- Dissect soft tissue to find ascending aorta
- Dissect soft tissue from around ascending aorta and target artery
- Expose sufficient length of aorta and target artery for proximal and distal control
- Choose appropriate diameter synthetic conduit

- Administer systemic anticoagulant and wait for circulation
- Place side-biting clamp on aortic arch
- Incise aorta longitudinally at proximal anastomosis site
- Anastomose synthetic conduit to aortic arch with vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to subclavian or carotid artery
- Divide subclavian or carotid between clamps
- Oversee proximal subclavian or carotid with vascular suture
- Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to distal end of divided subclavian or carotid
- Flush system to remove air and debris
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate chest
- Final check for hemostasis
- Re-approximate ribs or sternum
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

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CPT 35626 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 82 **Response Rate:** 30 (37%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	20.00	27.75	30.00	31.05	37.00
Pre-Service			98		
Intra-Service	120	180	180	210	260

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	109	99233X1 99232X1 99231X2
Discharge Day Mgmt	36	99238
Office Visits	38	99213X1 99212X1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

	Survey CPT 35626 (n=29)	Ref CPT 35102 (n=8)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	90	90
Intra-service time	180	210
Immediate Post-service time	30	38
Total critical care time	0	0
Total other hospital visit time	109	136
Discharge management time	36	36
Total office visit time	38	61

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

Pre-service	4.23	4.43
Intra-service	4.54	4.43
Post-service	3.81	4.14

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.43	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	4.63
Urgency of medical decision making	3.82	3.75

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.75	4.63
Physical effort required	4.46	4.63

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.82	4.63
Outcome depends on the skill and judgment of physician	4.75	4.88
Estimated risk of malpractice suit with poor outcome	4.46	4.38

CPT 35626 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has changed over the last 5 years. The more straightforward cases are now being treated by percutaneous angioplasty, and only the most complex patients undergo open surgery. In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis indicates that an RVW substantially greater than the current value is indicated. We believe that the Building Block value is lower than the survey median because the surgeons under-estimated intra-service time.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC survey

CPT Code 35626

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.095	17.10
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			6.88
Total RVW by Building Block Method =			25.57

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CPT 35626 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

50	thoracic surgery	18	clinic or group practice (not gppp)
43	cardiac surgery	30	general surgery
33	vascular surgery	2	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	7	Yes
0	0	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	7	more complex (more work) more straightforward cases now done by percutaneous angioplasty
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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CPT 35631

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

CPT Code: 35631	Global Period: 090	RUC Rec. RVW:	34.00
		SVS Rec. RVW:	34.00
		Median Survey RVW:	34.75
		Building Block RVW:	31.77
		2000 RVW:	24.60

CPT Descriptor: Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 66-year-old female complains of severe abdominal pain that begins 15 minutes after every meal and lasts for several hours. She avoids eating for fear of inducing the pain, and as a result she has lost 35 pounds over the past 6 months. Abdominal exam is benign. Duplex exam indicates complete occlusion of the superior mesenteric artery and severe stenosis of the celiac. An arteriogram confirms these findings. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's cardiac disease with anesthesia, patient positioning, scrub, prep, and drape. At operation an aorto-SMA bypass is performed using a Dacron conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize left lobe of liver & Transect diaphragmatic crus over upper abdominal aorta
- Clear soft tissue from upper abdominal aorta
- Expose adequate aorta to achieve proximal and distal control
- Dissect soft tissue to find diseased celiac, mesenteric, or renal artery
- Clear soft tissue from artery for sufficient length to achieve proximal and distal control
- Create retro-pancreatic tunnel if required
- Choose synthetic conduit of appropriate diameter
- Administer systemic anticoagulant and wait for circulation
- Place side-biting clamp on aorta
- Incise aorta longitudinally at proximal anastomosis site

- Anastomose synthetic conduit to aorta with vascular suture
- Remove clamp and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to celiac, mesenteric, or renal artery
- Incise celiac, mesenteric, or renal artery at anastomosis site
- Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to celiac, mesenteric, or renal artery
- Flush system to remove air and debris & remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate abdomen & final check for hemostasis
- Close abdominal incision & irrigate subcutaneous tissue & close skin

Description of Post-Service Work

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & write post-op orders and notes & dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary & outpatient visits as required for 90 days

CPT 35631 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 97

Response Rate: 30 (31%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	20.00	31.00	34.75	38.75	45.00
Pre-Service Time			110		
Intra-Service Time	100	185	225	240	330
Post-Service:	Total Time	CPT code / # of visits			
Immediate Post-Service	38				
Critical Care	0				
Other Hospital	139	99233X1 99232X2 99231X2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213X2 99212X1			

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 35631 (n=30)	Ref CPT 35102 (n=23)
Pre-service time	110	95
Intra-service time	225	210
Immediate Post-service time	38	45
Total critical care time	0	0
Total other hospital visit time	139	139
Discharge management time	36	36
Total office visit time	61	61

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

Pre-service	4.52	4.22
Intra-service	4.76	4.57
Post-service	4.14	3.70

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.73	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.70	3.91
Urgency of medical decision making	4.27	3.91

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.83	4.30
Physical effort required	4.60	4.39

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.90	4.52
Outcome depends on the skill and judgment of physician	4.87	4.52
Estimated risk of malpractice suit with poor outcome	4.20	3.87

CPT 35631 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has changed over the last 5 years. **The more straightforward cases are now treated with percutaneous angioplasty, and only the most complex cases undergo open surgery.** In addition, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Note: The final RVW recommendation for 35631 is 34.00 RVUs, less than the median survey value of 34.75. We recommend this reduction in order to maintain appropriate rank order with the analogous procedure that uses vein as conduit, CPT 35531. The median survey for 35531 is 35.50 RVUs. In order to maintain a 2.0 RVU difference between 35631 and 35531 to account for the extra work of harvesting a vein, we recommend reduction of 35631 to 34.00 RVUs and a slight increase in 35531 from its survey median of 35.50 to 36.00 RVUs.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35631

	Time	Intensity	RVU (= time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	35	0.0081	0.28
Pre-service total			1.63
Intra-service	225	0.095	21.38
Post-service			
Immediate post	38	0.0224	0.85
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.77
Total RVW by Building Block Method =			31.77

CPT 35631 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:
 [Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

598	vascular surgery	13	peripheral vascular disease
432	general surgery	10	family practice
165	thoracic surgery	8	pulmonary disease
65	cardiac surgery	3	plastic & reconstructive surgery
55	clinic or group practice (not gppp)	2	general practice
20	cardiology	2	nuclear medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1 7 **Yes**
 2 0 **No**

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
 1 0 I do not agree

Patients requiring this service are now:

1 7 **more complex (more work) because the more straightforward cases are now done my percutaneous angioplasty**
 0 0 less complex (less work)
 0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
 0 0 from inpatient to outpatient
 1 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35636	Global Period: 090	RUC Rec. RVW:	29.50
		SVS Rec. RVW:	29.50
		Median Survey RVW:	32.00
		Building Block RVW:	29.03
		2000 RVW:	22.46

CPT Descriptor: Bypass graft, with other than vein; splenorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Dissect soft tissue inferior to pancreas to find splenic artery
- Clear soft tissue from splenic artery
- Expose adequate splenic artery to achieve proximal and distal control
- Dissect soft tissue to find distal left renal artery
- Clear soft tissue from renal artery of sufficient length for proximal and distal control
- Choose synthetic conduit of appropriate diameter
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on splenic artery
- Incise splenic artery longitudinally at proximal anastomosis site
- Anastomose synthetic conduit to splenic artery with vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to left renal artery
- Incise left renal artery at anastomosis site
- Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to left renal artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses

- Reverse anticoagulant with protamine & Irrigate abdomen
- Final check for hemostasis & Close abdominal incision
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35636 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 97 **Response Rate:** 30 (31%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	28.00	29.69	32.00	39.00	48.00
Pre-Service Time			78		
Intra-Service Time			200		
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	150	99233x1, 99232x3, 99231x1			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

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CPT 35636 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

The final recommended RVW of 29.50 represents a downward adjustment from the survey mean to prevent a rank order anomaly. At 29.50 this procedure is 2.00 RVUs less than CPT 35536, splenorenal bypass graft using vein conduit. This is an appropriate adjustment to account for the extra work of harvesting a short segment of vein conduit for use in 35536, a code with a survey median value of 31.50.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35636

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	30	0.0224	0.67
Scrub, prep	23	0.0081	0.19
Pre-service total			1.42
Intra-service	200	0.093	18.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	3	1.06	3.18
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			9.01
Total RVW by Building Block Method =			29.03

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CPT 35636 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

20	vascular surgery	1	cardiac surgery
13	general surgery	1	clinic or group practice (not gppp)
7	cardiology	1	general practice
2	peripheral vascular disease	1	plastic & reconstructive surgery
1	anesthesiology	1	thoracic surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35650	Global Period: 090	RUC Rec. RVW:	19.00
		SVS Rec. RVW:	20.00
		Median Survey RVW:	20.00
		Building Block RVW:	15.83
		2000 RVW:	14.36

CPT Descriptor: Bypass graft, with other than vein; axillary-axillary

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle bilaterally
- Dissect soft tissue to find axillary artery on each side
- Avoid injury to nerves
- Clear soft tissue from around arteries
- Choose synthetic conduit of appropriate diameter
- Create subcutaneous tunnel from one axillary artery to the other
- Pull synthetic conduit through tunnel
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to axillary artery on inflow side
- Incise artery at proximal anastomosis site
- Anastomose synthetic conduit to artery with 6-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Apply proximal and distal arterial clamps on recipient side & Perform arteriotomy
- Cut synthetic conduit to appropriate length & Perform distal anastomosis
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses

- Reverse anticoagulant with protamine
- Irrigate incisions & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

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CPT 35650 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 30 (38%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.00	19.00	20.00	22.50	27.00
Pre-Service Time			75		
Intra-Service Time			110		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	71	99233x1, 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1, 99212x1

CPT 35650 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW. **We believe this Building Block is substantially less than the median survey value because the respondents under-estimated intra-service time.**

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35650

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	110	0.082	9.02
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.49
Total RVW by Building Block Method =			15.83

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CPT 35650 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

89	general surgery	1	anesthesiology
73	vascular surgery	1	cardiology
27	thoracic surgery		
7	cardiac surgery	1	internal medicine
5	clinic or group practice (not gppp)	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35654	Global Period: 090	RUC Rec. RVW:	25.00
		SVS Rec. RVW:	25.00
		Median Survey RVW:	25.00
		Building Block RVW:	23.75
		(Using median survey data)	
		Building Block RVW:	28.00
		(Using real skin-to-skin intra time)	
		2000 RVW:	18.61

CPT Descriptor: Bypass graft, with other than vein; axillary-femoral-femoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 80-year-old male with advanced congestive heart failure has critical ischemia of both lower extremities. Physical exam is notable for the absence of femoral pulses. An arteriogram performed by a brachial approach reveals complete occlusion of both common and external iliac arteries with reconstitution of the common femorals. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's multiple medical comorbidities with anesthesia, patient positioning, scrub, prep, drape, and wait. At operation an axillo-bifemoral bypass is performed using a PTFE conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin just inferior to clavicle & Dissect soft tissue to find axillary artery
- Avoid injury to nerves
- Clear soft tissue from around artery & Incise skin of both groins over femoral artery
- Dissect soft tissue to find artery
- Clear soft tissue from surface of both femoral arteries
- Create subcutaneous tunnel from axillary artery to femoral artery
- Create subcutaneous tunnel from one femoral artery to the other
- Choose two synthetic conduits of appropriate diameter

- Pull first synthetic conduit through ax-fem tunnel
- Pull second synthetic conduit through fem-fem tunnel
- Administer systemic anticoagulant and wait for circulation
- Apply proximal and distal arterial clamp to axillary artery
- Incise artery at proximal anastomosis site
- Anastomose synthetic conduit to artery with 5-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Apply proximal and distal arterial clamps to ipsilateral femoral artery
- Perform arteriotomy
- Cut synthetic conduit to appropriate length
- Perform distal anastomosis with 5-0 suture
- Flush system to remove air and debris, and remove clamps
- Apply additional sutures as needed to control hemorrhage
- Apply vascular clamps to distal-most end of ax-fem bypass conduit
- Incise ax-fem synthetic conduit between clamps
- Anastomose fem-fem synthetic conduit to ax-fem conduit with fine vascular suture
- Remove clamps and identify leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal vascular clamps to contralateral femoral artery
- Perform arteriotomy
- Anastomose fem-fem conduit to contralateral femoral artery with fine vascular suture
- Remove vascular clamps and identify leaks
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses bilaterally to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across all three anastomoses
- Reverse anticoagulant with protamine
- Irrigate incisions
- Final check for hemostasis
- Close soft tissue of all three incisions in multiple layers
- Irrigate subcutaneous tissue
- Close skin at all three incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35654 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 31 (39%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	20.90	22.75	25.00	28.06	40.00
Pre-Service Time			90		
Intra-Service Time	90	150	180	180	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	98	99232x2, 99231x2
Discharge Day Mgmt	36	99238
Office Visits	53	99213x1, 99212x2

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35654 (n=31)	Ref CPT 35656 (n=9)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	90	90
Intra-service time	180	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	98	48
Discharge management time	36	36
Total office visit time	53	53

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.82	3.11
Intra-service	3.68	3.00
Post-service	3.25	2.67

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.14	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.56
Urgency of medical decision making	3.83	3.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.93	3.56
Physical effort required	3.86	3.22

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.14	3.33
Outcome depends on the skill and judgment of physician	4.24	3.67
Estimated risk of malpractice suit with poor outcome	3.35	3.25

CPT 35654 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database. The second analysis supports our belief that surgeons tend to under-estimate skin-to-skin times on surveys.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC survey

CPT Code 35654

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	180	0.085	15.30
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			6.86
Total RVW by Building Block Method:			23.75

Building Block recalculated using actual skin-to-skin Intra-time = 230 (n=4) culled from a database of 5,000 vascular surgery operations performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is real skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code 35654

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	230	0.085	19.55
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0
99215	0	1.73	0
Post-service total			6.86
Total RVW by Building Block Method:			28.00

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CPT 35654 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery:

Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

540	general surgery	7	general practice
507	vascular surgery	3	internal medicine
174	thoracic surgery	3	nuclear medicine
58	clinic or group practice (not gppp)	3	nurse practitioner
54	cardiac surgery	3	orthopaedic surgery
29	cardiology	2	endocrinology
14	peripheral vascular disease	1	diagnostic radiology
1	family practice	1	obstetrics/gynecology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35661	Global Period: 090	RUC Rec. RVW:	19.00
		SVS Rec. RVW:	19.53
		Median Survey RVW:	19.53
		Building Block RVW:	17.80
		(Using survey median data)	
		Building Block RVW:	21.56
		(Using actual skin-to-skin intra)	
		2000 RVW:	13.18

CPT Descriptor: Bypass graft, with other than vein; femoral-femoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old male has critical ischemia of his left lower extremity. Physical exam reveals no left femoral pulse and a weak but palpable right femoral. An arteriogram identifies complete occlusion of the entire left common and external iliac arteries with reconstitution of the common femoral. On the right side there is a focal stenosis of the common iliac artery that is angioplastied successfully. The right ilia arterial system is widely patent following the angioplasty, and is considered a suitable inflow donor for a right-to-left femoral-femoral bypass graft. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's medical comorbidities with anesthesia, patient positioning, scrub, prep, drape and wait. At operation the femoral-femoral bypass is performed using a PTFE conduit with successful reperfusion of the left lower extremity. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin of both groins over common femoral artery
- Dissect soft tissue to find artery on each side
- Clear soft tissue from surface of both femoral arteries
- Create subcutaneous tunnel from one femoral artery to the other
- Choose synthetic conduit of appropriate diameter & Pull synthetic conduit through fem-fem tunnel
- Administer systemic anticoagulant and wait for circulation

- Apply proximal and distal arterial clamps to inflow femoral artery
- Incise artery at proximal anastomosis site
- Anastomose synthetic conduit to artery with 5-0 suture
- Test anastomosis for leaks and apply additional sutures as required
- Apply proximal and distal arterial clamps to contralateral femoral artery
- Perform arteriotomy & Cut synthetic conduit to appropriate length
- Perform distal anastomosis with 5-0 suture & Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses bilaterally to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate incisions & Final check for hemostasis
- Close soft tissue of both incisions in multiple layers
- Irrigate subcutaneous tissue & Close skin at both incisions

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes
- Dictate operative note & Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35661 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): SVS-AAVS

Sample Size: 80

Response Rate: 34 (43%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.62	19.00	19.53	20.00	25.00
Pre-Service Time			90		
Intra-Service Time	60	105	120	150	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1, 99232 ¹ / ₂ x3
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2, 99212x1

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35661 (n=34)	Ref CPT 35656 (n=33)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	90	90
Intra-service time	120	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	106
Discharge management time	36	36
Total office visit time	61	61

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

Pre-service	3.35	3.24
Intra-service	3.44	3.48
Post-service	2.85	2.84

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.55
Urgency of medical decision making	3.35	3.33

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.65	3.79
Physical effort required	3.32	3.48

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.64	3.72
Outcome depends on the skill and judgment of physician	3.97	4.00
Estimated risk of malpractice suit with poor outcome	3.48	3.56

CPT 35661 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database. The second analysis supports our belief that surgeons tend to under-estimate skin-to-skin times on surveys.

Building Block Method

Intra-service Intensity is median value for this service from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All time and visit data from RUC survey

CPT Code 35661

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	28	0.0224	0.63
Scrub, prep	30	0.0081	0.24
Pre-service total			1.54
Intra-service	120	0.080	9.60
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
Post-service total			6.66
Total RVW by Building Block Method:			17.80

Building Block recalculated using actual skin-to-skin surgery intra-time = 167 min (n=11) culled from a database of 5,000 vascular surgery operations performed by 31 surgeons in 1999.

Building Block Method

Intra-service Intensity is median value for this service from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

Intra-service time is real skin-to-skin time from vascular surgery database

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35661

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	28	0.0224	0.63
Scrub, prep	30	0.0081	0.24
Pre-service total			1.54
Intra-service	167	0.080	13.36
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
Post-service total			6.66
Total RVW by Building Block Method:			21.56

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CPT 35661 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

2,103	general surgery	4	emergency medicine
1,540	vascular surgery	4	plastic & reconstructive surgery
797	thoracic surgery	3	diagnostic radiology
273	cardiac surgery	3	orthopaedic surgery
184	clinic or group practice (not gppp)	3	surgical oncology
84	cardiology	3	pulmonary disease
70	peripheral vascular disease	1	urology
17	general practice	1	endocrinology
7	family practice	1	maxillofacial surgery
6	internal medicine	1	nephrology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35663	Global Period: 090	RUC Rec. RVW:	22.00
		SVS Rec. RVW:	24.00
		Median Survey RVW:	24.00
		Building Block RVW:	22.29
		2000 RVW:	14.17

CPT Descriptor: Bypass graft, with other than vein; ilioliac

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and iliac arteries
- Clear soft tissue from iliac arteries
- Expose adequate length of iliac arteries to achieve proximal and distal control
- Choose appropriate diameter synthetic conduit
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on inflow iliac artery
- Incise inflow iliac longitudinally at proximal anastomosis site
- Anastomose synthetic conduit to inflow iliac with vascular suture
- Remove clamps and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to diseased iliac artery beyond occlusion or stenosis
- Incise diseased iliac artery at distal anastomosis site
- Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to diseased iliac artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses

- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis
- Close abdominal incision
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- One, two, or more daily hospital visits, based on patient requirements
- Daily attention to wounds, bypass patency, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35663 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 76 **Response Rate:** 27 (36%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	17.00	22.00	24.00	26.46	36.00
Pre-Service Time			75		
Intra-Service Time			148		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	120	99233x1, 99232x2, 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2, 99212x1

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CPT 35663 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35663

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	25	0.0224	0.56
Same day evaluation	25	0.0224	0.56
Scrub, prep	25	0.0081	0.20
Pre-service total			1.32
Intra-service	147.5	0.089	13.13
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.84
Total RVW by Building Block Method =			22.29

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CPT 35663 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

31	general surgery	4	cardiac surgery
29	vascular surgery	4	cardiology
16	thoracic surgery	2	peripheral vascular disease
5	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 35665	Global Period: 090	RUC Rec. RVW:	21.00
		SVS Rec. RVW:	22.00
		Median Survey RVW:	22.00
		Building Block RVW:	21.07
		2000 RVW:	15.40

CPT Descriptor: Bypass graft, with other than vein; iliofemoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 66-year-old male complains of pain and weakness in his left lower extremity after walking 50 feet. Femoral, popliteal and ankle pulses are not palpable on the affected extremity. Doppler studies identify a systolic blood pressure of only 60-mm Hg at the left ankle. An arteriogram demonstrates complete occlusion of the left external iliac artery with reconstitution of the common femoral artery. Pre-service work includes final review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, patient positioning, scrub, prep, and drape. At operation an ilio-femoral bypass is performed using a Dacron conduit. Post-service work includes post-operative in-hospital care plus all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and iliac artery
- Clear soft tissue from iliac artery
- Expose adequate length of iliac artery to achieve proximal and distal control
- Incise skin over femoral artery & Dissect soft tissue to find femoral artery
- Clear soft tissue from around femoral artery
- Expose adequate length of femoral artery to achieve proximal and distal control
- Create tunnel from iliac artery to femoral artery
- Choose synthetic conduit of appropriate diameter
- Pull synthetic conduit through tunnel
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on iliac artery
- Incise iliac longitudinally at proximal anastomosis site

- Anastomose synthetic conduit to inflow iliac with vascular suture
- Remove clamp and test for leaks & Apply additional sutures as needed to control hemorrhage
- Pull synthetic conduit through tunnel to femoral artery
- Apply proximal and distal clamps to femoral artery at distal anastomosis site
- Incise femoral iliac artery at anastomosis site
- Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to femoral artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine & Irrigate abdomen & Final check for hemostasis
- Close abdominal incision & Irrigate subcutaneous tissue at femoral incision
- Close soft tissue at femoral incision in multiple layers & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient & Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary & Outpatient visits as required for 90 days

CPT 35665 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 76

Response Rate: 30 (39%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.00	21.00	22.00	25.88	36.00
Pre-Service Time			100		
Intra-Service Time	100	120	150	180	250

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1, 99231x3
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2, 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35665 (n=30)	Ref CPT 35656 (n=16)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	100	90
Intra-service time	150	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	68
Discharge management time	36	36
Total office visit time	61	53

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

Pre-service	3.83	3.25
Intra-service	3.90	3.25
Post-service	3.24	2.88

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.38
Urgency of medical decision making	3.00	2.63

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.38
Physical effort required	3.83	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.86	3.13
Outcome depends on the skill and judgment of physician	4.14	3.75
Estimated risk of malpractice suit with poor outcome	3.86	3.69

CPT 35665 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35665

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.086	12.83
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.66
Total RVW by Building Block Method =			21.07

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CPT 35665 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:
 [Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

861	vascular surgery	17	general practice
750	general surgery	3	nuclear medicine
268	thoracic surgery	2	family practice
71	clinic or group practice (not gppp)	1	diagnostic radiology
55	cardiac surgery	1	orthopaedic surgery
36	cardiology	1	plastic & reconstructive surgery
27	peripheral vascular disease	1	pulmonary disease 1 urology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions:
 (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
 0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
 0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
 0 0 less complex (less work)
 0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
 0 0 from inpatient to outpatient
 0 0 no change

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

CPT Code: 35666	Global Period: 090	RUC Rec. RVW: 22.19	SVS Rec. RVW: 22.19
		Median Survey RVW: 22.19	Building Block RVW: 21.64
			(Using median survey time)
		Building Block RVW: 21.55	2000 RVW: 19.19
			(Using actual skin-to-skin intra)

CPT Descriptor: Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 80-year-old male presents with dry gangrene of the great toe. He has a normal femoral pulse, but no palpable popliteal, ankle, or foot pulses. Angiography reveals complete occlusion of the superficial femoral and popliteal arteries, plus occlusion of the tibial artery origins. His anterior tibial reconstitutes at mid calf. All autogenous vein has been used for CABG operations. Pre-service work includes review of all preoperative studies, informed consent from patient, discussions with family, anesthesia, and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. A femoral-posterior tibial bypass is performed with synthetic conduit. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin in groin over common femoral artery & Dissect soft tissue to find common femoral artery
- Clear soft tissue from femoral bifurcation artery
- Expose adequate length of femoral artery to achieve proximal and distal control
- Incise skin over posterior tibial artery & Dissect soft tissue to find posterior tibial artery
- Clear soft tissue from around posterior tibial artery
- Expose adequate length of posterior tibial artery to achieve proximal and distal control
- Create tunnel from femoral artery to posterior tibial artery
- Choose synthetic conduit of appropriate diameter

- Pull synthetic conduit through tunnel & Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on femoral artery
- Incise femoral longitudinally at proximal anastomosis site
- Anastomose synthetic conduit to femoral artery with fine vascular suture
- Remove clamps and test for leaks & Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to posterior tibial artery at distal anastomosis site
- Incise posterior tibial at anastomosis site & Cut synthetic conduit to appropriate length
- Anastomose end of synthetic conduit to side of posterior tibial artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate femoral dissection site and posterior tibial exposure site
- Final check for hemostasis & Close soft tissue at femoral and posterior tibial dissection sites
- Irrigate subcutaneous tissue & Close skin at both sites

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Distal AV fistula to enhance bypass graft patency, if performed

CPT 35666 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 100

Response Rate: 30 (30%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	19.53	20.05	22.19	26.00	35.00
Pre-Service Time			90		
Intra-Service Time	80	120	150	195	300

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	106	99232x1 99231x4
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

	Survey CPT 35666 (n=30)	Ref CPT 35656 (n=13)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	90	95
Intra-service time	150	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	106	76
Discharge management time	36	36
Total office visit time	61	38

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

Pre-service	3.71	3.08
Intra-service	4.00	3.25
Post-service	3.39	2.67

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.62
Urgency of medical decision making	3.43	2.69

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.37	3.38
Physical effort required	3.73	3.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.23	3.62
Outcome depends on the skill and judgment of physician	4.40	3.62
Estimated risk of malpractice suit with poor outcome	3.43	2.85

CPT 35666 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following two Building Block analyses substantiate the median survey value from the RUC survey as an appropriate new RVW. The first uses RUC survey times and visits. The second substitutes real skin-to-skin intra-service time from our vascular surgery database. The second analysis supports our belief that surgeons tend to under-estimate skin-to-skin times.

Building Block Method

Intra-service Intensity is median value for this service from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All time and visit data from RUC survey

CPT Code 35666

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	150	0.085	12.75
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	4	0.64	2.56
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
Post-service total			7.30
Total RVW by Building Block Method			21.64

Building Block recalculated using actual skin-to-skin intra-time = 149 min (n=11) culled from a database of 5,000 vascular surgery operations performed by 31 surgeons in 1999

Building Block Method

Intra-service Intensity is median value for this service from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

Intra-service time is real skin-to-skin time from vascular surgery database

All other time and visit data from RUC survey

CPT Code 35666

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59
Intra-service	149	0.085	12.67
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	4	0.64	2.56
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
Post-service total			7.30
Total RVW by Building Block Method			21.55

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CPT 35666 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,267	general surgery	27	cardiology
1,054	vascular surgery	9	pulmonary disease
491	thoracic surgery	8	diagnostic radiology
99	clinic or group practice (not gppp)	8	general practice
91	cardiac surgery	3	surgical oncology
47	peripheral vascular disease	2	hand surgery
32	anesthesiology	1	emergency medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1	0	Yes
2	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
1	0	I do not agree

Patients requiring this service are now:

1	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
1	0	no change

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

CPT Code: 35671	Global Period: 090	RUC Rec. RVW:	19.33
		SVS Rec. RVW:	23.00
		Median Survey RVW:	23.00
		Building Block RVW:	19.13
		2000 RVW:	14.80

CPT Descriptor: Bypass graft, with other than vein; popliteal-tibial or –peroneal artery

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own “best” method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin below knee & Dissect popliteal space to find popliteal artery
- Clear soft tissue from popliteal artery
- Expose adequate length of popliteal artery to achieve proximal and distal control
- Incise skin over distal anterior tibial artery
- Dissect soft tissue to find anterior tibial artery
- Clear soft tissue from around anterior tibial artery
- Expose adequate length of anterior tibial artery to achieve proximal and distal control
- Create tunnel from popliteal artery to anterior tibial artery
- Choose synthetic conduit of appropriate diameter
- Pull synthetic conduit through tunnel
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on popliteal artery
- Incise popliteal longitudinally at proximal anastomosis site
- Anastomose synthetic conduit to popliteal artery with fine vascular suture
- Remove clamps and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to anterior tibial artery at distal anastomosis site
- Incise anterior tibial artery at anastomosis site
- Cut synthetic conduit to appropriate length

- Anastomose end of synthetic conduit to distal anterior tibial artery
- Flush system to remove air and debris
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern across both anastomoses
- Reverse anticoagulant with protamine
- Irrigate popliteal space and posterior tibial exposure site & Final check for hemostasis
- Close popliteal space and subcutaneous tissue at anterior tibial anastomosis site
- Irrigate subcutaneous tissue & Close skin at both sites
- Irrigate and close saphenous harvest site

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, bypass patency, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Distal AV fistula to enhance bypass graft patency, if performed

CPT 35671 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 96

Response Rate: 56 (58%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	15.00	20.50	23.00	26.00	35.00
Pre-Service Time			70		
Intra-Service Time			135		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	79	99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35671 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35671

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	25	0.0224	0.56
Same day evaluation	20	0.0224	0.45
Scrub, prep	25	0.0081	0.20
Pre-service total			1.21
Intra-service	135	0.085	11.48
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.44
Total RVW by Building Block Method =			19.13

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CPT 35671 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

200	general surgery	1	diagnostic radiology
191	vascular surgery	1	family practice
74	thoracic surgery	1	otolaryngology
33	cardiac surgery	1	plastic & reconstructive surgery
14	cardiology	1	pulmonary disease
14	clinic or group practice (not gppp)	1	urology
5	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

1 0 Yes
2 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
1 0 I do not agree

Patients requiring this service are now:

1 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35701	Global Period: 090	RUC Rec. RVW:	8.50
		SVS Rec. RVW:	14.50
		Median Survey RVW:	14.50
		Building Block RVW:	10.68
		2000 RVW:	5.55

CPT Descriptor: Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Avoid injury to cranial nerves
- Rapidly dissect soft tissue from around common, internal, and external carotid arteries
- Inspect carotid arteries for visually apparent external damage
- Palpate pulse in common, internal, and external carotid arteries
- Listen with Doppler to assure normal flow pattern in all three arteries
- Do not heparinize when artery appears and sounds entirely normal
- Irrigate wound to wash out hematoma & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic arteriogram if performed

CPT 35701 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 79 **Response Rate:** 27 (34%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	12.50	14.50	16.00	24.00
Pre-Service Time			55		
Intra-Service Time			60		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	30	99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35701 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis justifies a physician work RVU substantially greater than the current RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35701

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	60	0.070	4.20
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.60
Total RVW by Building Block Method =			10.68

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CPT 35701 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

151	general surgery	6	general practice
117	vascular surgery	6	hand surgery
67	thoracic surgery	5	cardiology
61	otolaryngology	4	peripheral vascular disease
43	neurosurgery	2	neurology
19	clinic or group practice (not gppp)	1	allergy/immunology
12	cardiac surgery	1	maxillofacial surgery
10	plastic & reconstructive surgery	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35721	Global Period: 090	RUC Rec. RVW:	7.18
		SVS Rec. RVW:	8.65
		Median Survey RVW:	8.65
		Building Block RVW:	9.07
		2000 RVW:	5.28

CPT Descriptor: Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old woman is stabbed in the thigh by a purse-snatcher. She arrives in the ED with active hemorrhage. ED physicians perform a rapid initial assessment, place large bore IVs, and control hemorrhage with direct pressure. Pre-service work includes obtaining informed consent, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent exploration of the femoral artery is performed, but no femoral artery injury is present. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along medial aspect of thigh proximal and adjacent to injury
- Rapidly dissect soft tissue to find superficial femoral artery
- Avoid injury to nerves and femoral vein
- Rapidly dissect soft tissue from around superficial femoral artery
- Inspect femoral artery for visually apparent external damage
- Palpate pulse in proximal and distal portions of artery
- Listen with Doppler to assure normal flow pattern in artery
- Do not heparinize if artery appears and sounds entirely normal
- Irrigate wound to wash out hematoma & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic arteriogram if performed

CPT 35721 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 95 **Response Rate:** 32 (24%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	3.50	7.18	8.65	10.80	19.00
Pre-Service Time			53		
Intra-Service Time	30	45	60	75	180

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	49	99232x1 99231x1
Discharge Day Mgmt	36	99238
Office Visits	30	99212x2

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
8.00	090	36831	Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)

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

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

	Survey CPT 35721 (n=32)	Ref CPT 36831 (n=10)
<u>TIME ESTIMATES (MEDIAN)</u>		
Pre-service time	53	90
Intra-service time	60	53
Immediate Post-service time	30	20
Total critical care time	0	0
Total other hospital visit time	49	19
Discharge management time	36	36
Total office visit time	30	15

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

Pre-service	3.23	2.44
Intra-service	2.97	2.44
Post-service	2.45	2.22

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.97	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.33
Urgency of medical decision making	4.03	2.50

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.03	2.90
Physical effort required	3.09	2.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.19	2.50
Outcome depends on the skill and judgment of physician	3.13	2.90
Estimated risk of malpractice suit with poor outcome	3.28	2.10

CPT 35721 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35721

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	20	0.0081	0.16
Pre-service total			0.83
Intra-service	60	0.062	3.72
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	0	0.65	0.00
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.51
Total RVW by Building Block Method =			9.07

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CPT 35721 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: ~~Commonly~~ Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

439	general surgery	3	family practice
277	vascular surgery	3	general practice
215	thoracic surgery	3	surgical oncology
104	cardiac surgery	2	emergency medicine
25	clinic or group practice (not gppp)	2	maxillofacial surgery
22	nephrology	2	nuclear medicine
18	cardiology	2	pulmonary disease
12	diagnostic radiology	1	anesthesiology
12	interventional radiology	1	infectious disease
12	plastic & reconstructive surgery	1	obstetrics/gynecology
9	orthopaedic surgery	1	ophthalmology
9	peripheral vascular disease	1	otolaryngology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2	0	Yes
30	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
2	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
2	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35741	Global Period: 090	RUC Rec. RVW:	8.00
		SVS Rec. RVW:	10.00
		Median Survey RVW:	10.00
		Building Block RVW:	9.80
		2000 RVW:	5.37

CPT Descriptor: Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along medial aspect of distal thigh or calf adjacent to injury
- Rapidly dissect soft tissue to find popliteal artery
- Avoid injury to nerves and popliteal vein
- Rapidly dissect soft tissue from around popliteal artery
- Inspect popliteal artery for visually apparent external damage
- Palpate pulse in proximal and distal portions of artery
- Listen with Doppler to assure normal flow pattern in artery
- Do not heparinize if artery appears and sounds entirely normal
- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)

- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35741 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 95 **Response Rate:** 32 (34%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	5.00	8.00	10.00	12.00	19.00
Pre-Service Time			50		
Intra-Service Time			75		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	30	99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 35741 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 35741

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	20	0.0081	0.16
Pre-service total			0.83
Intra-service	75	0.065	4.88
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			4.09
Total RVW by Building Block Method =			9.80

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CPT 35741 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

181	general surgery	5	peripheral vascular disease
162	vascular surgery	2	family practice
62	thoracic surgery	1	diagnostic radiology
18	clinic or group practice (not gppp)	1	neurosurgery
12	cardiac surgery	1	obstetrics/gynecology
12	cardiology	1	plastic & reconstructive surgery
6	orthopaedic surgery	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2	0	Yes
30	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
2	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
2	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 35905	Global Period: 090	RUC Rec. RVW:	31.25
		SVS Rec. RVW:	35.00
		Median Survey RVW:	35.00
		Building Block RVW:	37.95
		2000 RVW:	18.19

CPT Descriptor: Excision of infected graft; thorax

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform thoracotomy or median sternotomy & Dissect soft tissue to find infected graft
- Avoid injury to lung, heart, phrenic nerves
- Dissect soft tissue to find incorporated segments of graft, if any
- Clear soft tissue from entire length of infected graft
- Administer systemic anticoagulant and wait for circulation
- Place clamp on aortic arch & Disconnect proximal graft anastomosis
- Close aortotomy with vascular sutures
- Release side-biting aortic clamp and check for hemostasis
- Apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to artery just beyond infected graft
- Divide distal artery just beyond distal anastomosis of graft
- Oversee distal artery with vascular suture & Remove clamps
- Remove infected graft & Apply additional sutures as needed to control hemorrhage
- Reverse anticoagulant with protamine
- Irrigate chest & Final check for hemostasis
- Reapproximate ribs or sternum & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia.
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, antibiotic regimen, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 35905 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 82 **Response Rate:** 27 (33%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	21.00	31.25	35.00	40.00	50.00
Pre-Service Time			120		
Intra-Service Time			240		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	0	
Other Hospital	177	99233x1 99232x2 99231x4
Discharge Day Mgmt	36	99238
Office Visits	61	99213x2 99212x1

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CPT 35905 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 35905

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	45	0.0224	1.01
Same day evaluation	30	0.0224	0.67
Scrub, prep	45	0.0081	0.36
Pre-service total			2.04
Intra-service	240	0.100	24.00
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	5	0.64	3.20
99232	3	1.06	3.18
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			11.91
Total RVW by Building Block Method =			37.95

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CPT 35905 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

40	thoracic surgery	3	cardiac surgery
39	general surgery	1	anesthesiology
11	vascular surgery	1	cardiology
9	clinic or group practice (not gppp)	1	internal medicine

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 35907	Global Period: 090	RUC Rec. RVW:	35.00
		SVS Rec. RVW:	40.00
		Median Survey RVW:	40.00
		Building Block RVW:	36.25
		(Using median survey data)	
		2000 RVW:	19.24

CPT Descriptor: Excision of infected graft; abdomen

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 66-year-old male presents with fever, malaise, and back pain. He underwent repair of an aortic aneurysm with an infrarenal tube graft 10 years ago. CT scan findings indicate infection of his aortic graft. Pre-service work includes review of all preoperative studies, final discussions with patient, family, anesthesia, and nursing, plus dress, scrub, prepare equipment, wait, position patient, prep and drape. His operation includes excision of the infected graft, suture ligation of infrarenal aorta and common iliac arteries, and placement of an omental pedicle to protect the ligated aorta. Collateral circulation to the lower extremities is adequate. Post-service work includes immediate postoperative care starting after skin closure, subsequent in-hospital care, and all related outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & Dissect soft tissue to find infected graft
- Avoid injury to viscera
- Dissect soft tissue to find uninvolved sections of proximal aorta and iliac arteries
- Clear soft tissue from entire length of infected graft
- Administer systemic anticoagulant and wait for circulation
- Place cross-clamp on aorta proximal to and distal to graft anastomoses
- Disconnect proximal graft anastomosis & Close aortotomy with vascular sutures
- Release clamp and check for hemostasis
- Apply additional sutures as needed to control hemorrhage
- Mobilize omental flap to bolster aortic closure

- Suture omental flap in place & Disconnect distal graft anastomosis
- Remove infected graft from operative field & Oversee distal aorta with vascular suture
- Remove clamps & Apply additional sutures as needed to control hemorrhage
- Reverse anticoagulant with protamine
- Irrigate abdomen & Final check for hemostasis
- Close laparotomy & Irrigate subcutaneous tissue & Close skin if no overt contamination

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, antibiotic regimen, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Revascularization, if required

CPT 35907 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty: SVS / AAVS

Sample Size: 106

Response Rate: 31 (29%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	31.00	35.00	40.00	44.50	95.00
Pre-Service Time			120		
Intra-Service Time	30	208	240	300	630

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	0	
Other Hospital	177	99233X1 99232X2 99231X4
Discharge Day Mgmt	36	99238
Office Visits	61	99213X2 99212X1

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CPT 35907 KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
35.40	090	35091	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

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

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

	Survey CPT 35907 (n=31)	Ref CPT 35091 (n=12)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	120	90
Intra-service time	240	230
Immediate Post-service time	45	45
Total critical care time	0	0
Total other hospital visit time	177	174
Discharge management time	36	36
Total office visit time	61	61

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

Pre-service	4.67	4.55
Intra-service	4.83	4.91
Post-service	4.27	4.09

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.60	4.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	4.50
Urgency of medical decision making	4.70	3.67

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.63	4.73
Physical effort required	4.77	4.64

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.83	4.75
Outcome depends on the skill and judgment of physician	4.73	4.83
Estimated risk of malpractice suit with poor outcome	3.87	4.08

CPT 35907 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 35907

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	45	0.0224	1.01
Same day evaluation	30	0.0224	0.67
Scrub, prep	45	0.0081	0.36
Pre-service total			2.04
Intra-service	240	0.100	24.00
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
Post-service total			10.21
Total RVW by Building Block Method			36.25

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CPT 35907 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

188	general surgery	2	plastic & reconstructive surgery
170	vascular surgery	1	anesthesiology
42	thoracic surgery	1	gastroenterology
14	clinic or group practice (not gppp)	1	internal medicine
10	peripheral vascular disease	1	obstetrics/gynecology
5	cardiac surgery	1	colorectal surgery
4	cardiology	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
4 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 37565	Global Period: 090	RUC Rec. RVW:	10.88
		SVS Rec. RVW:	14.00
		Median Survey RVW:	14.00
		Building Block RVW:	10.26
		2000 RVW:	4.44

CPT Descriptor: Ligation, internal jugular vein

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is usually an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find internal jugular vein
- Avoid injury to cranial nerves and carotid artery
- Rapidly dissect soft tissue from around internal jugular vein
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Rapidly clamp internal jugular vein proximal and distal to injury
- Ligate vein & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulse to check for normal arterial flow
- Listen with Doppler to assure normal flow pattern across repair
- Reverse anticoagulant with protamine
- Irrigate wound to wash out hematoma
- Final check for hemostasis & Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37565 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176 **Response Rate:** 27 (15%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.00	10.88	14.00	15.75	18.00
Pre-Service Time			55		
Intra-Service Time			60		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	71	99233x1 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37565 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37565

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	60	0.065	3.90
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.49
Total RVW by Building Block Method =			10.26

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CPT 37565 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

45	general surgery	1	cardiology
15	otolaryngology	1	general practice
7	vascular surgery	1	internal medicine
2	cardiac surgery	1	ophthalmology
2	clinic or group practice (not gppp)	1	plastic & reconstructive surgery
2	thoracic surgery	1	surgical oncology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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

CPT Code: 37600	Global Period: 090	RUC Rec. RVW:	11.25
		SVS Rec. RVW:	14.50
		Median Survey RVW:	14.50
		Building Block RVW:	11.26
		2000 RVW:	4.57

CPT Descriptor: Ligation; external carotid artery

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is usually an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Avoid injury to cranial nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp common carotid artery to obtain proximal control
- Clamp distal common carotid to obtain distal control
- Clamp internal and external carotids
- Ligate external carotid proximal and distal to injury with fine vascular suture
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal internal carotid pulse to check for restitution of blood flow to brain
- Listen with Doppler to assure no flow in external carotid
- Reverse anticoagulant with protamine
- Irrigate wound & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37600 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176

Response Rate: 27 (15%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.00	11.25	14.50	16.00	24.00
Pre-Service Time			55		
Intra-Service Time			70		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	71	99233x1 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37600 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37600

	Time	Intensity	RVU
Pre-service			(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	70	0.070	4.90
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.49
Total RVW by Building Block Method =			11.26

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CPT 37600 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

47	otolaryngology	4	plastic & reconstructive surgery
22	general surgery	4	thoracic surgery
19	vascular surgery	3	internal medicine
7	neurosurgery	1	family practice
6	cardiac surgery	1	interventional radiology
5	clinic or group practice (not gppp)	1	orthopaedic surgery
4	emergency medicine	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 37605	Global Period: 090	RUC Rec. RVW:	13.11
		SVS Rec. RVW:	16.00
		Median Survey RVW:	16.00
		Building Block RVW:	13.11
		2000 RVW:	6.19

CPT Descriptor: Ligation; internal or common carotid artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is usually an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Avoid injury to cranial nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp common carotid artery to obtain proximal control
- Rapidly clamp distal common carotid for distal control if possible
- Clamp distal internal and external carotid to obtain distal control if necessary
- Ascertain adequate back pressure in internal carotid
- Ligate internal or common carotid proximal and distal to injury with fine vascular suture
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Reverse anticoagulant with protamine
- Irrigate wound & Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, cerebral function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37605 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176

Response Rate: 27 (15%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	15.00	16.00	18.00	28.00
Pre-Service Time			55		
Intra-Service Time			90		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	71	99233x1 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37605 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps justify the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37605

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	90	0.075	6.75
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.49
Total RVW by Building Block Method =			13.11

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CPT 37605 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

44	general surgery	3	cardiac surgery
33	vascular surgery	2	pulmonary disease
24	neurosurgery	1	family practice
9	otolaryngology	1	interventional radiology
7	clinic or group practice (not gppp)	1	neurology
7	thoracic surgery	1	peripheral vascular disease
4	diagnostic radiology	1	plastic & reconstructive surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0 0 Yes
0 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
0 0 I do not agree

Patients requiring this service are now:

0 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
0 0 no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 37609	Global Period: 010	RUC Rec. RVW:	3.00
		SVS Rec. RVW:	4.00
		Median Survey RVW:	4.00
		Building Block RVW:	4.67
		2000 RVW:	2.30

CPT Descriptor: Ligation or biopsy, temporal artery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old woman complains of severe left-sided headaches. Physical exam reveals tenderness over the temporal artery. Pre-service work includes review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient's comorbidities with anesthesia, positioning the patient, scrub, prep, and drape. At operation a temporal artery biopsy is performed. Post-service work includes post-op in-hospital care plus all related outpatient care for 10 days

Description of Pre-Service Work:

Pre-service work may begin on the day prior to surgery. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise skin over temporal artery pulse
- Dissect soft tissue to find temporal artery
- Dissect soft tissue from around artery
- Dissect segment of adequate length to allow satisfactory analysis
- Ligate artery at both ends of dissection
- Excise artery
- Irrigate wound
- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 10 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU)
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Assess for discharge suitability later in day
- Outpatient visits as required for 10 days

CPT 37609 SURVEY DATA

Presenter(s): Charles M, Shoemaker, MD (ASGS)
Gary R. Seabrook, MD (SVS-AAVS)

Specialty(s): American Society of General Surgeons
Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 230 **Response Rate:** 62 (27%)

Type of Sample: random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.00	3.00	4.00	5.00	9.00
Pre-Service Time			45		
Intra-Service Time	10	25	30	40	60

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	20	
Critical Care	0	
Other Hospital	0	
Discharge Day Mgmt	36	99238
Office Visits	15	99212x1

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KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
4.49	010	43750	Percutaneous placement of gastrostomy tube (PEG)

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

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

	Survey CPT 37609 (n=62)	Ref CPT 43750 (n=15)
<i>TIME ESTIMATES (MEDIAN)</i>		
Pre-service time	45	45
Intra-service time	30	20
Immediate Post-service time	20	15
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	36
Total office visit time	15	15

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

Pre-service	2.13	2.00
Intra-service	2.30	2.00
Post-service	1.87	1.70

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.23	2.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.21	2.25
Urgency of medical decision making	2.12	1.92

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.61	2.42
Physical effort required	2.23	2.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.98	2.08
Outcome depends on the skill and judgment of physician	2.21	2.17
Estimated risk of malpractice suit with poor outcome	2.00	2.17

CPT 37609 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

CPT 37609 has not been reviewed since the Harvard study; however, the intraoperative estimated time is still the same (30 minutes). This is a procedure that is primarily performed in both inpatient and outpatient settings (hospital or ASC, not office). As such there could be hospital visits and/or discharge management, along with an office visit within the 10-day global period. Although some of our survey respondents indicated one or two days in the hospital, a majority of the respondents indicated that the patient was discharged without a hospital stay (i.e., less than 24 hours). The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps justify the RUC survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey

CPT Code 37609

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	45	0.0224	1.01
Scrub, prep	0	0.0081	0.00
Pre-service total			1.01
Intra-service	30	0.050	1.50
Post-service			
Immediate post	20	0.0224	0.45
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	0	0.65	0.00
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			2.16
Total RVW by Building Block Method =			4.67

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CPT 37609 FREQUENCY INFORMATION

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

Specialty: General Surgery Commonly Sometimes Rarely
 Specialty: Vascular Surgery ~~Commonly~~ Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

15,092	general surgery	11	urology
4,290	ophthalmology	10	anesthesiology
2,125	vascular surgery	10	diagnostic radiology
1,513	otolaryngology	10	nuclear medicine
907	clinic or group practice (not gppp)	8	orthopaedic surgery
731	thoracic surgery	7	ASC
553	neurosurgery	4	allergy/immunology
467	plastic & reconstructive surgery	4	hand surgery
128	family practice	4	pediatric medicine
123	general practice	4	pulmonary disease
90	cardiac surgery	3	addiction medicine
78	peripheral vascular disease	2	endocrinology
78	surgical oncology	2	hematology/oncology
71	cardiology	2	osteopathic manipulative therapy
64	neurology	1	gastroenterology
61	colorectal surgery	1	hematology
30	dermatology	1	infectious disease
29	internal medicine	1	medical oncology
22	emergency medicine	1	obstetrics/gynecology
15	maxillofacial surgery	1	physical medicine and rehabilitation
12	critical care (intensivists)	1	rheumatology

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is SVS consensus committee count)

Has the work of performing this service changed in the past 5 years?

2 0 Yes
 35 7 No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
2	0	I do not agree

Patients requiring this service are now:

0	0	<u>more</u> complex (more work)
0	0	less complex (less work)
2	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
2	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 37615	Global Period: 090	RUC Rec. RVW:	5.73
		SVS Rec. RVW:	16.00
		Median Survey RVW:	18.00
		Building Block RVW:	13.61
		2000 RVW:	5.73

CPT Descriptor: Ligation, major artery (e.g., post-traumatic, rupture); neck

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly incise skin along anterior border of sternocleidomastoid muscle
- Rapidly dissect soft tissue to find common, external and internal carotid arteries
- Avoid injury to cranial nerves
- Rapidly dissect soft tissue from around arteries
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Anticoagulate patient if there are no other injuries that might bleed
- Rapidly clamp common carotid artery to obtain proximal control
- Rapidly clamp distal common carotid for distal control if possible
- Clamp distal internal and external carotid to obtain distal control if necessary
- Ascertain adequate back pressure in internal carotid
- Ligate major artery in neck with fine vascular suture
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Reverse anticoagulant with protamine
- Irrigate wound
- Final check for hemostasis
- Close soft tissue in multiple layers
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, mental status, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

Not included in this Procedure (Separately Billable)

- Diagnostic angiography, if performed

CPT 37615 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 176

Response Rate: 27 (15%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	15.00	18.00	18.70	28.00
Pre-Service Time			60		
Intra-Service Time			90		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	71	99233x1 99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37615 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps justify the RUC mini-survey median value as an appropriate new RVW.

Note: We reduced the final recommended RVW for this service from the survey median of 18.00 to 16.00 because this service is essentially the same as CPT 37605 (ligate internal or common carotid artery), and 37605 had a median survey value of 16.00 RVUs. We believe 16.00 is the best overall value for these two codes.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37615

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	90	0.080	7.20
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			5.49
Total RVW by Building Block Method =			13.61

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CPT 37615 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

29	otolaryngology	4	thoracic surgery
27	general surgery	1	anesthesiology
11	vascular surgery	1	cardiology
4	cardiac surgery	1	family practice
4	clinic or group practice (not gppp)	1	general practice
4	plastic & reconstructive surgery	1	peripheral vascular disease

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
0	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 37617	Global Period: 090	RUC Rec. RVW:	22.06
		SVS Rec. RVW:	26.00
		Median Survey RVW:	26.00
		Building Block RVW:	19.35
		2000 RVW:	15.95

CPT Descriptor: Ligation, major artery (e.g., post-traumatic, rupture); abdomen

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 70-year-old woman is stabbed in the abdomen. She arrives in the ED in hemorrhagic shock. ED physicians perform a rapid initial assessment, place large bore IVs, and initiate resuscitation. Pre-service work includes obtaining informed consent if possible, immediate discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. Emergent laparotomy reveals a transected hypogastric artery, and ligation is performed. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform laparotomy incision & explore abdomen to find site of hemorrhage
- Manually compress aorta if patient has exsanguinating hemorrhage
- Avoid injury to viscera
- Rapidly dissect soft tissue from surface of bleeding hypogastric artery
- Use digital pressure to control hemorrhage until clamps can be applied safely
- Rapidly clamp common iliac inflow above injury to obtain inflow control
- Rapidly expose hypogastric artery beyond injury
- Determine that back-bleeding from hypogastric is excellent
- Suture ligate hypogastric artery & Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure adequate flow pattern beyond ligation
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound to wash out hematoma

- Final check for hemostasis & Close laparotomy fascia
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings & Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes & Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family & with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, renal function, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37617 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 30 (32%) **Type of Sample:** Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	22.06	26.00	28.15	43.00
Pre-Service Time			58		
Intra-Service Time			120		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	45	
Critical Care	0	
Other Hospital	139	99233x1 99232x2 99231x2
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

	Survey CPT 37617 (n=30)	Ref CPT 35081 (n=12)
TIME ESTIMATES (MEDIAN)		
Pre-service time	58	90
Intra-service time	120	150
Immediate Post-service time	45	30
Total critical care time	0	0
Total other hospital visit time	139	147
Discharge management time	36	36
Total office visit time	38	38

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

Pre-service	4.60	4.00
Intra-service	4.63	4.58
Post-service	3.77	3.92

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	4.17
Urgency of medical decision making	4.87	3.42

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.33	4.42
Physical effort required	4.60	4.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.77	4.33
Outcome depends on the skill and judgment of physician	4.53	4.58
Estimated risk of malpractice suit with poor outcome	4.03	4.25

CPT 37617 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps substantiate the RUC survey median value as an appropriate new RVW. **We believe this Building Block is substantially lower than the median survey because the surgeons have most likely underestimated intra-service time. Unfortunately there are none of these cases in our vascular surgery skin-to-skin database to confirm that suspicion.**

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All time and visit data from RUC survey

CPT Code 37617

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	25	0.0081	0.20
Pre-service total			0.87
Intra-service	120	0.085	10.20
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	2	0.64	1.28
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			8.28
Total RVW by Building Block Method =			19.35

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CPT 37617 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

250	general surgery	6	urology
68	vascular surgery	4	colorectal surgery
35	thoracic surgery	4	plastic & reconstructive surgery
29	obstetrics/gynecology	3	internal medicine
13	gynecology/oncology	3	peripheral vascular disease
10	clinic or group practice (not gppp)	2	cardiology
8	surgical oncology	1	family practice
7	cardiac surgery	1	general practice

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
29	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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

CPT Code: 37618	Global Period: 090	RUC Rec. RVW:	4.84
		SVS Rec. RVW:	10.70
		Median Survey RVW:	10.70
		Building Block RVW:	13.58
		2000 RVW:	4.84

CPT Descriptor: Ligation, major artery (e.g., post-traumatic, rupture); extremity

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Rapidly perform extremity incision & find proximal (inflow) artery to gain vascular control
- Rapidly dissect soft tissue from surface of inflow artery
- Manually compress inflow artery if patient has exsanguinating hemorrhage
- Avoid injury to nerves
- Rapidly dissect soft tissue from surface of injured artery
- Apply proximal and distal vascular clamps
- Ascertain that collateral circulation is adequate to perfuse distal portion of limb
- Suture-ligate artery
- Remove clamps
- Apply additional sutures as needed to control hemorrhage
- Listen with Doppler to assure adequate flow pattern beyond ligation
- Correct coagulopathy with fresh frozen plasma, platelets, cryoprecipitate
- Irrigate wound
- Final check for hemostasis
- Close soft tissue
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, adequacy of distal perfusion, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37618 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 30 (38%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.50	8.00	10.70	14.00	22.00
Pre-Service Time			60		
Intra-Service Time			73		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37618 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37618

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	73	0.075	5.48
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.19
Total RVW by Building Block Method =			13.58

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CPT 37618 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

497	general surgery	3	colorectal surgery
298	vascular surgery	3	family practice
78	thoracic surgery	2	anesthesiology
40	plastic & reconstructive surgery	2	emergency medicine
31	orthopaedic surgery	2	general practice
22	clinic or group practice (not gppp)	2	surgical oncology
15	cardiac surgery	1	internal medicine
8	hand surgery	1	nephrology
5	cardiology	1	urology
5	peripheral vascular disease		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

2 0 Yes
30 7 No

This service represents new technology that has become more familiar (i.e., less work).

0 0 I agree
2 0 I do not agree

Patients requiring this service are now:

2 0 more complex (more work)
0 0 less complex (less work)
0 0 no change

The usual site-of-service has changed:

0 0 from outpatient to inpatient
0 0 from inpatient to outpatient
2 0 no change

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

CPT Code: 37650	Global Period: 090	RUC Rec. RVW:	7.80
		SVS Rec. RVW:	8.80
		Median Survey RVW:	8.80
		Building Block RVW:	9.10
		2000 RVW:	5.13
CPT Descriptor: Ligation of femoral vein			

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is usually an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Incise thigh
- Dissect soft tissue to find femoral vein
- Dissect soft tissue from surface of femoral vein
- Suture-ligate femoral vein
- Apply additional sutures as needed to control hemorrhage
- Irrigate wound
- Final check for hemostasis
- Close soft tissue
- Irrigate subcutaneous tissue
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, leg swelling, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37650 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 80 **Response Rate:** 31 (39%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	4.00	7.10	8.80	11.25	20.00
Pre-Service Time			60		
Intra-Service Time			60		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	30	99232x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

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CPT 37650 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis substantiates the RUC mini-survey median value as an appropriate new RVW.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37650

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	60	0.070	4.20
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	1	1.06	1.06
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			3.98
Total RVW by Building Block Method =			9.10

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CPT 37650 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

36	general surgery	6	cardiology
29	vascular surgery	4	plastic & reconstructive surgery
13	thoracic surgery	2	cardiac surgery
7	clinic or group practice (not gppp)	1	orthopaedic surgery

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

3	0	Yes
29	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
3	0	I do not agree

Patients requiring this service are now:

2	0	<u>more</u> complex (more work)
1	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
3	0	no change

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 37660	Global Period: 090	RUC Rec. RVW:	21.00
		SVS Rec. RVW:	25.00
		Median Survey RVW:	25.00
		Building Block RVW:	16.65
		2000 RVW:	10.61

CPT Descriptor: Ligation of common iliac vein

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a rarely performed service that was evaluated by RUC-approved mini-survey. Thus, no clinical vignette was established.

Description of Pre-Service Work:

Pre-service work begins on the day or night of surgery since this is usually an emergency operation. Pre-Service Work begins after the decision to operate and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform emergent laparotomy & rapid abdominal exploration
- Incise retroperitoneum over aortic bifurcation
- Dissect soft tissue to find common iliac vein
- Dissect soft tissue from surface of common iliac vein
- Suture-ligate common iliac vein
- Apply additional sutures as needed to control hemorrhage
- Irrigate abdomen
- Final check for hemostasis
- Close retroperitoneum
- Close laparotomy incision
- Close skin

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, status of leg swelling, nutrition, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

CPT 37660 SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): Society for Vascular Surgery – American Association for Vascular Surgery

Sample Size: 94 **Response Rate:** 28 (30%)

Type of Sample: Random (mail/fax)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	15.00	21.00	25.00	27.50	40.00
Pre-Service Time			60		
Intra-Service Time			120		

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	90	99233x1 9232x1 99231x1
Discharge Day Mgmt	36	99238
Office Visits	37	99213x1 99212x1

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CPT 37660 ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years.

Response: The work of this service has not changed over the last 5 years. Rather, we believe it was not accurately evaluated during the original Harvard / Hsiao extrapolations. The following Building Block analysis helps substantiate the RUC mini-survey median value as an appropriate new RVW.

We suspect the discrepancy between median survey value and Building Block value is due to a significant underestimate of intra-service time by our survey respondents, but there is no hard data in our skin-to-skin database to substantiate the impression.

Building Block Method

Intra-service Intensity is median value from the SVS/AAVS Intensity Survey

Other Intensity factors from the original Harvard Stone formula

All other time and visit data from RUC mini-survey / Consensus Panel

CPT Code 37660

	Time	Intensity	RVU (=time x intensity)
Pre-service			
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			0.92
Intra-service	120	0.080	9.60
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			6.13
Total RVW by Building Block Method =			16.65

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CPT 37660 FREQUENCY INFORMATION

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

Specialty: Vascular Surgery: Commonly Sometimes Rarely

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

Specialty: Vascular Surgery: No national data available for this code. We suspect this service is performed most often in Medicare beneficiaries.

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.

1998 Medicare frequency from HCFA utilization file:

[Does not include frequency for PA's or mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

31	general surgery	1	general practice
18	vascular surgery	1	interventional radiology
10	thoracic surgery	1	neurosurgery
6	diagnostic radiology	1	obstetrics/gynecology
5	clinic or group practice (not gppp)		

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

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

0	0	Yes
29	7	No

This service represents new technology that has become more familiar (i.e., less work).

0	0	I agree
0	0	I do not agree

Patients requiring this service are now:

0	0	more complex (more work)
0	0	less complex (less work)
0	0	no change

The usual site-of-service has changed:

0	0	from outpatient to inpatient
0	0	from inpatient to outpatient
0	0	no change

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Vascular Surgery Intensity Project

We used the following reference table of intra-service intensities to evaluate intensities of all vascular surgery services. This reference table contains benchmark general surgery services. Baseline intensity is 031, the established value for the intra-service intensity of E/M. The maximum intensity is 108, a value for CPT 47122, hepatic trisegmentectomy. To convert these intensities to the factor "Intra-service Work Per Unit Time", simply multiply by 0.001, such that E/M would be 0.031 and hepatic trisegmentectomy would be 0.108. These reference values for the surgical services were derived by the American College of Surgeons General Surgery Coding and Reimbursement Committee and have been used extensively by that committee.

Intensity Reference Table

CPT Code	Descriptor	Intensity Value
99213	Level 3 Outpatient Visit	.031
46255	Hemorrhoidectomy, internal & external, simple	.042
19160	Partial mastectomy	.056
47100	Liver wedge biopsy	.060
44320	Colostomy, skin level cecostomy	.070
49505	Repair reducible hernia, adult	.070
44950	Appendectomy	.073
49000	Exploratory Laparotomy	.075
38100	Splenectomy	.075
47600	Cholecystectomy	.078
47562	Lap Cholecystectomy	.078
44005	Lysis of adhesions	.079
19240	Modified radical mastectomy	.080
44120	Small bowel resection and re-anastomosis	.081
44140	Partial colectomy with anastomosis	.081
43632	Partial gastrectomy with gastrojejunostomy	.088
47120	Hepatectomy, partial lobectomy	.090
45110	Proctectomy, complete AP Resection	.093
48150	Pancreatectomy, Whipple	.098
47122	Hepatic trisegmentectomy	.108

The intensities determined for all vascular surgery services by 44 responding vascular surgeons are listed starting on the next page.

Vascular Surgery Intensity Survey Results

CPT Code	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum
33875	Descending Thoracic aorta graft, with or without bypass	0.090	0.100	0.105	0.105	0.108	0.120
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	0.097	0.108	0.110	0.113	0.120	0.150
34001	Carotid, subclavian, innominate embolectomy/thrombectomy by neck incision	0.060	0.080	0.085	0.084	0.090	0.105
34051	Innominate, subclavian embolectomy / thrombectomy by thoracotomy	0.070	0.090	0.092	0.092	0.095	0.110
34101	Axillary, brachial, innominate, subclavian embolectomy/thrombectomy by arm incision	0.055	0.070	0.075	0.074	0.080	0.095
34111	Radial, ulnar embolectomy / thrombectomy by arm incision	0.050	0.069	0.075	0.074	0.080	0.100
34151	Renal, celiac, mesenteric, aortoiliac embolectomy / thrombectomy by abdominal	0.072	0.087	0.090	0.090	0.092	0.100
34201	Femoropopliteal, aortoiliac embolectomy / thrombectomy by leg incision	0.050	0.073	0.077	0.076	0.082	0.095
34203	Popliteal-tibial-peroneal embolectomy / thrombectomy by leg incision	0.054	0.075	0.080	0.078	0.085	0.100
34401	Vena cava, iliac vein thrombectomy, by abdominal incision	0.070	0.085	0.090	0.089	0.094	0.120
34421	Vena cava, iliac vein thrombectomy by leg incision	0.050	0.075	0.080	0.079	0.084	0.100

CPT Code	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum
34451	Vena cava, iliac fem-pop vein thrombectomy by abdominal and leg incision	0.070	0.084	0.088	0.088	0.095	0.102
34471	Subclavian vein thrombectomy by neck incision	0.050	0.075	0.080	0.078	0.083	0.090
34490	Axillary and subclavian vein thrombectomy by arm incision	0.050	0.070	0.078	0.076	0.080	0.095
34501	Valvuloplasty of femoral vein	0.050	0.073	0.080	0.078	0.085	0.100
34502	Vena cava reconstruction, any method	0.080	0.090	0.098	0.098	0.105	0.120
34510	Venous valve transposition, any vein donor	0.050	0.078	0.084	0.082	0.085	0.100
34520	Cross-over vein graft to venous system	0.050	0.079	0.085	0.083	0.088	0.100
34530	Saphenopopliteal vein anastomosis	0.050	0.078	0.081	0.082	0.085	0.100
35001	Carotid, subclavian aneurysm repair by neck incision	0.080	0.085	0.089	0.089	0.093	0.105
35002	Carotid, subclavian ruptured aneurysm repair by neck	0.085	0.090	0.095	0.097	0.100	0.120
35005	Vertebral artery aneurysm repair	0.075	0.089	0.090	0.092	0.097	0.110
35011	Axillary, brachial artery aneurysm repair by arm incision	0.060	0.080	0.080	0.081	0.085	0.095
35013	Axillary, brachial artery aneurysm repair by arm incision, ruptured	0.070	0.083	0.087	0.087	0.090	0.105
35021	Innominate, subclavian aneurysm repair by thoracotomy	0.075	0.090	0.095	0.095	0.099	0.110
35022	Innominate, subclavian ruptured aneurysm repair through thoractomy	0.085	0.097	0.100	0.102	0.107	0.125
35045	Radial or ulnar artery aneurysm repair	0.060	0.075	0.080	0.079	0.085	0.100
35081	Infrarenal abdominal aortic aneurysm repair, tube graft	0.075	0.090	0.090	0.092	0.095	0.108

CPT Code	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum
35082	Infrarenal abdominal aortic aneurysm repair, tube, ruptured	0.085	0.098	0.100	0.102	0.105	0.120
35091	AAA repair involving visceral arteries (SMA, celiac, renal)	0.090	0.100	0.105	0.105	0.108	0.120
35092	AAA repair involving visceral arteries, ruptured	0.095	0.105	0.108	0.110	0.115	0.130
35102	Infrarenal AAA repair with bifurcated graft	0.085	0.094	0.096	0.097	0.100	0.115
35103	Infrarenal AAA repair with bifurcated graft, ruptured	0.090	0.100	0.105	0.104	0.108	0.125
35111	Splenic artery aneurysm repair	0.075	0.080	0.087	0.086	0.090	0.105
35112	Splenic artery aneurysm repair, ruptured	0.078	0.090	0.095	0.094	0.100	0.115
35121	Hepatic, celiac, renal, SMA aneurysm repair	0.080	0.088	0.092	0.093	0.099	0.110
35122	Hepatic, celiac, renal, SMA aneurysm repair, ruptured	0.080	0.094	0.100	0.099	0.107	0.120
35131	Iliac artery (common, hypogastric, external) aneurysm repair	0.080	0.085	0.090	0.090	0.095	0.105
35132	Iliac artery aneurysm repair, ruptured	0.082	0.095	0.099	0.099	0.100	0.120
35141	Femoral artery aneurysm repair (common, profunda, SFA)	0.060	0.080	0.085	0.083	0.088	0.095
35142	Femoral artery aneurysm repair (common, profunda, SFA), ruptured	0.068	0.083	0.088	0.088	0.095	0.105
35151	Popliteal artery aneurysm repair	0.070	0.082	0.085	0.086	0.090	0.100
35152	Popliteal artery aneurysm repair, ruptured	0.072	0.087	0.090	0.092	0.095	0.105
35180	Congenital AV Fistula; head & neck	0.070	0.082	0.088	0.089	0.095	0.110
35182	Congenital AV Fistula; thorax and abdomen	0.080	0.090	0.098	0.097	0.102	0.120
35184	Congenital AV Fistula; extremities	0.065	0.081	0.085	0.085	0.090	0.102
35188	Acquired or Traumatic AVF head and neck	0.070	0.080	0.089	0.088	0.094	0.110
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35189	Acquired or Traumatic AVF thorax and abdomen	0.080	0.090	0.100	0.097	0.104	0.120
35190	Acquired or Traumatic AVF extremities	0.065	0.080	0.083	0.084	0.088	0.100
35201	Direct repair neck vessel (e.g. trauma)	0.070	0.080	0.085	0.084	0.090	0.105
35206	Direct repair blood vessel upper extremity	0.065	0.076	0.080	0.080	0.085	0.090
35207	Direct repair blood vessel hand, finger	0.060	0.078	0.082	0.082	0.088	0.100
35211	Direct repair intra-thoracic blood vessel with bypass (e.g. trauma)	0.085	0.095	0.098	0.099	0.101	0.130
35216	Direct repair intrathoracic blood vessel without bypass (e.g. trauma)	0.085	0.090	0.095	0.096	0.100	0.130
35221	Direct repair intra-abdominal blood vessel	0.072	0.084	0.090	0.088	0.093	0.115
35226	Direct repair blood vessel lower extremity	0.060	0.078	0.080	0.081	0.085	0.090
35231	Repair neck vessel with vein graft (e.g. trauma)	0.070	0.083	0.088	0.087	0.090	0.105
35236	Repair blood vessel with vein graft; upper extremity	0.070	0.080	0.085	0.084	0.090	0.095
35241	Repair blood vessel with vein graft; intrathoracic, with bypass (e.g. trauma)	0.085	0.095	0.100	0.100	0.103	0.130
35246	Repair blood vessel with vein graft; intrathoracic, without bypass (e.g. trauma)	0.085	0.093	0.098	0.097	0.100	0.130
35251	Repair intra-abdominal blood vessel with vein graft	0.075	0.088	0.093	0.092	0.095	0.120
35256	Repair blood vessel with vein graft; lower extremity	0.065	0.081	0.085	0.085	0.090	0.100
35261	Repair neck vessel with synthetic graft (e.g. trauma)	0.070	0.082	0.086	0.086	0.090	0.105
35266	Repair blood vessel with synthetic graft; upper extremity	0.070	0.080	0.083	0.083	0.087	0.095
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35271	Repair blood vessel with synthetic graft; intrathoracic, with bypass (e.g. trauma)	0.080	0.095	0.098	0.098	0.101	0.130
35276	Repair blood vessel with synthetic graft; intrathoracic without bypass (e.g. trauma)	0.080	0.092	0.097	0.096	0.100	0.130
35281	Repair intra-abdominal blood vessel with synthetic graft	0.073	0.085	0.090	0.091	0.095	0.116
35286	Repair with synthetic graft; lower extremity	0.065	0.080	0.085	0.084	0.088	0.095
35301	Carotid Endarterectomy	0.078	0.081	0.087	0.087	0.090	0.100
35311	Subclavian, innominate by thoracic incision	0.080	0.091	0.095	0.097	0.100	0.110
35321	Axillary, brachial endarterectomy with or without patch	0.060	0.078	0.080	0.081	0.085	0.100
35331	Abdominal aorta endarterectomy with or without patch	0.075	0.088	0.092	0.093	0.096	0.110
35341	Mesenteric, celiac, or renal endarterectomy with or without patch	0.075	0.090	0.095	0.096	0.100	0.110
35351	Iliac endarterectomy with or without patch	0.070	0.085	0.090	0.089	0.091	0.105
35355	Iliofemoral endarterectomy with or without patch	0.070	0.088	0.090	0.090	0.095	0.100
35361	Combined aorto-iliac endarterectomy with or without patch	0.080	0.090	0.095	0.095	0.100	0.110
35363	Combined aortoiliofemoral endarterectomy with or without patch	0.080	0.091	0.096	0.096	0.100	0.115
35371	Common femoral endarterectomy with or without patch	0.060	0.080	0.081	0.081	0.085	0.095
35372	Deep (profunda) femoral endarterectomy with or without patch	0.065	0.080	0.083	0.083	0.087	0.095
35381	Femoral and/or popliteal, and/or tibioperoneal endarterectomy with or without patch	0.065	0.082	0.085	0.085	0.090	0.098
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35506	Carotid -subclavian bypass using vein	0.075	0.082	0.085	0.087	0.090	0.105
35508	Carotid-vertebral bypass using vein	0.070	0.085	0.088	0.089	0.093	0.105
35509	Carotid-carotid bypass using vein	0.070	0.082	0.088	0.088	0.091	0.105
35511	Subclavian-subclavian bypass using vein	0.070	0.082	0.085	0.087	0.090	0.105
35515	Subclavian-vertebral bypass using vein	0.070	0.085	0.088	0.089	0.092	0.105
35516	Subclavian-axillary bypass using vein	0.070	0.081	0.085	0.086	0.090	0.105
35518	Axillary-axillary bypass using vein	0.070	0.080	0.084	0.084	0.088	0.100
35521	Axillary-femoral bypass using vein	0.070	0.083	0.085	0.086	0.090	0.102
35526	Aortosubclavian or Aorto-carotid bypass using vein	0.085	0.094	0.098	0.099	0.103	0.115
35531	Aortoceliac or Aortomesenteric bypass using vein	0.080	0.090	0.095	0.095	0.100	0.110
35533	Axillary-femoral-femoral bypass using vein	0.070	0.084	0.088	0.089	0.095	0.112
35536	Splenorenal bypass using vein	0.072	0.090	0.095	0.094	0.098	0.105
35541	Aortoiliac or Aorto-bi-iliac bypass using vein	0.075	0.090	0.095	0.095	0.100	0.115
35546	Aortofemoral or Aorto-bifemoral bypass using vein	0.077	0.090	0.095	0.096	0.100	0.115
35551	Aortofemoral-popliteal bypass using vein	0.070	0.094	0.098	0.097	0.100	0.130
35556	Femoral-popliteal bypass using vein	0.065	0.084	0.088	0.086	0.090	0.100
35558	Femoral-femoral bypass using vein	0.070	0.080	0.085	0.083	0.089	0.098
35560	Aorto-renal bypass using vein	0.070	0.090	0.095	0.094	0.098	0.112
35563	Ilio-iliac bypass using vein	0.060	0.085	0.090	0.090	0.095	0.108
35565	Iliofemoral bypass using vein	0.060	0.085	0.090	0.088	0.093	0.105
35566	Femoral-tibial bypass using vein	0.070	0.087	0.090	0.090	0.095	0.105
35571	Popliteal-tibial. – peroneal, other distal vessel using vein	0.065	0.085	0.090	0.090	0.095	0.105
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35582	Aortofemoral-popliteal (fem-pop portion in-situ)	0.080	0.093	0.096	0.098	0.100	0.130
35583	Femoral-popliteal bypass using in-situ vein	0.075	0.084	0.090	0.089	0.092	0.105
35585	Femoral-tibial, -peroneal, using in-situ vein	0.075	0.088	0.091	0.092	0.095	0.107
35587	Popliteal-tibial, peroneal, using in-situ vein	0.075	0.087	0.092	0.091	0.095	0.106
35601	Carotid-carotid bypass using prosthetic conduit	0.075	0.082	0.087	0.087	0.090	0.105
35606	Carotid-subclavian bypass using prosthetic conduit	0.075	0.080	0.085	0.086	0.090	0.105
35612	Subclavian-subclavian bypass using prosthetic conduit	0.067	0.081	0.085	0.085	0.089	0.105
35616	Subclavian-axillary bypass using prosthetic conduit	0.075	0.081	0.085	0.085	0.088	0.105
35621	Axillary-femoral bypass using prosthetic conduit	0.070	0.080	0.084	0.084	0.090	0.100
35623	Axillary-popliteal or -tibial bypass using prosthetic conduit	0.070	0.085	0.088	0.087	0.092	0.100
35626	Aorto-subclavian or Aorto-carotid bypass using prosthetic	0.085	0.093	0.096	0.098	0.102	0.115
35631	Aorto-celiac, Aorto-mesenteric, Aorto-renal using prosthetic	0.009	0.090	0.095	0.093	0.099	0.110
35636	Spleno-renal bypass using prosthetic	0.070	0.090	0.093	0.092	0.095	0.105
35641	Aorto-iliac or Aorto-bi-iliac bypass using prosthetic	0.071	0.089	0.094	0.092	0.095	0.110
35642	Carotid-vertebral bypass using prosthetic conduit	0.070	0.084	0.088	0.087	0.090	0.105
35645	Subclavian-vertebral bypass using prosthetic conduit	0.070	0.084	0.087	0.088	0.090	0.105
35646	Aorto-femoral or Aorto-bifemoral bypass using prosthetic	0.073	0.090	0.094	0.093	0.097	0.110
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35650	Axillary-axillary bypass using prosthetic conduit	0.070	0.080	0.082	0.082	0.085	0.096
35654	Axillary-femoral-femoral bypass using prosthetic conduit	0.070	0.084	0.085	0.086	0.090	0.100
35656	Femoral-popliteal bypass using prosthetic conduit	0.062	0.080	0.083	0.083	0.086	0.105
35661	Femoral-femoral bypass using prosthetic conduit	0.065	0.078	0.080	0.081	0.085	0.095
35663	Ilio-iliac bypass using prosthetic conduit	0.058	0.085	0.090	0.087	0.092	0.103
35665	Ilio-femoral bypass using prosthetic conduit	0.058	0.082	0.087	0.086	0.090	0.100
35666	Femoral-tibial, or – peroneal bypass using prosthetic conduit	0.063	0.083	0.085	0.086	0.090	0.100
35671	Popliteal-tibial or – peroneal bypass using prosthetic conduit	0.064	0.082	0.085	0.086	0.090	0.100
35682	2 distant site vein segment harvest + anastomosis, Add-On code	0.020	0.050	0.070	0.064	0.078	0.095
35683	>2 distant site vein harvest + anastomoses, Add-On code	0.025	0.060	0.071	0.070	0.080	0.100
35691	Vertebral to Carotid Transposition or Reimplantation	0.070	0.085	0.090	0.089	0.094	0.100
35693	Vertebral to Subclavian	0.070	0.085	0.090	0.089	0.093	0.105
35694	Subclavian to Carotid	0.075	0.085	0.090	0.088	0.090	0.100
35695	Carotid to Subclavian	0.075	0.085	0.090	0.088	0.090	0.100
35700	Reoperation Add-On code for fem-pop, fem-tib	0.020	0.055	0.075	0.069	0.085	0.100
35701	Exploration without repair, carotid artery	0.040	0.068	0.071	0.070	0.075	0.090
35721	Exploration without repair, femoral artery	0.020	0.054	0.070	0.065	0.075	0.090
35741	Exploration without repair, popliteal artery	0.035	0.060	0.070	0.067	0.075	0.090
35800	Explore neck for post-op hemorrhage, thrombosis, infection	0.050	0.070	0.075	0.077	0.085	0.100
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
35820	Explore chest for post-op hemorrhage, thrombosis, infection	0.060	0.080	0.085	0.085	0.090	0.110
35840	Explore abdomen for post-op hemorrhage, thrombosis, infection	0.065	0.076	0.081	0.083	0.090	0.100
35860	Explore extremity for post-op hemorrhage, thromb, infect	0.040	0.069	0.075	0.072	0.080	0.095
35870	Repair graft-enteric fistula	0.085	0.100	0.105	0.105	0.110	0.130
35875	Thrombectomy of arterial or venous bypass (synthetic) graft (not dialysis graft)	0.056	0.070	0.075	0.075	0.082	0.095
35876	Thrombectomy with revision arterial or venous (synthetic) graft (not dialysis)	0.060	0.076	0.082	0.080	0.085	0.095
35879	Revise lower extremity bypass (vein) graft with vein patch	0.055	0.075	0.080	0.079	0.085	0.095
35881	Revise lower extremity bypass (vein) graft w/ vein interposition	0.058	0.079	0.081	0.081	0.087	0.095
35901	Excision of infected graft; neck	0.065	0.085	0.090	0.090	0.091	0.110
35903	Excision of infected graft; extremity	0.050	0.075	0.084	0.082	0.090	0.105
35905	Excision of infected graft; thorax	0.085	0.095	0.100	0.102	0.108	0.130
35907	Excision of infected graft; abdomen	0.085	0.099	0.100	0.103	0.108	0.128
36468	Inject sclerosing solution single or mult spider veins limb, trunk	0.030	0.040	0.040	0.047	0.055	0.080
36469	Inject sclerosing solution face	0.025	0.040	0.050	0.053	0.060	0.100
36470	Inject sclerosing solution single vein	0.025	0.035	0.040	0.044	0.050	0.080
36471	Inject sclerosing solution multiple veins same leg	0.030	0.040	0.045	0.049	0.059	0.080
36819	Arteriovenous hemodialysis fistula by basilic vein transposition	0.048	0.075	0.080	0.078	0.085	0.090
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
36821	Arteriovenous hemodialysis fistula, any site (eg Cimino type)	0.040	0.070	0.078	0.073	0.080	0.090
36825	Arteriovenous hemodialysis fistula using autogenous graft	0.045	0.074	0.078	0.076	0.083	0.090
36830	Arteriovenous hemodialysis fistula using prosthetic graft	0.040	0.070	0.076	0.074	0.080	0.090
36831	Thrombectomy of Arteriovenous dialysis fistula	0.040	0.060	0.070	0.068	0.076	0.090
36832	Revision of Arteriovenous dialysis fistula	0.043	0.066	0.075	0.073	0.080	0.090
36833	Thrombectomy and Revision of Arteriovenous dialysis fistula	0.043	0.068	0.075	0.074	0.083	0.090
37565	Ligation, internal jugular vein	0.035	0.056	0.065	0.065	0.075	0.085
37600	Ligation, external carotid artery	0.040	0.060	0.070	0.068	0.075	0.095
37605	Ligation internal or common carotid artery	0.045	0.065	0.075	0.075	0.084	0.115
37607	Ligation or banding of hemodialysis arteriovenous fistula	0.025	0.056	0.070	0.065	0.075	0.090
37609	Ligation or biopsy of temporal artery	0.035	0.041	0.050	0.054	0.060	0.090
37615	Ligation, major artery (eg post-traumatic, rupture) neck	0.050	0.070	0.080	0.079	0.088	0.115
37616	Ligation, major artery (eg post-traumatic, rupture) chest	0.075	0.086	0.090	0.091	0.095	0.110
37617	Ligation, major artery (eg post-traumatic, rupture) abdomen	0.065	0.080	0.085	0.085	0.090	0.101
37618	Ligation, major artery (eg post-traumatic, rupture) extremity	0.030	0.070	0.075	0.074	0.084	0.100
37620	Interruption IVC extravascular, intravascular (umbrella device)	0.045	0.060	0.072	0.070	0.080	0.092
37650	Ligation of femoral vein	0.040	0.060	0.073	0.069	0.080	0.095
CPT	Descriptor	Minimum	25th %	Median	Mean	75th %	Maximum

Code							
37660	Ligation of common iliac vein	0.055	0.075	0.080	0.080	0.085	0.105
37700	Ligation and division of greater saphenous vein, at Sapheno-femoral junction or distal interruptions	0.040	0.046	0.063	0.060	0.070	0.085
37720	Ligation, division, complete stripping GSV or LSV	0.040	0.056	0.069	0.065	0.075	0.085
37730	Ligation, division, complete stripping GSV and LSV	0.040	0.060	0.070	0.068	0.075	0.085
37760	Ligation perforators, subfascial, radical Linton type	0.045	0.059	0.071	0.068	0.080	0.090
37780	Ligation and division LSV at saphenopop junction	0.040	0.050	0.063	0.061	0.072	0.080
37785	Ligation, division, and/or excision recurrent or sec veins one leg	0.040	0.050	0.065	0.063	0.075	0.095

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**AMA/Specialty Society RVS Update Committee
Five-Year Review of the RBRVS**

General Surgery

Historical Information/Public Comments to HCFA

General Surgery's Participation in the Harvard/Hsaio Studies

In the early stages of the Harvard/Hsaio studies, the American College of Surgeons (ACS) made the decision that they would not participate in this early construction of the Resource-Based Relative Value System (RBRVS). To guarantee the input of general surgeons in the valuation of the general surgery procedures, Harvard researchers turned to the American Medical Association (AMA) to nominate individual general surgeons to participate in this review. The ACS has long maintained that these individual general surgeons did not provide overall representation of general surgery in the United States, and as a result, many of their services were mis-valued upon implementation of the RBRVS. Additionally, the ACS has argued that the Harvard/Hsiao study failed to fully take into account the pre- and post-operative components of their work.

Initial Five-Year Review of RBRVS

In the initial Five-Year Review of the RBRVS, the ACS submitted a comment to the Health Care Financing Administration that a study by Abt Associates identified many general surgical procedures that were mis-valued. The ACS specifically requested a review of 30 general surgery procedures, selected based on the magnitude of the change and Medicare utilization data. The ACS recommended both increases and decreases to the work RVUs for these services. The American Society of Colon and Rectal Surgeons (ASCRS) submitted comments indicating that the partial colectomy and hemorrhoidectomy codes should be reviewed to place them in a more correct rank order from least to most difficult. A Medicare Carrier Medical Director (CMD) also identified rank order problems in these families, and also identified three overvalued procedures. The American Society of General Surgeons (ASGS) also submitted comments on a number of procedures, including several general surgery and colon and rectal surgery procedures and their suggestions were consistent with some of those made by the ACS and ASCRS.

The RUC reviewed survey data from 175 surgeons, comparisons to the final Harvard study results, comparison to key reference services, and analysis of Medicare claims data for a total of 51 surgical procedures identified by one or more of these three surgical

specialties societies. The RUC recommended that 14 of these services be increased, 6 codes be decreased, 1 code referred to CPT, and that the existing work RVUs be maintained for the remaining 30 codes.

1996 – 2000 Work Completed by ACS' General Surgery Coding & Reimbursement Committee

Shortly after the completion of the initial Five-Year Review of the RBRVS, the ACS began an extensive review of all of the general surgery procedures through its General Surgery Coding and Reimbursement Committee. This committee includes general surgeons and representatives from other closely related surgical specialties (eg, colon and rectal surgery, pediatric surgery and vascular surgery). The committee includes physicians who practice in different settings (eg, solo private practice, large group practice, and academic institutions) and in different locations in the United States. This committee utilized a building block methodology to analyze the component parts of each surgical procedure and presented the results to HCFA in several meetings (August and December 1997, May and August 1998, and January 2000).

The ACS committee initially reviewed each of their services by subtracting the pre-and post-service work (primarily hospital and office Evaluation and Management visits) from the total work to compute "intra-operative work." The College found that more than 100 codes that had intra-service times greater than one hour, had intra-work RVUs less than 4.00. Based on their analyses some codes even had negative intra-work, as the combined pre-and post work accounted for more than the total work RVU for the procedure. The ACS also compared the intra-operative work per unit time (IWPUT) for general surgery services with other services on the Medicare payment schedule, and determined that many general surgery codes are misvalued in comparison to other services.

The College argues that the failure of Harvard and HCFA to recognize that the work of post-surgical E/M service and non-surgical E/M services are comparable has resulted in this mis-valuation of many surgical global services.

Building Block Methodology

After concluding that general surgery is misvalued relative to other specialties on the RBRVS, the College decided to utilize the "Building Block Methodology" (BBM) to recalculate work RVUs for the services performed predominately by general surgeons. The College utilized the following steps in this methodology:

- Sixteen benchmark codes were selected and aligned in order of their perceived IWPUT. The assigned intensities fall within the range of 0.031 (office visits) to 0.108 (significant less than the highest IWPUT of 0.200 on the MFS).

- 322 codes performed predominately by general surgeons were divided into 31 families of similar services and an anchor code was selected for each family. This anchor code was either the most frequently performed service or the base CPT code for the family. The anchor codes were also assigned an IWPUT of 0.031 to 0.108 by the ACS committee and became the basis for assigning intensities to the other codes within a family of similar services.
- The most current RUC or Harvard time and visit data were reviewed for each of the 322 general surgery codes, and in some cases changes were made to reflect current practice. For example, the number of hospital visits may have been reduced as the length of stay associated with the procedure may have decreased since it was initially evaluated.
- Pre-service work RVUs were calculated using one of seven pre-service time estimates that the ACS developed based on 1) surgical approach; 2) type of sedation or anesthesia; and 3) site of service.
- Intra-service work RVUs were calculated by multiplying the assigned IWPUT and existing intra-time.
- Post-service work RVUs were calculated using current work RVUs for hospital visits and discounted work RVUs for office visits.
- Pre, intra, and post work RVUs were summed to equal the recommended new work RVU for each code.

The ACS submitted the results of this building block methodology to HCFA on March 1, 2000 for consideration in this Five-Year Review of the RBRVS. The College specifically noted that their submission differed from the typical Five-Year Review where codes are identified because there has been a specific change in the work performed. Rather, the ACS emphasized that their analysis determined that general surgery has been systematically undervalued.

The American Society of General Surgeons (ASGS) also submitted a listing of services they had determined to be undervalued. The American Society of Colon and Rectal Surgeons (ASCRS) submitted a letter in support of the ACS efforts and identified 12 specific services (also included in the ACS proposal) that should be reviewed.

Data Collection Efforts

After HCFA forwarded the ACS proposal, and all other comment letter submitted on the Five-Year Review, to the RUC for review, the RUC asked its Research Subcommittee to review the approach proposed by the College. The Research Subcommittee and RUC reviewed this proposal in April 2000, and agreed to reaffirm its action on intensity of September 27, 1997 and allow intra-service

intensities and times to be developed by surveys or a consensus panel and be presented as relative intra-service work per unit time numbers. The use of this information in no way changes the current RUC policies regarding the use and interpretation of IWPUT information. The September 27, 1997 RUC action specifically stated that, "Intra-service intensity or IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. The RUC further observes that most formulas for the calculation of IWPUT use imputed values, there is no preferable formula." The RUC also concluded that "In calculating post procedure work, discounted E/M equivalent values should be used."

The Five-Year Review Workgroup 2 (convened to review the general surgery recommendations) met via conference call on June 7, and several other times over the summer, to review proposals or to address questions that the College had in the process of collecting data. Responding to the RUC's action in April and early feedback from Workgroup 2, the ACS proposed to survey 16 of the 31 anchor codes. Anchor codes are either the most frequently performed service or the base code for each of the 31 families of similar services included in the ACS comment letter and proposal to HCFA. In addition, ACS planned to survey laparoscopic cholecystectomy.

The workgroup expressed general concern regarding the number of codes to be surveyed (17 codes) in comparison to the number of codes in which a change in the work relative value is requested (322 codes). A workgroup member questioned why all 31 anchor codes would not be surveyed. The ACS representatives explained that several of the anchor codes would be used as reference services, rather than surveyed directly. The workgroup agreed that codes should not be surveyed and also be included on the reference service list. Other workgroup members suggested that other codes from each of the 31 families be selected and that the ACS originally selected anchor code did not necessarily have to be the code surveyed.

It was suggested that the College select codes to survey where the requested work RVU represented a significant increase or decrease over the existing current work RVU. Finally, ACS suggested that they may review the original 31 families and may make some modifications to re-group these codes into fewer families of services.

The workgroup indicated that they did not have a specific suggestion regarding the absolute number of codes to be surveyed by ACS. However, the workgroup expressed their opinion that they were likely to view survey results for the codes surveyed using the traditional RUC survey as more compelling than recommendations developed via a consensus panel. The workgroup suggested that the College carefully select codes to survey that would provide the needed information to successfully extrapolate the data from the survey code to other non-surveyed codes in the family.

On August 1, 2000, the ACS submitted recommendations for 314 codes (eight codes were “transferred” to APSA for pediatric surgery survey and recommendations). A traditional RUC survey was utilized for 32 codes (high volume or family base codes) and a mini-survey was conducted for the remaining 282 codes. The ASGS participated in the survey of 14 codes and the ASCRS participated in surveying eight codes. The College indicated that the traditional RUC survey tended to assign higher work RVUs (in comparison to BBM) to codes at the low end of the scale and lower work RVUs to codes at the high end of the scale. The ACS contended that this was due to the “compression” phenomenon and proposed to correct this problem by recommending the 25th percentile of the survey results for the work RVUs at the low end of the scale and the 75th percentile for the work RVUs at the high end of the scale.

The ACS surveyed 32 codes, but argued that acceptance of these survey results without adjustments to the other codes in the families would create distortion in the relativity within and across families. The College recommended that a regression methodology to extrapolate these surveyed results to all 314 codes. Their technique utilized their building block methodology rank ordering of codes and adjusted the scale to more closely correspond to the scale of the survey respondents.

RUC Review

The RUC reviewed each of the 32 codes, where data had been collected from a full RUC survey, in great detail. This review included all of the mechanisms that the RUC typically employs in reviewing work relative value recommendations, including: review of survey time and intensity in comparison to the key reference service selected; comparison to other services on the Multi-specialty Points of Comparison (MPC); and previous RUC data or review of the code or family of services. In some codes the ACS building block calculations are similar to the RUC’s recommendations. **However, the building block methodology was not used as the source of determining work relative values.**

The RUC did not accept the regression analysis originally proposed by general surgery. Although the phenomenon of compression is recognized in magnitude estimation, to adopt a method of compensation for this, at this point in the evolution of the RBRVS, would be unfair to other specialties, and throw the established scale into disarray.

In general, the RUC reviewed the grouping of services that the ACS had proposed and made modifications if these groupings were not reflective of codes with similar physician work. After the RUC was comfortable with the groupings, the committee reviewed each family and its anchor code (original 32 codes reviewed) to determine whether the change to the anchor code should be applied to the entire family of codes. In some instances, the RUC agreed that these changes should occur to ensure that rank order and relativity distortions were not created by a change to the anchor code. The RUC determined that the most appropriate way to extrapolate these changes to the anchor codes to other codes in the grouping of services was to retain the relativity in the existing Medicare Payment

Schedule. A ratio of the recommended work RVU for the anchor code to the existing work RVU for the anchor code was multiplied by the existing work RVUS for other codes in the grouping, when the RUC determined that the underlying rationale for changing the anchor code should apply to the entire group of services.

In other instances the RUC decided that the “anchor” did not apply to certain codes. In those circumstances, either a new value was recommended or the present value was maintained.

The RUC urges HCFA to adopt the RUC’s recommendation on these general surgery codes, which include recommendations to increase the work RVU for 242 codes, decrease the work RVU for 22 codes, and maintain the work RVU for 50 codes.

**AMA/Specialty Society RVS Update Committee
RBRVS Five-Year Review
RUC Recommendations
Workgroup 2 - General Surgery**

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 1 a Thyroid						
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	10.53	11.90	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p> <p>The ASGS commented that the service is currently undervalued.</p>	<p>The RUC agreed that this service, along with all of the thyroid codes are undervalued and recommends a 13% increase to all of the codes grouped into the "thyroid" category. The RUC agreed with a commenting specialty that a current rank order anomaly exists as this service is more work than 60210 Partial thyroid lobectomy, unilateral; with or without isthmusectomy (work RVU = 10.88), however it is currently valued lower than 60210. A survey of 69 general surgeons indicated a median work RVU of 12.50, however, the RUC determined that the 25th percentile survey work RVU of 11.90 was more appropriate. The RUC compared 60220 to two other surgical procedures, codes 32654 Thoracoscopy, surgical; with pleurodesis, with control of traumatic hemorrhage (work RVU = 12.44) and 58520 Hysterorrhaphy, repair of ruptured uterus (nonobstetrical) (work RVU = 11.92). The survey respondents indicated that 60220 has 63 minutes pre-time, 90 minutes intra-service time, one hospital visit, and two office visits. Existing time data for 32654 indicates 60 minutes pre-time, 120 minutes intra-service time, two hospital visits, and two office visits. Existing time data for 58520 indicates 40 minutes pre-time, 90 minutes intra-service time, four hospital visits and two office visits. Based on a review of this data and in determining an appropriate increment over code 60210, the RUC recommends a work RVU of 11.90 for code 60220.</p>	4
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	18.20	20.57	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p>	<p>The RUC recommends an increase consistent with the increase to CPT code 60220 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 13% increase of 60220 from the current work RVU.</p>	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	23.88	26.99	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 60220 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 13% increase of 60220 from the current work RVU.	4
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	15.46	17.47	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 60220 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 13% increase of 60220 from the current work RVU.	4
60270	Thyroidectomy, including substernal thyroid gland; sternal split or transthoracic approach	17.94	20.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 60220 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 13% increase of 60220 from the current work RVU.	4
60271	Thyroidectomy, including substernal thyroid gland; cervical approach	14.89	16.83	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 60220 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 13% increase of 60220 from the current work RVU.	4

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		2000	RUC			
CPT		Work	Rec			
Code	Description	RVU	RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 1 b Endocrine						
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);	17.03	17.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	19.88	19.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 2 Lymphadenectomy						
38740	Axillary lymphadenectomy; superficial	6.77	8.42	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38745 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 38745 from the current work RVU.	4
38745	Axillary lymphadenectomy; complete	8.84	11.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase to CPT code 38745 and the corresponding lymphadenectomy grouping of services as these services have been undervalued since the inception of the RBRVS. The RUC reviewed data from a survey of 40 general surgeons who compared this service to 60210 Partial thyroid lobectomy, unilateral, with or without isthmusectomy (work RVU = 10.88). The survey respondents indicated that this service was identical in pre-time (58 minutes), intra-time (90 minutes) and same day post-time (25 minutes) and intensity to 60210. The respondents indicated that the number and level of office visits is greater for 38745 than 60210. The survey work RVU median for 38745 is 13.10. The RUC notes that this service is typically provided in the outpatient hospital setting (23 hour observation status) and therefore, deducted the hospital visit work from the median to arrive at a calculated work RVU of 11.18. The RUC reviewed another reference code from the MPC, 32100 Thoracotomy, major; with exploration and biopsy (work RVU = 11.84). The intra-service time for codes 32100 and 38745 is identical. Code 32100 typically requires a longer hospital length of stay. Considering all of this evidence and determining that the physician work for 38745 is most similar to code 60210, the RUC recommends a 24% increase in 38745 to 11.00.	4
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)	8.74	10.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38745 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 38745 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	16.06	19.98	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38745 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 38745 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 3 Lymph - Incision/Excision						
38300	Drainage of lymph node abscess or lymphadenitis; simple	1.53	1.99	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4
38305	Drainage of lymph node abscess or lymphadenitis; extensive	4.61	6.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4
38308	Lymphangiectomy or other operations on lymphatic channels	4.95	6.45	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4
38500	Biopsy or excision of lymph node(s); superficial (separate procedure)	2.88	3.75	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC recommends that 38500 and the entire grouping of lymph - incision/excision codes are undervalued and suggests a 30% increase to the work RVUs for each of these services. The RUC reviewed data from a survey of 41 general surgeons who indicated that this service is identical in time and intensity to CPT code 36533 Insertion of implantable venous access device, with or without subcutaneous reservoir (work RVU = 5.32). The specialty indicated that the survey respondents overestimated the work (survey median = 5.00) and recommends the 25th percentile of the survey work RVU. The RUC also noted that this service is typically performed in an outpatient setting (78% of Medicare utilization data) and, therefore, deducted any hospital work from the survey median to arrive at a work RVU of 3.72. The RUC, therefore, recommends a work RVU of 3.75.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
38510	Biopsy or excision of lymph node(s); deep cervical node(s)	4.14	6.43	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC agreed with the specialty that this service is currently undervalued and reviewed data from a survey of 32 general surgeons. The respondents indicated a survey work RVU median of 7.71. The respondents also included a hospital discharge day in their respondents, however, 78% of these procedures is performed in an outpatient setting. The RUC, therefore, deducted the work related to this hospital visit from the survey median to calculate a work RVU of 6.43. This recommendation is slightly more than the 25th percentile of the survey work RVU. A commenting specialty society also indicated that this service requires meticulous care to avoid injury to the adjacent neurovascular structures such as cranial nerves XI (spinal accessory) and XII (hypoglossal). Also, there is the occasional risk of injury to the thoracic duct in the neck.	4
38520	Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad	5.12	6.67	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4
38525	Biopsy or excision of lymph node(s); deep axillary node(s)	4.66	6.07	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4
38530	Biopsy or excision of lymph node(s); internal mammary node(s) (separate procedure)	6.13	7.98	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 38500 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 30% increase of 38500 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 4 Intestines -Excision/Incision						
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	13.84	16.23	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44010	Duodenotomy, for exploration, biopsy(s), or foreign body removal	10.68	12.52	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44020	Enterotomy, small bowel, other than duodenum; for exploration, biopsy(s), or foreign body removal	11.93	13.99	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44021	Enterotomy, small bowel, other than duodenum; for decompression (eg, Baker tube)	12.01	14.08	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44025	Colotomy, for exploration, biopsy(s), or foreign body removal	12.18	14.28	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	11.40	14.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC agreed that this service is currently undervalued, particularly in relationship to the key reference service 44800 Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct (work RVU = 11.23). However, the RUC argued that the survey median of 15.50 based on a survey of 36 general surgeons was too high in comparison to cod 63017 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or disectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar (work RVU = 15.94). This service requires greater physician time than code 44050 (90 minutes pre-time, 150 minutes intra-time, 5 hospital visits, and 3 office visits). The RUC agreed that code 44050 was more comparable in work to code 32500 Removal of lung, other than total pneumonectomy; wedge resection, single or multiple (work RVU = 14.30). The RUC recommends that code 44050 be increased to 14.03, the 25th percentile of the survey work RVU.	4
44110	Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization, or fistulization; single enterotomy	10.07	11.81	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44111	Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies	12.19	14.29	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44120	Enterectomy, resection of small intestine; single resection and anastomosis	14.50	17.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	This service is currently on the RUC's MPC. However, most codes with similar current work RVUs have shorter length of hospital stays. This procedure typically includes a length stay of 7 days as bowel function has been affected by the surgical procedure. The RUC recommends an increase in the work RVU for this service to create appropriate rank order among other services on the MPC. The RUC reviewed data from a survey of 59 general and colon & rectal surgeons who indicated a survey median of 17.00, pre-service time of 60 minutes, intra-service time of 90 minutes, 6 hospital visits, and 2 office visits. This is comparable to code 44140 Colectomy, partial; with anastomosis (work RVU = 18.35) with pre-service time of 90 minutes, intra-time of 150 minutes, 7 hospital visits, and 3 office visits. 44140 was surveyed in this five-year review and the RUC recommends no change in work RVUs. The time data from this survey indicates 63 minutes pre, 125 minutes intra, 6 hospital visits, and 3 office visits.	1
44125	Enterectomy, resection of small intestine; with enterostomy	14.96	17.54	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	12.36	14.49	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS comment that this code is currently undervalued in the family of codes.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4
44160	Colectomy with removal of terminal ileum and ileocolostomy	15.88	18.62	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	11.23	11.23	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44820	Excision of lesion of mesentery (separate procedure)	10.31	12.09	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 44120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 5 Intestines - External Fistulization						
44300	Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure)	8.88	12.11	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44310	Ileostomy or jejunostomy, non-tube (separate procedure)	11.70	15.95	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44312	Revision of ileostomy; simple (release of superficial scar) (separate procedure)	5.88	8.02	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44314	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	11.04	15.05	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44316	Continent ileostomy (Kock procedure) (separate procedure)	15.47	21.09	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44320	Colostomy or skin level cecostomy; (separate procedure)	12.94	17.64	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC agreed that this service is currently undervalued and considered the mid-point between the 25th percentile (15.00) and the median (20.00) survey work RVU to be an appropriate reflection of the work involved in this service. The specialty had calculated, via the building block methodology, a work RVU of 17.64. The RUC also agreed that this service be ranked between codes 44120 Enterectomy, resection of small intestine; single resection and anastomosis (work RVU = 17.00) and 44140 Colectomy, partial; with anastomosis (work RVU = 18.35). The key reference service selected by 24 of the 53 general surgeons responding to the survey, code 44626 Closure of enterostomy, large or small intestine, with resection and colorectal anastomosis (eg, closure of Hartmann type procedure) (work RVU = 22.59) includes 70 minutes pre-time, 160 minutes intra-time, 7 hospital visits, and 3 office visits. Code 44320 requires 75 minutes pre-time, 90 minutes intra-time, 6 hospital visits, and 3 office visits. The RUC recommends that the increment of additional intra-service time indicates that the survey median for this service is not appropriate, and therefore, recommends a work RVU of 17.64.	1
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	5.66	7.72	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	11.32	15.43	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	12.46	16.99	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44320 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 38% increase of 43120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 6 Intestines - Colectomy						
44140	Colectomy, partial; with anastomosis	18.35	18.35	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	This procedure was reviewed in the previous five-year review and the time data for this survey was generally consistent with the time data collected five-years ago. Therefore, the RUC concluded that no compelling evidence was presented that work RVU for this service had changed over the previous five-years. The RUC also concluded that the time data for two other services was greater and offered additional rationale for retaining a value of 18.35 for code 44140. Code 32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy) (work RVU = 18.32) includes 60 minutes pre-time, 180 minutes intra, 2 critical care visits, 6 hospital visits, and three office visits. Code 50230 Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy (work RVU = 22.07) includes 41 minutes pre, 222 minutes intra, 9 hospital visits, and 2.5 office visits. After review of the above data, the RUC determined that 44140 is currently appropriately valued.	2
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	20.17	20.17	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	18.89	18.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS comment that this code is currently undervalued in the family of codes.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	23.18	23.18	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	24.16	24.16	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	21.01	21.01	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	20.04	20.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS comment that this code is currently undervalued in the family of codes.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44152	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy	24.41	24.41	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44153	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	26.83	26.83	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	24.44	24.44	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	23.01	23.01	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. ASCRS commented that this 44156 is less than 44155 and "out of family value."	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 7 Intestines - Repair						
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	10.61	11.91	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44603	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations	14.00	15.72	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	14.28	16.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The specialty society changed its original recommendation to request the 25th percentile of the survey work RVU of 16.03, rather than the survey median of 20.85. The RUC agreed that this was appropriate as the survey respondents (46 general and colon & rectal surgeons) overstated the post-operative hospital visits work. The RUC agreed that the critical care visit and one level 99231 should be deducted from the survey median to reflect a more typical length of stay for this procedure. The RUC agreed that this service is currently undervalued and recommends the 25th percentile of the survey work RVU of 16.03. The RUC also notes that the committee reviewed this service in July 1993. At this time, the RUC recommended a budget neutral recommendation as codes 44602-44604 replaced a deleted code, 44600.	1
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy	15.37	17.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44615	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction	14.19	15.93	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44620	Closure of enterostomy, large or small intestine;	10.87	12.20	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44625	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal	13.41	15.05	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	25.36	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44640	Closure of intestinal cutaneous fistula	14.83	16.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44650	Closure of enteroenteric or enterocolic fistula	15.25	17.12	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44660	Closure of enterovesical fistula; without intestinal or bladder resection	14.63	16.42	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44661	Closure of enterovesical fistula; with bowel and/or bladder resection	16.99	19.07	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44680	Intestinal plication (separate procedure)	13.72	15.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44700	Exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	14.35	16.11	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4
44850	Suture of mesentery (separate procedure)	9.57	10.74	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44604 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 12% increase of 44604 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 8 Anus/Rectum - Hemorrhoids/Fistula						
45000	Transrectal drainage of pelvic abscess	4.52	3.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
45020	Incision and drainage of deep supralelevator, pelvirectal, or retrorectal abscess	4.72	4.05	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
45100	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	3.68	3.16	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
45108	Anorectal myomectomy	4.76	4.09	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	4.96	4.26	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46045	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia	4.32	3.71	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46060	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	5.69	4.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46250	Hemorrhoidectomy, external, complete	4.53	3.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46255	Hemorrhoidectomy, internal and external, simple;	5.36	4.60	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46257	Hemorrhoidectomy, internal and external, simple; with fissurectomy	6.28	5.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46258	Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy	6.67	5.73	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS commented that this service is undervalued for work intensity.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46260	Hemorrhoidectomy, internal and external, complex or extensive;	7.42	6.37	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46261	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy	8.24	7.08	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46262	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy	8.73	7.50	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC accepted the specialty's recommendation that the work of code 46262 and the other anus/rectum - hemorrhoids/fistula procedures in this grouping of services have decreased in the past five-years and recommends a 14% decrease. The specialty presented data from a survey of 31 general and colon & rectal surgeons who indicated a median work RVU of 7.50. The survey indicates 40 minutes pre-time, 45 minutes intra-time, and two office visits. A survey was conducted for this service five-years ago which indicated 60 minutes pre-time, 60 minutes intra-time, and three office visits. The RUC understands that this service is typically performed in an outpatient hospital setting. Based on a review of this data, the RUC recommends a decrease in the work RVU for code 46262 to 7.50.	3
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	3.72	3.20	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46275	Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular	4.56	3.92	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton	5.98	5.14	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46288	Closure of anal fistula with rectal advancement flap	7.13	6.13	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46934	Destruction of hemorrhoids, any method; internal	4.08	3.51	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46936	Destruction of hemorrhoids, any method; internal and external	4.30	3.69	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46945	Ligation of internal hemorrhoids; single procedure	2.14	1.84	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3
46946	Ligation of internal hemorrhoids; multiple procedures	3.00	2.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends a decrease consistent with the decrease to CPT code 46262 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 14% decrease of 46262 from the current work RVU.	3

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		2000 RUC				
CPT Code	Description	Work RVU	Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 9 a Anus/Rectum - 10 day global						
45900	Reduction of proclidentia (separate procedure) under anesthesia	1.83	2.61	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 46221 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 43% increase of 46221 from the current work RVU.	4
45905	Dilation of anal sphincter (separate procedure) under anesthesia other than local	1.61	2.30	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 46221 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 43% increase of 46221 from the current work RVU.	4
45910	Dilation of rectal stricture (separate procedure) under anesthesia other than local	1.96	2.80	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS commented that this code nomenclature is unclear and there is a need to redefine as anal stricture and add new code for rectal.	The RUC recommends an increase consistent with the increase to CPT code 46221 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 43% increase of 46221 from the current work RVU.	4
45915	Removal of fecal impaction or foreign body (separate procedure) under anesthesia	2.20	3.14	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 46221 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 43% increase of 46221 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	1.43	2.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed data from 27 general and colon & rectal surgeons that indicated that code 46221 and the other services in the anus/rectum - 10 day global grouping of services are significantly undervalued and should be increased by 43%. It was noted that septic deaths have been associated with this procedure. The RUC was concerned that the respondents chose 46255 Hemorrhoidectomy, internal and external, simple (work RVU = 5.36) as the key reference service as it has a 090 global. The RUC determined that the respondents incorrectly included hospital discharge work and an additional office visit beyond the 10 day global period. The RUC agreed that one office visit is typical in the 010 global period and it is usually at the 99213 level as an anoscopy is performed. The RUC deducted this work from the survey median of 3.75 to calculate a recommended work RVU of 2.04. This is slightly less than the 25th percentile of the survey median and compares directly to code 52000 Cystourethroscopy (separate procedure) (work RVU = 2.01) which includes 12 minutes pre-time, 14 minutes intra-time, and 12 minutes post-time.	4
46754	Removal of Thiersch wire or suture, anal canal	1.54	2.20	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 46221 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 43% increase of 46221 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 9 b Anus/Rectum - 10 day global						
46083	Incision of thrombosed hemorrhoid, external	1.40	1.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46230	Excision of external hemorrhoid tags and/or multiple papillae	2.57	2.57	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46320	Enucleation or excision of external thrombotic hemorrhoid	1.61	1.61	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC recommends that the work RVU for code 46320 and the anus/rectum - 10 day global grouping of services be maintained as no compelling evidence as presented to increase the work RVUs for these services.	2
46935	Destruction of hemorrhoids, any method; external	2.43	2.43	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46940	Curettage or cauterization of anal fissure, including dilation of anal sphincter (separate procedure); initial	2.32	2.32	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46942	Curettage or cauterization of anal fissure, including dilation of anal sphincter (separate procedure); subsequent	2.04	2.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 9 c Anus (destruction) - 10 day global						
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	1.91	1.91	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46910	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	1.86	1.86	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46916	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	1.86	1.86	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46917	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	1.86	1.86	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46922	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	1.86	1.86	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method	2.76	2.76	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC recommends that the current value for this service and the family of destruction of anus lesions be maintained as no compelling evidence to increase these services. The RUC noted that the specialty should request CPT to better define "simple" and "extensive" destruction included in CPT codes 46900-46924.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 10 Anus/Rectum - Repair						
45505	Proctoplasty; for prolapse of mucous membrane	6.02	7.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45540	Proctopexy for prolapse; abdominal approach	12.92	16.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45541	Proctopexy for prolapse; perineal approach	10.64	13.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45550	Proctopexy combined with sigmoid resection, abdominal approach	18.26	23.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	<p>This service was previously reviewed in the initial five-year review of the RBRVS. At that time, the RUC reviewed a comment from a Medicare Carrier Medical Director that stated that 45550 was undervalued and should be valued 10% more than 44140 Colectomy, partial; with anastomosis (current work RVU = 18.35). A specialty society survey indicated that the code was indeed undervalued, but found the work to be equal to 44140, not 10% more than 44140 as stated in th CMD comment. The specialty society commented that this service remains undervalued and explained that this service requires one additional hour of intra-service time than code 44140.</p> <p>The RUC reviewed the current survey of 29 general and colon and rectal surgeons and agrees that this service is equivalent to code 44626 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure). (work RVU = 22.59). Code 44626 requires 60 minutes pre-time, 180 minutes intra-time, 7 hospital visits, and 3 office visits, which is directly comparable to code 45550. The RUC, therefore, recommends the survey median of 23.00.</p>	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
45560	Repair of rectocele (separate procedure)	8.40	10.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45562	Exploration, repair, and presacral drainage for rectal injury;	12.21	15.38	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	18.63	23.47	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45800	Closure of rectovesical fistula;	14.11	17.77	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45805	Closure of rectovesical fistula; with colostomy	16.50	20.78	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45820	Closure of rectourethral fistula;	14.67	18.48	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
45825	Closure of rectourethral fistula; with colostomy	16.87	21.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46700	Anoplasty, plastic operation for stricture; adult	7.25	9.13	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	8.14	10.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
46753	Graft (Thiersch operation) for rectal incontinence and/or prolapse	6.58	8.29	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
46760	Sphincteroplasty, anal, for incontinence, adult; muscle transplant	11.46	14.43	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
46761	Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)	10.99	13.84	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4
46762	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter	10.09	12.71	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45550 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 45550 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 11 Hernia						
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	4.68	5.48	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49501	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated	7.58	8.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49505	Repair initial inguinal hernia, age 5 years or over; reducible	6.49	7.60	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p> <p>The ASGS commented that the service is currently undervalued.</p>	<p>The RUC recommends that the survey median of 8.24 be reduced by 1/2 of a discharge day (because this service is typically performed in an outpatient hospital setting) to arrive at a calculated recommended work RVU of 7.60.</p> <p>The RUC reviewed this code, and the other codes in the hernia family, in April 1993 and recommended a work RVU of 6.32, which represented no change over the current work RVU at that time. The general surgeons commented in the previous five-year review that this code should be increased to 8.66. However, the RUC concluded that the family of codes had already undergone substantial review by the RUC and HCFA refinement panels, although the refinement panel work was done prior to the CPT revisions. No evidence was presented that the work of the service had changed since the most recent review (new/revised CPTs in 1994) and the RUC recommended that the work RVUs be maintained.</p> <p>The general surgeons now contend that these services are in fact undervalued and the RUC agrees based on the survey results and a comparison to other services on the reference lists. The general surgeons cited three CPT codes (26531, 29881, and 43268) to use as comparison to the family anchor code 49505. Although 49505 requires slightly less intra-service time than the endoscopic reference procedure 43268, the anchor code entails significantly greater post-service time than the 0-day global 43268. In addition, pre-service time is slightly greater for 49505 and 43268. The times required by the other reference codes (26531 and 29881) are quite similar to the selected anchor code. This comparison shows that the work of CPT 49505 is comparable to the work required by the selected reference codes.</p>	4
49507	Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated	8.17	9.57	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p>	<p>The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.</p>	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49520	Repair recurrent inguinal hernia, any age; reducible	8.22	9.63	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	10.22	11.97	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49525	Repair inguinal hernia, sliding, any age	7.32	8.57	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49540	Repair lumbar hernia	8.87	10.39	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49550	Repair initial femoral hernia, any age; reducible	7.37	8.63	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	8.06	9.44	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49555	Repair recurrent femoral hernia; reducible	7.71	9.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49557	Repair recurrent femoral hernia; incarcerated or strangulated	9.52	11.15	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49560	Repair initial incisional or ventral hernia; reducible	9.88	11.57	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	12.17	14.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49565	Repair recurrent incisional or ventral hernia; reducible	9.88	11.57	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	12.30	14.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)	4.86	5.69	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated	5.75	6.73	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49580	Repair umbilical hernia, under age 5 years; reducible	3.51	4.11	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49582	Repair umbilical hernia, under age 5 years; incarcerated or strangulated	5.68	6.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49585	Repair umbilical hernia, age 5 years or over; reducible	5.32	6.23	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49587	Repair umbilical hernia, age 5 years or over; incarcerated or strangulated	6.46	7.56	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4
49590	Repair spigelian hernia	7.29	8.54	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49505 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 17% increase of 49505 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 12 a Stomach - Gastrectomy						
43620	Gastrectomy, total; with esophagoenterostomy	22.54	30.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43638 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 33% increase of 43638 from the current work RVU.	4
43621	Gastrectomy, total; with Roux-en-Y reconstruction	23.06	30.73	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43638 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 33% increase of 43638 from the current work RVU.	4
43622	Gastrectomy, total; with formation of intestinal pouch, any type	24.41	32.53	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43638 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 33% increase of 43638 from the current work RVU.	4
43638	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;	21.76	29.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC agreed that this service is currently undervalued and recommends the survey median of 29.00 based on a survey of 31 general surgeons. This service is comparable to code 35081 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta (work RVU = 28.01). Code 42638 requires 75 minutes pre-time, 210 minutes intra-time, 9 hospital visits, and 4 office visits. Code 35081 has existing RUC survey time of 108 pre-time, 203 minutes intra-time, 10 hospital visits, and 2 office visits. In general, the survey respondents indicated that the intensities factors for both services are similar. The RUC recommended a work RVU of 22.13 for this service in 1993 (this value should be increased to include the increase E/M work since the initial five-year review). The RUC notes that this recommendation was based on a survey of gastroenterologists, however, general surgeons typically perform this service. The RUC recommends an increase for 43638 to the survey median of 29.00	4

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CPT Code	Description	2000	RUC	Public Comment to HCFA	RUC Rationale	Key
		Work RVU	Rec RVU			
43639	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloroplasty or pyloromyotomy	22.25	29.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43638 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 33% increase of 43638 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 12 b Stomach - Gastrectomy/Vagotomy						
43631	Gastrectomy, partial, distal; with gastroduodenostomy	19.66	22.59	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends that this service is currently undervalued and recommends that this service is comparable in work to CPT code 44626 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure) (work RVU = 22.59). Both services require 75 minutes pre-time, 150 minutes intra-time, 7 hospital visits, and 3 office visits. This recommendation is also the mid-point between the 25th percentile (22.00) and median (23.70) survey work RVU based on a survey of 40 general surgeons. The RUC noted that the RUC reviewed this service in 1993, however, it appears that gastroenterology led this survey process and this procedure is typically performed by general surgeons.	4
43632	Gastrectomy, partial, distal; with gastrojejunostomy	19.66	22.59	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43631 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 43631 from the current work RVU.	4
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	20.10	23.10	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43631 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 43631 from the current work RVU.	4
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	21.86	25.12	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43631 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 43631 from the current work RVU.	4
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	14.81	17.02	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43631 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 43631 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43641	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	15.03	17.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43631 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 43631 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 13 a Stomach - Incision/Excision/Repair						
43500	Gastrotomy; with exploration or foreign body removal	8.44	11.05	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43501	Gastrotomy; with suture repair of bleeding ulcer	15.31	20.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43502	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	17.67	23.13	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43510	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	9.99	13.08	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	7.63	9.99	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43605	Biopsy of stomach; by laparotomy	9.15	11.98	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43610	Excision, local; ulcer or benign tumor of stomach	11.15	14.60	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43611	Excision, local; malignant tumor of stomach	13.63	17.84	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43800	Pyloroplasty	10.46	13.69	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43810	Gastroduodenostomy	11.19	14.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43820	Gastrojejunostomy; without vagotomy	11.74	15.37	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43825	Gastrojejunostomy; with vagotomy, any type	14.68	19.22	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	7.28	9.53	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommended an increase in the work RVU for this service in the initial five-year review, however, HCFA did not accept the full increase that was recommended because HCFA chose to use 49507 as a reference and did not believe that 43830 was more work than 49507. The RUC still maintains that this service is undervalued and recommends the 25th percentile of the survey work RVU of 9.53 based on a survey of 37 general surgeons who indicated an LOS of 5-6 days and 2 office visits. The RUC also notes the rapid decline in utilization of this procedure as the easier cases are done percutaneously.	4
43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)	11.92	15.60	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	11.89	15.56	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4
43870	Closure of gastrostomy, surgical	7.40	9.69	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43830 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 31% increase of 43830 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 13 b Stomach - Incision/Excision/Repair						
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	14.71	18.47	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	14.85	18.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastro enterostomy	19.15	24.05	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small bowel reconstruction to limit absorption	21.44	26.92	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)	23.41	29.39	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	19.69	24.72	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	20.83	26.16	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; without vagotomy	19.91	25.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase in the work RVU for code 43860 to correct a current rank order anomaly between this procedure and code 44626 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure) (work RVU = 22.59). Code 43860 includes greater length of stay and additional hospital visits than 44626. Code 43860 typically requires 75 minutes pre-time, 180 minutes intra-time, 9 hospital visits, and 3 office visits. Code 44626 requires 60 minutes pre-time, 180 minutes intra-time, 7 hospital visits, and 3 office visits. The RUC recommends the survey median work RVU of 25.00 for this service based on a survey of 29 general surgeons.	4
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; with vagotomy	21.12	26.52	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4
43880	Closure of gastrocolic fistula	19.63	24.65	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43860 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 26% increase of 43860 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 14 a Abdomen, Peritoneum, Omentum						
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	11.68	11.68	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed this service in the initial five-year review and recommended an increase at that time. The time data from this initial survey is nearly identical to the time data collected in the current survey. The RUC also agreed that this service is ranked appropriately on the MPC in comparison to code 32100 Thoracotomy, major; with exploration and biopsy (work RVU = 11.84). Both services require similar time and intensity. After review of all available information, the RUC recommends that the current work RVU be maintained for code 49000.	2
49002	Reopening of recent laparotomy	10.49	10.49	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	12.28	12.28	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49200	Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas;	10.25	10.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49201	Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive	14.84	14.84	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49220	Staging celiotomy (laparotomy) for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	14.88	14.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	11.14	11.14	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent	5.54	5.54	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49422	Removal of permanent intraperitoneal cannula or catheter	6.25	6.25	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49425	Insertion of peritoneal-venous shunt	11.37	11.37	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49426	Revision of peritoneal-venous shunt	9.63	9.63	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49429	Removal of peritoneal-venous shunt	7.40	7.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49900	Suture, secondary, of abdominal wall for evisceration or dehiscence	12.28	12.28	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
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Family: 14 b Abdomen, Peritoneum, Omentum

49020	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open	16.79	20.73	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	<p>The general surgeons commented in the previous five-year review that the drainage of peritoneal, subdiaphragmatic and retroperitoneal abscesses were undervalued and the RUC agreed. However, the RUC was concerned that these codes were being utilized for services performed percutaneously and referred the issue to CPT. In CPT 1997, separate codes were created to describe these percutaneous services and the RUC then recommended increases to the existing open codes. 49020 was reviewed by the RUC in April 1996. At that time, the specialty recommended a work RVU of 16.50, however, the RUC submitted a recommendation of 14.25.</p> <p>The RUC reviewed the current survey of 28 general surgeons and determined that the 25th percentile survey work RVU of 20.73 is a more accurate reflection of the work required to perform this service. The RUC also compared an MPC code, 61312 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural (work RVU = 24.57) to code 49020. Both codes have similar pre-time (60 minutes), intra-time (120 minutes), and office visits (3 visits). Code 61312 requires greater hospital post-service work (15 visits versus 10 visits for 49020).</p> <p>Based on a review of this data and information, the RUC agreed that this service remains undervalued and recommends the 25th percentile survey work RVU of 20.73.</p>	4
49040	Drainage of subdiaphragmatic or subphrenic abscess; open	9.94	12.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49020 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 23% increase of 49020 from the current work RVU.	4
49060	Drainage of retroperitoneal abscess; open	11.66	14.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49020 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 23% increase of 49020 from the current work RVU.	4

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CPT Code	Description	2000 RUC		Public Comment to HCFA	RUC Rationale	Key
		Work RVU	Rec RVU			
49085	Removal of peritoneal foreign body from peritoneal cavity	8.93	11.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 49020 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 23% increase of 49020 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 14 c Ligation of peritoneal-venous shunt						
49428	Ligation of peritoneal-venous shunt	2.38	6.06	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	<p>The RUC reviewed a survey of 22 general surgeons for code 49428 who indicated that this service typically requires 45 minutes pre-time, 35 minutes intra-time, two hospital visits, and two office visits and compared this information to the data collected by general surgery and obstetrics/gynecology in 1994. At that time, a survey median of 4.04 was indicated for the service with similar pre and intra-time. However, it appears that the post-operative work has increased in the past five years as this current survey indicates an additional hospital visit and an additional office visit. In addition, the RUC had previously recommended that code 49428 be valued more than 37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions. (current work RVU = 3.73). 37700 requires similar intra-time (41 minutes) but less pre-time (19 minutes) and post-operative visits (.5 hospital and 2 office visits).</p> <p>The current survey respondents also utilized key reference service 49422 Removal of permanent intraperitoneal cannula or catheter (work RVU = 6.26) which requires very similar physician time, but was ranked as less intense than 49428.</p> <p>After consideration of this data and information, the RUC recommends the 25th percentile survey work RVU of 6.06.</p>	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 15 Appendix						
44900	Incision and drainage of appendiceal abscess; open	8.82	10.14	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44950 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 44950 from the current work RVU.	4
44950	Appendectomy;	8.70	10.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommended an increase for both codes 44950 and 44970 to 8.25. As the utilization of laparoscopic appendectomy has increased and negative appendectomies has decreased due to improved diagnostic techniques utilizing CT scans, the patient base for the open appendectomy has changed. The RUC agreed that open appendectomy should be valued higher than laparoscopic appendectomy. The RUC calculated an incremental difference between 44950 and 44970 after reviewing the post-operative work, which includes 1 additional hospital visit (99231 = 0.64) and 1 additional office visit (99213 = 0.65) for the open procedure. This 1.29 increment was added to the work RVU for 44970 (8.70) to compute a work RVU of 9.99. This calculated work RVU is similar to the median work RVU of 10.00 based on a survey of 42 general surgeons. The RUC, therefore, recommends an increase in the work RVU to 10.00.	1
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	10.74	12.34	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 44950 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 15% increase of 44950 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 16 Rectum - Proctectomy/Excision						
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	23.80	28.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC agreed that this code is currently undervalued and noted that this service was identified as undervalued during the initial five-year review. However, at that time, the general surgeons did not pursue a RUC survey. For this five-year review, general surgery and colon and rectal surgery were able to obtain 32 survey respondents who indicated that this service requires 80 minutes pre-time, 180 minutes intra-time, 8 hospital visits, and 4 office visits. This is directly comparable to a code on the MPC, code 61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma (work RVU = 28.45). Code 61510 requires 105 minutes pre-time, 200 minutes intra, 8 hospital visits, and 4 office visits. The RUC recommends the survey median of 28.00.	1
45112	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)	25.96	30.54	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	25.99	30.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	23.22	27.32	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	20.89	24.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy	26.21	30.84	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45123	Proctectomy, partial, without anastomosis, perineal approach	14.20	16.71	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	38.39	45.16	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU. The RUC notes that this service currently has the same value as two other pelvic exenteration codes, code 51597 and 58240 and these services may need to be reviewed to ensure that a rank order anomaly has not been created. Code 45126 was reviewed by the RUC in May 1998. At that time, the RUC accepted the survey median presented by the specialty society which was based on the premise that codes 45126, 51597, and 58240 should be valued the same and any revaluation for these three major operations would have to wait until the next (current) five-year review.	4
45130	Excision of rectal procidentia, with anastomosis; perineal approach	13.97	16.44	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASCRS comment that this code is currently undervalued in the family of codes.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	16.39	19.28	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45160	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach	13.02	15.32	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45170	Excision of rectal tumor, transanal approach	9.77	11.49	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4
45190	Destruction of rectal tumor, any method (eg, electrodesiccation) transanal approach	8.28	9.74	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 45110 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 18% increase of 45110 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 17 Biliary Tract						
47420	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty	16.72	19.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47425	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	16.68	19.83	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47460	Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)	15.17	18.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47480	Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure)	9.10	10.82	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47600	Cholecystectomy;	11.42	13.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47605	Cholecystectomy; with cholangiography	12.36	14.69	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47610	Cholecystectomy with exploration of common duct;	15.83	18.82	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47612	Cholecystectomy with exploration of common duct; with choledochenterostomy	15.80	18.78	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	17.36	20.64	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47711	Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic	19.37	23.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47712	Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic	25.44	30.24	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47715	Excision of choledochal cyst	15.81	18.80	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47716	Anastomosis, choledochal cyst, without excision	13.83	16.44	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47720	Cholecystoenterostomy; direct	13.38	15.91	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47721	Cholecystoenterostomy; with gastroenterostomy	16.08	19.12	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47740	Cholecystoenterostomy; Roux-en-Y	15.54	18.48	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47741	Cholecystoenterostomy; Roux-en-Y with gastroenterostomy	17.95	21.34	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	21.74	25.85	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	20.93	24.88	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	22.29	26.50	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends the specialty's survey work RVU median of 26.50 based on a survey of 28 general surgeons. The respondents compared 47780 with key reference service 47760 Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract (work RVU = 21.74) and agreed that this procedure is undervalued in comparison to the current work RVU for 47760. Code 47780 includes 55 additional minutes of intra-service time and additional hospital visits. The RUC also notes a decline in Medicare utilization for this service as the easier cases are treated with stents by gastroenterologists. Only the patients that can not be approached laparoscopically receive the procedure described in 47780.	1
47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract	26.23	31.18	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	19.60	23.30	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47801	Placement of choledochal stent	12.76	15.17	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47802	U-tube hepaticoenterostomy	18.13	21.55	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4
47900	Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)	16.74	19.90	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47780 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 19% increase of 47780 from the current work RVU.	4

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CPT Code	Description	2000 RUC		Public Comment to HCFA	RUC Rationale	Key
		Work RVU	Rec RVU			
Family: 18 Esophagus - Repair/Reconstruction						
43320	Esophagostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	16.07	19.93	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	16.58	20.57	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	16.17	20.06	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43326	Esophagogastric fundoplasty; with gastroplasty (eg, Collis)	15.91	19.74	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43330	Esophagomyotomy (Heller type); abdominal approach	15.94	19.77	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43331	Esophagomyotomy (Heller type); thoracic approach	16.23	20.13	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	15.81	19.61	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach	16.81	20.85	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach	12.72	15.78	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43351	Esophagostomy, fistulization of esophagus, external; thoracic approach	14.79	18.35	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43352	Esophagostomy, fistulization of esophagus, external; cervical approach	12.30	15.26	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	28.78	35.70	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	<p>The RUC agreed that this rarely performed (less than 15 in 1998 per Medicare utilization data) is currently undervalued and includes substantial post-operative Evaluation and Management work. A survey of 30 general surgeons indicated that this service is most comparable to code 35091 Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (work RVU = 35.40). The survey respondents indicated that 43360 includes 90 minutes pre-time, 270 minutes intra-time, 8 hospital visits, and 4 office visits. The key reference code 35091 includes 100 minutes pre time, 240 intra-time, two critical care visits, 8 hospital visits, and 4 office visits. In general, the survey respondents indicated that 35091 was slightly more intense than 43360. The RUC agreed that the 30 minutes of additional intra-service time for code 43360 was offset by the additional critical care time included in code 35091. The specialty also indicated that few surgeons have performed this procedures (only 10 of the 30 respondents had any direct experience in the past 12 months). These ten experienced surgeons indicated that this service did include critical care and responded that the length of stay was actually 14 days.</p> <p>The RUC reviewed code 33426 Vavulopasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring (work RVU = 31.03). This service was surveyed in the initial five-year review and the survey data included 60 minutes pre-time, 250 minutes intra-time, three ICU visits, six other hospital visits, and two office visits.</p> <p>The RUC considered this information in recommending the survey median of 35.70 for this service. The RUC also notes that the CPT descriptor may be reviewed and revised in the CPT-5 project as the code currently includes various services which may represent different work.</p>	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small bowel reconstruction, including bowel mobilization, preparation, and anastomosis(es)	32.65	40.50	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43400	Ligation, direct, esophageal varices	17.09	21.20	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43401	Transection of esophagus with repair, for esophageal varices	17.81	22.09	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	16.13	20.01	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43410	Suture of esophageal wound or injury; cervical approach	10.86	13.47	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43415	Suture of esophageal wound or injury; transthoracic or transabdominal approach	17.06	25.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC agreed that this service is undervalued and notes that the Harvard physician time for this procedure is significantly less than the current survey time. Harvard time included 39 minutes of pre-time, 133 minutes of intra-time, one ICU visit, six other hospital visits, and 3 office visits. The current survey includes 75 minutes pre-time, 150 minutes intra-time, one ICU visit, eight other hospital visits, and 4 office visits. The RUC did not agree to the specialty's recommendation to accept the 75th percentile survey work RVU of 31.99, but rather agreed that the survey median of 25.00 was more appropriate.	4
43420	Closure of esophagostomy or fistula; cervical approach	11.57	14.35	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4
43425	Closure of esophagostomy or fistula; transthoracic or transabdominal approach	16.95	21.03	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 43360 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 24% increase of 43360 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 19 Liver						
47010	Hepatotomy; for open drainage of abscess or cyst, one or two stages	10.28	16.01	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	9.70	15.11	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47100	Biopsy of liver, wedge	7.49	11.67	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47120	Hepatectomy, resection of liver; partial lobectomy	22.79	35.50	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The specialty recommended an increase in the work RVU for code 47120 based on the 75th percentile of the survey work RVU (35.50) based on a survey of 28 general surgeons. The RUC compared this service to 45110 Proctectomy; complete, combined abdominoperineal, with colostomy (recommend work RVU = 28.00). The survey time data for 47120 indicate that this service requires 45 minutes of additional intra-service time and one additional critical care visit. The RUC added a 4.00 increment for the additional critical care visit and a 3.00 increment for the 45 minutes of intra-service time to compute a total work RVU of 35.00 (28.00 + 4.00 + 3.00 = 35.00). This is very similar to the 75th percentile survey work RVU of 35.50, which the RUC recommends be adopted.	1
47122	Hepatectomy, resection of liver; trisegmentectomy	35.39	55.13	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47125	Hepatectomy, resection of liver; total left lobectomy	31.58	49.19	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47130	Hepatectomy, resection of liver; total right lobectomy	34.25	53.35	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47300	Marsupialization of cyst or abscess of liver	9.68	15.08	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47350	Management of liver hemorrhage; simple suture of liver wound or injury	12.56	19.56	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	17.28	26.92	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47361	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	30.25	47.12	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	11.88	18.51	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	20.86	32.49	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 47120 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 56% increase of 47120 from the current work RVU.	4

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		2000 RUC				
CPT Code	Description	Work RVU	Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 20 a Spleen-Incision/Excision/Repair						
38100	Splenectomy; total (separate procedure)	13.01	14.50	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p> <p>The ASGS commented that the service is currently undervalued.</p>	<p>The RUC agreed that this service and the other codes in the spleen-incision/excision/repair grouping of codes are currently undervalued and recommends an 11% increase in the work RVUs for these services. The RUC reviewed the data based on a survey of 41 general surgeons and concluded that the survey median of 16.00 was too high, and recommends instead the 25th percentile of the survey work RVU of 14.50. The RUC compared the survey time for code 38100 of 55 minutes pre-time, 90 minutes intra-service time, five hospital visits, and two office visits to the time data for three other surgical procedures. CPT code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) (work RVU = 15.24) includes 60 minutes pre-time, 120 minutes intra-service time, 5 hospital visits, and two office visits. CPT code 38720 Cervical lymphadenectomy (complete) (work RVU = 13.61) is on the RUC's MPC and includes 60 minutes pre-time, 150 minutes intra-time, six hospital visits, and four office visits. CPT code 63017 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical (work RVU = 15.94) is on the RUC's MPC and includes 90 minutes pre-time, 150 minutes intra-time, five hospital visits, and three office visits. After review of the above data, the RUC recommends the 25th percentile of the survey work RVU of 14.50 for code 38100.</p>	4
38101	Splenectomy; partial (separate procedure)	13.74	15.31	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p>	<p>The RUC recommends an increase consistent with the increase to CPT code 38100 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 11% increase of 38100 from the current work RVU.</p>	4
38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy	14.19	15.82	<p>The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.</p>	<p>The RUC recommends an increase consistent with the increase to CPT code 38100 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 11% increase of 38100 from the current work RVU.</p>	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 20 b Pancreatitis management						
48000	Placement of drains, peripancreatic, for acute pancreatitis;	14.91	28.07	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48805 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 88% increase of 48805 from the current work RVU.	4
48001	Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy	18.83	35.45	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48805 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 88% increase of 48805 from the current work RVU.	4
48005	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis	22.40	42.17	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	In June 1993, the RUC recommended work RVUs for code 48005, along with codes 48000 and 48001. The RUC based these recommendations on a global period of 000 to allow individual reporting of Evaluation and Management codes performed as these services require substantial post-operative management. HCFA accepted the RUC's recommendation, but published a global period of 090 days. The RUC's previous recommendation of 13.42 for the day of procedure work only clearly did not include the 20.50 hospital visits (including 3 critical care visits) and 4 office visits. The RUC recommends that code 48005 (and codes 48000 and 48001) be increased to capture this significant post-operative work. The work RVU of 13.42 plus the post-operative discounted E/M visits work RVUs of 33.07 is slightly higher (46.49) than the survey median of 42.17. The RUC recommends the median work RVU of 42.17 based on a survey of 26 general surgeons.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 21 Pancreatectomy						
48020	Removal of pancreatic calculus	14.22	15.70	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48100	Biopsy of pancreas, open, any method (eg, fine needle aspiration, needle core biopsy, wedge biopsy)	11.08	12.23	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48120	Excision of lesion of pancreas (eg, cyst, adenoma)	14.36	15.85	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	20.78	22.94	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	21.76	24.02	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	23.91	26.40	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
48148	Excision of ampulla of Vater	15.71	17.34	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	43.48	48.00	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC found the survey data from 44 general and colon and rectal surgeons to be compelling and recommends the survey median work RVU of 48.00. The RUC reviewed this service in June 1993 and recommended a work RVU of 43.00 at that time. If the increases to E/M services performed in a surgical global period were applied to this previous RUC recommendation, the current work RVU should be closer to the survey median of 48.00 as the RUC database currently includes a length of stay of 21 days and 5 office visits.	4
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	39.63	43.75	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	43.38	47.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	39.95	44.10	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
48155	Pancreatectomy, total	22.32	24.64	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48180	Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)	22.39	24.72	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48500	Marsupialization of cyst of pancreas	13.84	15.28	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48510	External drainage, pseudocyst of pancreas; open	12.96	14.31	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48520	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct	14.12	15.59	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48540	Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y	17.86	19.72	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4
48545	Pancreatorrhaphy for trauma	16.47	18.18	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
48547	Duodenal exclusion with gastrojejunostomy for pancreatic trauma	23.40	25.83	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC recommends an increase consistent with the increase to CPT code 48150 to retain the current rank order and relativity within the grouping of services. A work RVU was calculated based on a recommended 10% increase of 48150 from the current work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
Family: 22 Laparoscopy						
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	10.15	10.15	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	12.15	12.15	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44200	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)	14.44	14.44	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
44970	Laparoscopy, surgical, appendectomy	8.70	8.70	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
47562	Laparoscopy, surgical; cholecystectomy	11.09	11.09	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	The RUC recommends that the current work RVU be maintained as no compelling evidence was presented to increase the work RVU for this service.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.94	11.94	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	14.23	14.23	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
47570	Laparoscopy, surgical; cholecystoenterostomy	12.58	12.58	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49320	Laparoscopy, surgical, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.10	5.10	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The ASGS commented that the service is currently undervalued.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49650	Laparoscopy, surgical; repair initial inguinal hernia	6.27	6.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	8.24	8.24	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	No compelling data was presented to recommend an increase in the current work RVU for this service.	2

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APPENDIX A (revised 10/26/00) - RUC General Surgery Recommendations and Time and Visit Data

FAM	Svy Type	CPT	Descriptor	glb	2000 MFS RVW	RUC Rec	% CHG RUC / MFS	WKGP KEY	PRE min	INTRA min	SD IMM min	Total Hosp Post op Visits	9 9 9 9 9	9 9 9 9 9	Total Off Visits	9 9 9 9 9	9 9 9 9 9
1a 1A: Thyroid																	
1a	F	60220	Total thyroid lobectomy, unilateral; with or without isthmus	90	10.53	11.90	13%	4	63	90	25	2.0	0 0 0 1	1.0	2.0	0 0 1 1	0
1a	M	60252	Thyroidectomy, total or subtotal for malignancy; with isthmus	90	18.20	20.57	13%	4	60	180	30	4.0	0 0 2 1	1.0	3.0	0 0 2 1	0
1a	M	60254	Thyroidectomy, total or subtotal for malignancy; with isthmus	90	23.88	26.99	13%	4	60	210	30	4.0	0 0 2 1	1.0	3.0	0 0 2 1	0
1a	M	60260	Thyroidectomy, removal of all remaining thyroid tissue	90	15.46	17.47	13%	4	60	145	30	3.0	0 0 1 1	1.0	2.0	0 0 1 1	0
1a	M	60270	Thyroidectomy, including substernal thyroid gland; sternotomy	90	17.94	20.27	13%	4	60	180	30	7.0	1 2 2 1	1.0	3.0	0 0 2 1	0
1a	M	60271	Thyroidectomy, including substernal thyroid gland; cervical	90	14.89	16.83	13%	4	60	150	30	3.0	0 0 1 1	1.0	2.0	0 0 1 1	0
1b 1b: Endocrine																	
1b	M	60540	Adrenalectomy, partial or complete, or exploration of adrenal	90	17.03	17.03	0%	2									
1b	M	60545	Adrenalectomy, partial or complete, or exploration of adrenal	90	19.88	19.88	0%	2									
2 2: Lymphadenectomy																	
2	M	38740	Axillary lymphadenectomy; superficial	90	6.77	8.42	24%	4	60	60	30	0.5	0 0 0 0	0.5	3.0	0 0 2 1	0
2	F	38745	Axillary lymphadenectomy; complete	90	8.84	11.00	24%	4	58	90	25	0.5	0 0 0 0	0.5	3.0	0 1 1 1	0
2	M	38760	Inguinofemoral lymphadenectomy, superficial, including ilio	90	8.74	10.88	24%	4	60	70	30	0.5	0 0 0 0	0.5	3.0	0 0 2 1	0
2	M	38765	Inguinofemoral lymphadenectomy, superficial, in continuity	90	16.06	19.98	24%	4	60	120	30	5.0	0 1 2 1	1.0	3.0	0 0 2 1	0
3 3: Lymph - Incision/Excision																	
3	M	38300	Drainage of lymph node abscess or lymphadenitis; simple	10	1.53	1.99	30%	4	45	20	30	0.0	0 0 0 0	0.0	2.0	0 0 1 1	0
3	M	38305	Drainage of lymph node abscess or lymphadenitis; extensive	90	4.61	6.00	30%	4	45	30	30	0.5	0 0 0 0	0.5	3.0	0 0 2 1	0
3	M	38308	Lymphangiomyoma or other operations on lymphatic channels	90	4.95	6.45	30%	4	45	45	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1	0
3	F	38500	Biopsy or excision of lymph node(s); superficial (separate	10	2.88	3.75	30%	1	35	30	15	0.5	0 0 0 0	0.5	1.0	0 0 0 1	0
3	F	38510	Biopsy or excision of lymph node(s); deep cervical node	90	4.14	6.43	55%	4	45	45	20	0.5	0 0 0 0	0.5	1.0	0 0 1 0	0
3	M	38520	Biopsy or excision of lymph node(s); deep cervical node	90	5.12	6.67	30%	4	45	60	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1	0
3	M	38525	Biopsy or excision of lymph node(s); deep axillary node	90	4.66	6.07	30%	4	45	45	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1	0
3	M	38530	Biopsy or excision of lymph node(s); internal mammary	90	6.13	7.98	30%	4	45	73	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1	0
4 4: Intestines - Excision/Incision																	
4	M	44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	90	13.84	16.23	17%	4	60	120	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	M	44010	Duodenotomy, for exploration, biopsy(s), or foreign body	90	10.68	12.52	17%	4	60	90	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1	0
4	M	44020	Enterotomy, small bowel, other than duodenum; for exploration	90	11.93	13.99	17%	4	60	90	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	M	44021	Enterotomy, small bowel, other than duodenum; for debridement	90	12.01	14.08	17%	4	60	90	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	M	44025	Colotomy, for exploration, biopsy(s), or foreign body	90	12.18	14.28	17%	4	60	90	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	F	44050	Reduction of volvulus, intussusception, internal hernia	90	11.40	14.03	23%	4	60	83	30	7.0	0 0 2 4	1.0	2.0	0 0 1 1	0
4	M	44110	Excision of one or more lesions of small or large bowel	90	10.07	11.81	17%	4	60	90	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	M	44111	Excision of one or more lesions of small or large bowel	90	12.19	14.29	17%	4	60	120	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1	0
4	F	44120	Enterectomy, resection of small intestine; single resection	90	14.50	17.00	17%	1	60	90	30	6.0	0 0 2 3	1.0	2.0	0 0 2 0	0
4	M	44125	Enterectomy, resection of small intestine; with enterostomy	90	14.96	17.54	17%	4	60	120	30	7.0	0 2 2 2	1.0	2.0	0 0 2 0	0
4	M	44130	Enteroenterostomy, anastomosis of intestine, with or without	90	12.36	14.49	17%	4	60	120	30	7.0	0 2 2 2	1.0	2.0	0 0 2 0	0
4	M	44800	Excision of Meckel's diverticulum (diverticulectomy) or	90	11.23	11.23	0%	2									
4	M	44820	Excision of lesion of mesentery (separate procedure)	90	10.31	12.09	17%	4	60	90	30	6.0	0 0 2 3	1.0	2.0	0 0 2 0	0
6	M	60	Colectomy with removal of terminal ileum and ileocolic	90	15.88	18.67	17%	4	63	120	45	7.0	0 2 2 2	1.0	3.0	0 0 1 2	0

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5: Intestines - External Fistulization																								
5	M	44300	Enterostomy or cecostomy, tube (eg, for decompressi	90	8.88	12.11	36%	4	75	60	30	6.0	0	0	2	3	1.0	2.0	0	0	2	0	0	
5	M	44310	Ileostomy or jejunostomy, non-tube (separate procedu	90	11.70	15.95	36%	4	75	63	30	6.0	0	0	2	3	1.0	2.0	0	0	2	0	0	
5	M	44312	Revision of ileostomy; simple (release of superficial sc	90	5.88	8.02	36%	4	75	60	30	4.0	0	0	2	1	1.0	2.0	0	0	2	0	0	
5	M	44314	Revision of ileostomy; complicated (reconstruction in-c	90	11.04	15.05	36%	4	75	120	30	6.0	0	0	2	3	1.0	3.0	0	0	2	1	0	
5	M	44316	Continent ileostomy (Kock procedure) (separate proce	90	15.47	21.09	36%	4	75	150	30	8.0	0	1	3	3	1.0	3.0	0	0	2	1	0	
5	F	44320	Colostomy or skin level cecostomy; (separate procedu	90	12.94	17.64	36%	1	75	90	30	7.0	0	1	2	3	1.0	3.0	0	1	1	1	0	
5	M	44340	Revision of colostomy; simple (release of superficial s	90	5.66	7.72	36%	4	75	60	30	4.0	0	0	2	1	1.0	3.0	0	1	1	1	0	
5	M	44345	Revision of colostomy; complicated (reconstruction in-	90	11.32	15.43	36%	4	75	120	30	6.0	0	0	2	3	1.0	3.0	0	1	1	1	0	
5	M	44346	Revision of colostomy; with repair of paracolostomy he	90	12.46	16.99	36%	4	75	120	30	7.0	0	2	2	2	1.0	3.0	0	1	1	1	0	
6: Intestines - Colectomy																								
6	F	44140	Colectomy, partial; with anastomosis	90	18.35	18.35	0%	2																
6	M	44143	Colectomy, partial; with end colostomy and closure of	90	20.17	20.17	0%	2																
6	M	44144	Colectomy, partial; with resection, with colostomy or il	90	18.89	18.89	0%	2																
6	M	44145	Colectomy, partial; with colectomy (low pelvic a	90	23.18	23.18	0%	2																
6	M	44146	Colectomy, partial; with colectomy (low pelvic a	90	24.16	24.16	0%	2																
6	M	44150	Colectomy, total, abdominal, without proctectomy; with	90	21.01	21.01	0%	2																
6	M	44151	Colectomy, total, abdominal, without proctectomy; with	90	20.04	20.04	0%	2																
6	M	44152	Colectomy, total, abdominal, without proctectomy; with	90	24.41	24.41	0%	2																
6	M	44153	Colectomy, total, abdominal, without proctectomy; with	90	26.83	26.83	0%	2																
6	M	44155	Colectomy, total, abdominal, with proctectomy; with ile	90	24.44	24.44	0%	2																
6	M	44156	Colectomy, total, abdominal, with proctectomy; with cd	90	23.01	23.01	0%	2																
7: Intestines - Repair																								
7	M	44602	Suture of small intestine (enterorrhaphy) for perforated	90	10.61	11.91	12%	4	60	90	30	7.0	1	2	2	1	1.0	2.0	0	0	1	1	0	
7	M	44603	Suture of small intestine (enterorrhaphy) for perforated	90	14.00	15.72	12%	4	60	120	30	8.0	1	2	2	2	1.0	2.0	0	0	1	1	0	
7	F	44604	Suture of large intestine (colorrhaphy) for perforated u	90	14.28	16.03	12%	1	60	90	30	7.0	0	1	2	3	1.0	2.0	0	0	2	0	0	
7	M	44605	Suture of large intestine (colorrhaphy) for perforated u	90	15.37	17.25	12%	4	60	125	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44615	Intestinal stricturoplasty (enterotomy and enterorrhaph	90	14.19	15.93	12%	4	60	105	30	7.0	0	2	2	2	1.0	2.0	0	0	1	1	0	
7	M	44620	Closure of enterostomy, large or small intestine;	90	10.87	12.20	12%	4	60	90	30	7.0	0	2	2	2	1.0	2.0	0	0	1	1	0	
7	M	44625	Closure of enterostomy, large or small intestine; with r	90	13.41	15.05	12%	4	60	120	30	7.0	0	2	2	2	1.0	2.0	0	0	1	1	0	
7	M	44626	Closure of enterostomy, large or small intestine; with r	90	22.59	25.36	12%	4	60	150	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44640	Closure of intestinal cutaneous fistula	90	14.83	16.65	12%	4	60	150	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44650	Closure of enteroenteric or enterocolic fistula	90	15.25	17.12	12%	4	60	150	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44660	Closure of enterovesical fistula; without intestinal or bl	90	14.63	16.42	12%	4	60	150	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44661	Closure of enterovesical fistula; with bowel and/or blad	90	16.99	19.07	12%	4	60	180	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44680	Intestinal plication (separate procedure)	90	13.72	15.40	12%	4	60	165	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0	
7	M	44700	Exclusion of small bowel from pelvis by mesh or other	90	14.35	16.11	12%	4	60	95	30	6.0	0	0	2	3	1.0	2.0	0	0	1	1	0	
7	M	44850	Suture of mesentery (separate procedure)	90	9.57	10.74	12%	4	60	60	30	6.0	0	0	2	3	1.0	2.0	0	0	1	1	0	
8: Anus/Rectum - Hemorrhoids/Fistula																								
8	M	45000	Transrectal drainage of pelvic abscess	90	4.52	3.88	-14%	3	90	45	30	4.0	0	1	2	0	1.0	2.0	0	0	2	0	0	

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8	M	45020	Incision and drainage of deep supraleator, pelvirectal	90	4.72	4.05	-14%	3	90	38	30	4.0	0 0 1 2 1.0	3.0	0 0 2 1 0
8	M	45100	Biopsy of anorectal wall, anal approach (eg, congenita	90	3.68	3.16	-14%	3	60	30	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	45108	Anorectal myomectomy	90	4.76	4.09	-14%	3	60	45	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46040	Incision and drainage of ischioirectal and/or perirectal	90	4.96	4.26	-14%	3	60	30	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	M	46045	Incision and drainage of intramural, intramuscular, or s	90	4.32	3.71	-14%	3	60	25	30	2.0	0 0 0 1 1.0	3.0	0 0 2 1 0
8	M	46060	Incision and drainage of ischioirectal or intramural abs	90	5.69	4.89	-14%	3	60	50	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	M	46250	Hemorrhoidectomy, external, complete	90	4.53	3.89	-14%	3	60	40	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46255	Hemorrhoidectomy, internal and external, simple;	90	5.36	4.60	-14%	3	60	45	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46257	Hemorrhoidectomy, internal and external, simple; with	90	6.28	5.40	-14%	3	60	55	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46258	Hemorrhoidectomy, internal and external, simple; with	90	6.67	5.73	-14%	3	60	70	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	M	46260	Hemorrhoidectomy, internal and external, complex or	90	7.42	6.37	-14%	3	60	60	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46261	Hemorrhoidectomy, internal and external, complex or	90	8.24	7.08	-14%	3	60	70	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	F	46262	Hemorrhoidectomy, internal and external, complex or	90	8.73	7.50	-14%	3	40	45	20	0.5	0 0 0 0 0.5	3.0	0 0 1 2 0
8	M	46270	Surgical treatment of anal fistula (fistulectomy/fistulot	90	3.72	3.20	-14%	3	60	30	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46275	Surgical treatment of anal fistula (fistulectomy/fistulot	90	4.56	3.92	-14%	3	60	40	30	0.5	0 0 0 0 0.5	2.0	0 0 1 1 0
8	M	46280	Surgical treatment of anal fistula (fistulectomy/fistulot	90	5.98	5.14	-14%	3	60	60	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	M	46288	Closure of anal fistula with rectal advancement flap	90	7.13	6.13	-14%	3	60	65	30	0.5	0 0 0 0 0.5	3.0	0 0 2 1 0
8	M	46934	Destruction of hemorrhoids, any method; internal	90	4.08	3.51	-14%	3	30	23	20	0.0	0 0 0 0 0.0	2.0	0 0 1 1 0
8	M	46936	Destruction of hemorrhoids, any method; internal and	90	4.30	3.69	-14%	3	30	60	20	0.0	0 0 0 0 0.0	1.0	0 0 0 1 0
8	M	46945	Ligation of internal hemorrhoids; single procedure	90	2.14	1.84	-14%	3	30	15	30	0.0	0 0 0 0 0.0	2.0	0 0 1 1 0
8	M	46946	Ligation of internal hemorrhoids; multiple procedures	90	3.00	2.58	-14%	3	30	25	30	0.0	0 0 0 0 0.0	1.0	0 0 0 1 0

9a 9A: Anus/Rectum - 10 day global

9a	M	45900	Reduction of procidentia (separate procedure) under a	10	1.83	2.61	43%	4	90	15	20	2.0	0 0 1 0 1.0	1.0	0 0 0 1 0
9a	M	45905	Dilation of anal sphincter (separate procedure) under a	10	1.61	2.30	43%	4	60	15	20	0.5	0 0 0 0 0.5	1.0	0 0 0 1 0
9a	M	45910	Dilation of rectal stricture (separate procedure) under a	10	1.96	2.80	43%	4	60	15	20	0.5	0 0 0 0 0.5	1.0	0 0 0 1 0
9a	M	45915	Removal of fecal impaction or foreign body (separate	10	2.20	3.14	43%	4	60	30	20	0.5	0 0 0 0 0.5	1.0	0 0 0 1 0
9a	F	46221	Hemorrhoidectomy, by simple ligature (eg, rubber ban	10	1.43	2.04	43%	4	15	15	15	0.0	0 0 0 0 0.0	1.0	0 0 1 0 0
9a	M	46754	Removal of Thiersch wire or suture, anal canal	10	1.54	2.20	43%	4	20	20	15	2.0	0 0 0 1 1.0	3.0	0 0 2 1 0

9b 9B: Anus/Rectum - 10 day global

9b	M	46083	Incision of thrombosed hemorrhoid, external	10	1.40	1.40	0%	2							
9b	M	46230	Excision of external hemorrhoid tags and/or multiple p	10	2.57	2.57	0%	2							
9b	F	46320	Enucleation or excision of external thrombotic hemorr	10	1.61	1.61	0%	2							
9b	M	46935	Destruction of hemorrhoids, any method; external	10	2.43	2.43	0%	2							
9b	M	46940	Curettage or cauterization of anal fissure, including dil	10	2.32	2.32	0%	2							
9b	M	46942	Curettage or cauterization of anal fissure, including dil	10	2.04	2.04	0%	2							

9c 9C: Anus (destruction) - 10 day global

9c	M	46900	Destruction of lesion(s), anus (eg, condyloma, papillor	10	1.91	1.91	0%	2							
9c	M	46910	Destruction of lesion(s), anus (eg, condyloma, papillor	10	1.86	1.86	0%	2							
9c	M	46916	Destruction of lesion(s), anus (eg, condyloma, papillor	10	1.86	1.86	0%	2							
9c	M	46917	Destruction of lesion(s), anus (eg, condyloma, papillor	10	1.86	1.86	0%	2							

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9c	M	46922	Destruction of lesion(s), anus (eg, condyloma, papillor	10	1.86	1.86	0%	2																
9c	F	46924	Destruction of lesion(s), anus (eg, condyloma, papillor	10	2.76	2.76	0%	2																

10 10: Anus/Rectum - Repair

10	M	45505	Proctoplasty; for prolapse of mucous membrane	90	6.02	7.58	26%	4	90	83	30	0.5	0	0	0	0	0.5	3.0	0	1	1	1	0	0
10	M	45540	Proctopexy for prolapse; abdominal approach	90	12.92	16.27	26%	4	90	118	30	6.0	0	0	3	2	1.0	2.0	0	0	2	0	0	0
10	M	45541	Proctopexy for prolapse; perineal approach	90	10.64	13.40	26%	4	90	100	30	4.0	0	0	2	1	1.0	3.0	0	0	2	1	0	0
10	F	45550	Proctopexy combined with sigmoid resection, abdomi	90	18.26	23.00	26%	1	70	180	30	7.0	0	0	2	4	1.0	3.0	0	0	2	1	0	0
10	M	45560	Repair of rectocele (separate procedure)	90	8.40	10.58	26%	4	90	90	30	4.0	0	0	1	2	1.0	2.0	0	0	1	1	0	0
10	M	45562	Exploration, repair, and presacral drainage for rectal in	90	12.21	15.38	26%	4	90	95	30	7.0	0	2	2	2	1.0	4.0	0	0	2	2	0	0
10	M	45563	Exploration, repair, and presacral drainage for rectal in	90	18.63	23.47	26%	4	90	130	30	8.0	0	2	3	2	1.0	4.0	0	0	2	2	0	0
10	M	45800	Closure of rectovesical fistula;	90	14.11	17.77	26%	4	90	120	30	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0	0
10	M	45805	Closure of rectovesical fistula; with colostomy	90	16.50	20.78	26%	4	90	145	30	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0	0
10	M	45820	Closure of rectourethral fistula;	90	14.67	18.48	26%	4	90	100	30	6.0	0	0	3	2	1.0	3.0	0	0	2	1	0	0
10	M	45825	Closure of rectourethral fistula; with colostomy	90	16.87	21.25	26%	4	90	140	30	8.0	0	2	3	2	1.0	4.0	0	0	2	2	0	0
10	M	46700	Anoplasty, plastic operation for stricture; adult	90	7.25	9.13	26%	4	90	83	30	0.5	0	0	0	0	0.5	3.0	0	0	2	1	0	0
10	M	46750	Sphincteroplasty, anal, for incontinence or prolapse; a	90	8.14	10.25	26%	4	90	95	30	6.0	0	0	3	2	1.0	3.0	0	0	2	1	0	0
10	M	46753	Graft (Thiersch operation) for rectal incontinence and/	90	6.58	8.29	26%	4	90	60	30	3.0	0	0	0	2	1.0	2.0	0	0	1	1	0	0
10	M	46760	Sphincteroplasty, anal, for incontinence, adult; muscle	90	11.46	14.43	26%	4	90	170	30	7.0	0	2	2	2	1.0	5.0	0	1	2	2	0	0
10	M	46761	Sphincteroplasty, anal, for incontinence, adult; levator	90	10.99	13.84	26%	4	90	90	30	4.0	0	0	2	1	1.0	3.0	0	0	2	1	0	0
10	M	46762	Sphincteroplasty, anal, for incontinence, adult; implant	90	10.09	12.71	26%	4	90	120	30	6.0	0	1	2	2	1.0	4.0	0	0	2	2	0	0

11 11: Hernia

11	M	49500	Repair initial inguinal hernia, age 6 months to under 5	90	4.68	5.48	17%	4	45	45	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49501	Repair initial inguinal hernia, age 6 months to under 5	90	7.58	8.88	17%	4	45	60	30	2.0	0	0	0	1	1.0	2.0	0	0	1	1	0	0
11	F	49505	Repair initial inguinal hernia, age 5 years or over; redu	90	6.49	7.60	17%	4	37	60	20	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49507	Repair initial inguinal hernia, age 5 years or over; inca	90	8.17	9.57	17%	4	45	68	30	2.0	0	0	0	1	1.0	2.0	0	0	1	1	0	0
11	M	49520	Repair recurrent inguinal hernia, any age; reducible	90	8.22	9.63	17%	4	45	60	23	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49521	Repair recurrent inguinal hernia, any age; incarcerated	90	10.22	11.97	17%	4	45	90	30	2.0	0	0	0	1	1.0	2.0	0	0	1	1	0	0
11	M	49525	Repair inguinal hernia, sliding, any age	90	7.32	8.57	17%	4	45	60	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49540	Repair lumbar hernia	90	8.87	10.39	17%	4	45	85	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49550	Repair initial femoral hernia, any age; reducible	90	7.37	8.63	17%	4	45	60	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49553	Repair initial femoral hernia, any age; incarcerated or	90	8.06	9.44	17%	4	45	75	30	2.0	0	0	0	1	1.0	2.0	0	0	1	1	0	0
11	M	49555	Repair recurrent femoral hernia; reducible	90	7.71	9.03	17%	4	45	85	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49557	Repair recurrent femoral hernia; incarcerated or strang	90	9.52	11.15	17%	4	45	90	30	2.0	0	0	0	1	1.0	2.0	0	0	1	1	0	0
11	M	49560	Repair initial incisional or ventral hernia; reducible	90	9.88	11.57	17%	4	45	90	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49561	Repair initial incisional or ventral hernia; incarcerated	90	12.17	14.25	17%	4	45	100	30	4.0	0	0	2	1	1.0	2.0	0	0	1	1	0	0
11	M	49565	Repair recurrent incisional or ventral hernia; reducible	90	9.88	11.57	17%	4	45	100	30	3.0	0	0	1	1	1.0	2.0	0	0	1	1	0	0
11	M	49566	Repair recurrent incisional or ventral hernia; carcera	90	12.30	14.40	17%	4	45	120	30	4.0	0	0	2	1	1.0	2.0	0	0	1	1	0	0
11	M	49570	Repair epigastric hernia (eg, preperitoneal fat); reducti	90	4.86	5.69	17%	4	45	60	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0
11	M	49572	Repair epigastric hernia (eg, preperitoneal fat); incarce	90	5.75	6.73	17%	4	45	60	30	4.0	0	0	2	1	1.0	2.0	0	0	1	1	0	0
11	M	49580	Repair umbilical hernia, under age 5 years; reducible	90	3.51	4.11	17%	4	45	38	30	0.5	0	0	0	0	0.5	2.0	0	0	1	1	0	0

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11	M	49582	Repair umbilical hernia, under age 5 years; incarcerated	90	5.68	6.65	17%	4	45	48	30	2.0	0 0 0 1	1.0	2.0	0 0 1 1 0
11	M	49585	Repair umbilical hernia, age 5 years or over; reducible	90	5.32	6.23	17%	4	45	45	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1 0
11	M	49587	Repair umbilical hernia, age 5 years or over; incarcerated	90	6.46	7.56	17%	4	45	60	30	2.0	0 0 0 1	1.0	2.0	0 0 1 1 0
11	M	49590	Repair spigelian hernia	90	7.29	8.54	17%	4	45	60	30	0.5	0 0 0 0	0.5	2.0	0 0 1 1 0

12a 12A: Stomach - Gastrectomy

12a	M	43620	Gastrectomy, total; with esophagoenterostomy	90	22.54	30.04	33%	4	75	180	30	10.0	2 2 3 2	1.0	3.0	0 0 2 1 0
12a	M	43621	Gastrectomy, total; with Roux-en-Y reconstruction	90	23.06	30.73	33%	4	75	200	30	10.0	2 2 3 2	1.0	3.0	0 0 2 1 0
12a	M	43622	Gastrectomy, total; with formation of intestinal pouch	90	24.41	32.53	33%	4	75	230	30	10.0	2 2 3 2	1.0	3.0	0 0 2 1 0
12a	F	43638	Gastrectomy, partial, proximal, thoracic or abdominal	90	21.76	29.00	33%	4	75	210	30	10.0	0 2 2 5	1.0	4.0	0 1 2 1 0
12a	M	43639	Gastrectomy, partial, proximal, thoracic or abdominal	90	22.25	29.65	33%	4	75	210	30	10.0	2 2 3 2	1.0	3.0	0 0 2 1 0

12b 12B: Stomach - Gastrectomy/Vagotomy

12b	F	43631	Gastrectomy, partial, distal; with gastroduodenostomy	90	19.66	22.59	15%	4	75	150	30	8.0	0 0 2 5	1.0	3.0	0 0 2 1 0
12b	M	43632	Gastrectomy, partial, distal; with gastrojejunostomy	90	19.66	22.59	15%	4	75	150	30	8.0	0 2 3 2	1.0	3.0	0 0 2 1 0
12b	M	43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	90	20.10	23.10	15%	4	75	175	30	8.0	0 2 3 2	1.0	3.0	0 0 2 1 0
12b	M	43634	Gastrectomy, partial, distal; with formation of intestinal pouch	90	21.86	25.12	15%	4	75	200	30	8.0	0 2 3 2	1.0	3.0	0 0 2 1 0
12b	M	43640	Vagotomy including pyloroplasty, with or without gastrectomy	90	14.81	17.02	15%	4	60	120	30	7.0	0 2 2 2	1.0	3.0	0 0 2 1 0
12b	M	43641	Vagotomy including pyloroplasty, with or without gastrectomy	90	15.03	17.27	15%	4	60	150	30	7.0	0 2 2 2	1.0	3.0	0 0 2 1 0

13a 13A: Stomach - Incision/Excision/Repair

13a	M	43500	Gastrotomy; with exploration or foreign body removal	90	8.44	11.05	31%	4	60	60	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0
13a	M	43501	Gastrotomy; with suture repair of bleeding ulcer	90	15.31	20.04	31%	4	60	120	30	7.0	1 1 2 2	1.0	3.0	0 0 2 1 0
13a	M	43502	Gastrotomy; with suture repair of pre-existing esophageal stricture	90	17.67	23.13	31%	4	60	120	30	7.0	1 1 2 2	1.0	3.0	0 0 2 1 0
13a	M	43510	Gastrotomy; with esophageal dilation and insertion of dilator	90	9.99	13.08	31%	4	60	120	30	6.0	0 1 2 2	1.0	3.0	0 0 2 1 0
13a	M	43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt)	90	7.63	9.99	31%	4	60	60	30	4.0	0 1 1 1	1.0	2.0	0 0 1 1 0
13a	M	43605	Biopsy of stomach; by laparotomy	90	9.15	11.98	31%	4	60	60	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0
13a	M	43610	Excision, local; ulcer or benign tumor of stomach	90	11.15	14.60	31%	4	60	90	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0
13a	M	43611	Excision, local; malignant tumor of stomach	90	13.63	17.84	31%	4	60	100	30	7.0	0 2 2 2	1.0	3.0	0 0 2 1 0
13a	M	43800	Pyloroplasty	90	10.46	13.69	31%	4	60	90	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0
13a	M	43810	Gastroduodenostomy	90	11.19	14.65	31%	4	60	105	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1 0
13a	M	43820	Gastrojejunostomy; without vagotomy	90	11.74	15.37	31%	4	60	90	30	7.0	0 2 2 2	1.0	2.0	0 0 1 1 0
13a	M	43825	Gastrojejunostomy; with vagotomy, any type	90	14.68	19.22	31%	4	60	120	30	7.0	0 2 2 2	1.0	3.0	0 0 2 1 0
13a	F	43830	Gastrostomy, open; without construction of gastric tube	90	7.28	9.53	31%	4	50	60	25	5.0	0 0 1 3	1.0	2.0	0 0 2 0 0
13a	M	43832	Gastrostomy, open; with construction of gastric tube (Jejunum)	90	11.92	15.60	31%	4	60	75	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0
13a	M	43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer	90	11.89	15.56	31%	4	60	90	30	8.0	1 2 2 2	1.0	3.0	0 0 2 1 0
13a	M	43870	Closure of gastrostomy, surgical	90	7.40	9.69	31%	4	60	60	30	6.0	0 1 2 2	1.0	2.0	0 0 1 1 0

13b 13B: Stomach - Incision/Excision/Repair

13b	M	43842	Gastric restrictive procedure, without gastric bypass, fundoplication	90	14.71	18.47	26%	4	60	150	30	7.0	1 1 2 2	1.0	3.0	0 0 2 1 0
13b	M	43843	Gastric restrictive procedure, without gastric bypass, fundoplication	90	14.85	18.65	26%	4	60	150	30	7.0	1 1 2 2	1.0	3.0	0 0 2 1 0
13b	M	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity	90	19.15	24.05	26%	4	60	180	30	8.0	1 2 2 2	1.0	4.0	0 0 3 1 0
13b	M	43847	Gastric restrictive procedure, with gastric bypass for morbid obesity	90	21.44	26.92	26%	4	60	220	30	8.0	1 2 2 2	1.0	4.0	0 0 3 1 0
13b	M	43848	Revision of gastric restrictive procedure for morbid obesity	90	23.41	29.38	26%	4	75	180	30	8.0	1 2 2 2	1.0	4.0	0 0 3 1 0

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13b	M	43850	Revision of gastroduodenal anastomosis (gastroduodenal)	90	19.69	24.72	26%	4	75	150	30	8.0	0 2 3 2 1.0	3.0	0 0 2 1 0
13b	M	43855	Revision of gastroduodenal anastomosis (gastroduodenal)	90	20.83	26.16	26%	4	75	175	30	7.0	0 2 2 2 1.0	3.0	0 0 2 1 0
13b	F	43860	Revision of gastrojejunal anastomosis (gastrojejunal)	90	19.91	25.00	26%	1	75	180	30	10.0	0 2 2 5 1.0	3.0	0 0 2 1 0
13b	M	43865	Revision of gastrojejunal anastomosis (gastrojejunal)	90	21.12	26.52	26%	4	75	180	30	7.0	0 2 2 2 1.0	3.0	0 0 2 1 0
13b	M	43880	Closure of gastrocolic fistula	90	19.63	24.65	26%	4	60	120	30	7.0	0 2 2 2 1.0	3.0	0 0 2 1 0

14a 14A: Abdomen, Peritoneum, Omentum

14a	F	49000	Exploratory laparotomy, exploratory celiotomy with or without	90	11.68	11.68	0%	2							
14a	M	49002	Reopening of recent laparotomy	90	10.49	10.49	0%	2							
14a	M	49010	Exploration, retroperitoneal area with or without biopsy	90	12.28	12.28	0%	2							
14a	M	49200	Excision or destruction by any method of intra-abdominal	90	10.25	10.25	0%	2							
14a	M	49201	Excision or destruction by any method of intra-abdominal	90	14.84	14.84	0%	2							
14a	M	49220	Staging celiotomy (laparotomy) for Hodgkins disease	90	14.88	14.88	0%	2							
14a	M	49255	Omentectomy, epiploectomy, resection of omentum (small)	90	11.14	11.14	0%	2							
14a	M	49900	Suture, secondary, of abdominal wall for evisceration	90	12.28	12.28	0%	2							
14a	M	49421	Insertion of intraperitoneal cannula or catheter for drainage	90	5.54	5.54	0%	2							
14a	M	49422	Removal of permanent intraperitoneal cannula or catheter	10	6.25	6.25	0%	2							
14a	M	49425	Insertion of peritoneal-venous shunt	90	11.37	11.37	0%	2							
14a	M	49426	Revision of peritoneal-venous shunt	90	9.63	9.63	0%	2							
14a	M	49429	Removal of peritoneal-venous shunt	10	7.40	7.40	0%	2							

14b 14B: Abdomen, Peritoneum, Omentum

14b	F	49020	Drainage of peritoneal abscess or localized peritonitis	90	16.79	20.73	23%	4	60	120	30	11.0	1 2 2 5 1.0	4.0	0 1 2 1 0
14b	M	49040	Drainage of subdiaphragmatic or subphrenic abscess	90	9.94	12.27	23%	4	60	85	45	8.0	1 2 3 1 1.0	3.0	0 0 1 2 0
14b	M	49060	Drainage of retroperitoneal abscess; open	90	11.66	14.40	23%	4	60	85	45	7.0	1 2 2 1 1.0	3.0	0 0 1 2 0
14b	M	49085	Removal of peritoneal foreign body from peritoneal cavity	90	8.93	11.03	23%	4	60	60	30	6.0	0 1 3 1 1.0	2.0	0 0 1 1 0

14c 14C: Abdomen, Peritoneum, Omentum

14c	F	49428	Ligation of peritoneal-venous shunt	10	2.38	6.06	155%	1	45	35	23	3.0	0 0 1 1 1.0	2.0	0 0 1 1 0
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15 15: Appendix

15	M	44900	Incision and drainage of appendiceal abscess; open	90	8.82	10.14	15%	4	50	60	30	6.0	0 2 2 1 1.0	3.0	0 0 2 1 0
15	F	44950	Appendectomy;	90	8.70	10.00	15%	1	50	60	25	3.0	0 0 0 2 1.0	2.0	0 0 1 1 0
15	M	44960	Appendectomy; for ruptured appendix with abscess or	90	10.74	12.34	15%	4	50	75	30	6.0	0 2 2 1 1.0	3.0	0 0 1 2 0

16 16: Rectum - Proctectomy/Excision

16	F	45110	Proctectomy; complete, combined abdominoperineal, pull-through	90	23.80	28.00	18%	1	80	180	30	9.0	0 1 3 4 1.0	4.0	0 1 1 2 0
16	M	45112	Proctectomy, combined abdominoperineal, pull-through	90	25.96	30.54	18%	4	80	200	45	8.0	0 2 2 3 1.0	3.0	0 0 2 1 0
16	M	45113	Proctectomy, partial, with rectal mucosectomy, ileoanal	90	25.99	30.58	18%	4	80	200	45	8.0	0 2 2 3 1.0	3.0	0 0 2 1 0
16	M	45114	Proctectomy, partial, with anastomosis; abdominal approach	90	23.22	27.32	18%	4	80	210	45	9.0	1 2 3 2 1.0	3.0	0 1 1 1 0
16	M	45116	Proctectomy, partial, with anastomosis; transsacral approach	90	20.89	24.58	18%	4	80	160	45	8.0	1 2 2 2 1.0	3.0	0 1 1 1 0
16	M	45119	Proctectomy, combined abdominoperineal pull-through	90	26.21	30.84	18%	4	80	210	45	8.0	0 2 2 3 1.0	3.0	0 0 2 1 0
16	M	45123	Proctectomy, partial, without anastomosis, perineal approach	90	14.20	16.71	18%	4	80	270	45	6.0	0 1 2 2 1.0	3.0	0 1 1 1 0
16	M	45126	Pelvic exenteration for colorectal malignancy, with proctectomy	90	38.39	45.16	18%	4	80	120	45	9.0	2 2 2 2 1.0	4.0	0 1 2 1 0
16	M	45130	Excision of rectal procidentia, with anastomosis; perineal	90	13.97	16.44	18%	4	80	120	45	6.0	0 1 2 2 1.0	3.0	0 0 2 1 0

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16	M	45135	Excision of rectal procidentia, with anastomosis; abdom	90	16.39	19.28	18%	4	80	220	45	8.0	0	2	2	3	1.0	4.0	0	1	2	1	0	0
16	M	45160	Excision of rectal tumor by proctotomy, transsacral or	90	13.02	15.32	18%	4	80	60	45	3.0	0	0	0	2	1.0	3.0	0	1	1	1	0	0
16	M	45170	Excision of rectal tumor, transanal approach	90	9.77	11.49	18%	4	80	30	45	3.0	0	0	1	1	1.0	3.0	0	0	2	1	0	0
16	M	45190	Destruction of rectal tumor, any method (eg, electrode	90	8.28	9.74	18%	4	80	60	45	0.5	0	0	0	0	0.5	3.0	0	0	2	1	0	0

17 Biliary Tract

17	M	47420	Cholechootomy or choledochostomy with exploration	90	16.72	19.88	19%	4	75	180	30	6.0	0	2	2	1	1.0	3.0	0	0	1	2	0	0
17	M	47425	Cholechootomy or choledochostomy with exploration	90	16.68	19.83	19%	4	75	180	30	7.0	0	2	3	1	1.0	3.0	0	0	1	2	0	0
17	M	47460	Transduodenal sphincterotomy or sphincteroplasty, wi	90	15.17	18.04	19%	4	75	130	30	7.0	0	2	3	1	1.0	3.0	0	0	1	2	0	0
17	M	47480	Cholecystotomy or cholecystostomy with exploration,	90	9.10	10.82	19%	4	75	80	30	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0	0
17	M	47600	Cholecystectomy;	90	11.42	13.58	19%	4	75	80	30	4.0	0	1	1	1	1.0	2.0	0	0	1	1	0	0
17	M	47605	Cholecystectomy; with cholangiography	90	12.36	14.69	19%	4	75	90	30	4.0	0	1	1	1	1.0	2.0	0	0	1	1	0	0
17	M	47610	Cholecystectomy with exploration of common duct;	90	15.83	18.82	19%	4	75	120	30	6.0	0	2	2	1	1.0	2.0	0	0	1	1	0	0
17	M	47612	Cholecystectomy with exploration of common duct; wi	90	15.80	18.78	19%	4	75	150	45	7.0	0	2	3	1	1.0	2.0	0	0	1	1	0	0
17	M	47620	Cholecystectomy with exploration of common duct; wi	90	17.36	20.64	19%	4	75	180	45	7.0	0	2	3	1	1.0	2.0	0	0	1	1	0	0
17	M	47711	Excision of bile duct tumor, with or without primary rep	90	19.37	23.03	19%	4	75	180	45	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47712	Excision of bile duct tumor, with or without primary rep	90	25.44	30.24	19%	4	75	210	45	10.0	1	2	3	3	1.0	3.0	0	0	2	1	0	0
17	M	47715	Excision of choledochal cyst	90	15.81	18.80	19%	4	75	180	45	7.0	0	2	3	1	1.0	3.0	0	0	2	1	0	0
17	M	47716	Anastomosis, choledochal cyst, without excision	90	13.83	16.44	19%	4	75	120	45	7.0	0	2	3	1	1.0	3.0	0	0	2	1	0	0
17	M	47720	Cholecystoenterostomy; direct	90	13.38	15.91	19%	4	75	90	45	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0	0
17	M	47721	Cholecystoenterostomy; with gastroenterostomy	90	16.08	19.12	19%	4	75	120	45	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47740	Cholecystoenterostomy; Roux-en-Y	90	15.54	18.48	19%	4	75	120	45	7.0	0	2	3	1	1.0	3.0	0	0	2	1	0	0
17	M	47741	Cholecystoenterostomy; Roux-en-Y with gastroentero	90	17.95	21.34	19%	4	75	150	45	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47760	Anastomosis, of extrahepatic biliary ducts and gastroi	90	21.74	25.85	19%	4	75	130	45	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47765	Anastomosis, of intrahepatic ducts and gastrointestinal	90	20.93	24.88	19%	4	75	200	45	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
17	F	47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts	90	22.29	26.50	19%	1	75	190	30	8.0	0	2	2	3	1.0	3.0	0	1	1	1	0	0
17	M	47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts	90	26.23	31.18	19%	4	75	210	45	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47800	Reconstruction, plastic, of extrahepatic biliary ducts w	90	19.60	23.30	19%	4	75	163	45	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47801	Placement of choledochal stent	90	12.76	15.17	19%	4	75	110	30	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0	0
17	M	47802	U-tube hepaticoenterostomy	90	18.13	21.55	19%	4	75	160	30	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
17	M	47900	Suture of extrahepatic biliary duct for pre-existing injur	90	16.74	19.90	19%	4	75	120	45	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0	0

18 Esophagus - Repair/Reconstruction

18	M	43320	Esophagogastrostomy (cardioplasty), with or without v	90	16.07	19.93	24%	4	90	180	30	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
18	M	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, H	90	16.58	20.57	24%	4	90	120	30	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0	0
18	M	43325	Esophagogastric fundoplasty; with fundic patch (Thal-	90	16.17	20.06	24%	4	90	150	30	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0	0
18	M	43326	Esophagogastric fundoplasty; with gastropasty (eg, C	90	15.91	19.74	24%	4	90	150	30	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0	0
18	M	43330	Esophagomyotomy (Heller type); abdominal approach	90	15.94	19.77	24%	4	90	120	30	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0	0
18	M	43331	Esophagomyotomy (Heller type); thoracic approach	90	16.23	20.13	24%	4	90	120	30	7.0	1	2	2	1	1.0	3.0	0	0	2	1	0	0
18	M	43340	Esophagojejunostomy (without total gastrectomy); abd	90	15.81	19.61	24%	4	90	180	60	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
18	M	43341	Esophagojejunostomy (without total gastrectomy); tho	90	16.81	20.85	24%	4	90	180	60	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0	0
18	M	43350	Esophagostomy, fistulization of esophagus, external; a	90	12.72	15.78	24%	4	90	170	60	9.0	1	2	3	2	1.0	4.0	0	0	3	1	0	0

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18	M	43351	Esophagostomy, fistulization of esophagus, external; c	90	14.79	18.35	24%	4	90	165	60	9.0	1	2	3	2	1.0	4.0	0	0	3	1	0
18	M	43352	Esophagostomy, fistulization of esophagus, external; c	90	12.30	15.26	24%	4	90	90	60	7.0	0	2	2	2	1.0	3.0	0	0	2	1	0
18	F	43360	Gastrointestinal reconstruction for previous esophage	90	28.78	35.70	24%	4	90	270	40	9.0	0	2	3	3	1.0	4.0	0	1	2	1	0
18	M	43361	Gastrointestinal reconstruction for previous esophage	90	32.65	40.50	24%	4	90	300	60	12.0	3	3	3	2	1.0	4.0	0	0	3	1	0
18	M	43400	Ligation, direct, esophageal varices	90	17.09	21.20	24%	4	90	120	45	11.0	3	2	3	2	1.0	3.0	0	0	2	1	0
18	M	43401	Transection of esophagus with repair, for esophageal	90	17.81	22.09	24%	4	90	150	45	11.0	3	2	3	2	1.0	3.0	0	0	2	1	0
18	M	43405	Ligation or stapling at gastroesophageal junction for p	90	16.13	20.01	24%	4	90	135	45	11.0	3	2	3	2	1.0	4.0	0	0	3	1	0
18	M	43410	Suture of esophageal wound or injury; cervical approa	90	10.86	13.47	24%	4	90	90	30	7.0	1	2	2	1	1.0	3.0	0	0	2	1	0
18	F	43415	Suture of esophageal wound or injury; transthoracic or	90	17.06	25.00	47%	4	75	150	45	10.0	1	2	3	3	1.0	4.0	0	1	2	1	0
18	M	43420	Closure of esophagostomy or fistula; cervical approac	90	11.57	14.35	24%	4	90	90	30	6.0	0	2	2	1	1.0	3.0	0	0	2	1	0
18	M	43425	Closure of esophagostomy or fistula; transthoracic or	90	16.95	21.03	24%	4	90	180	45	11.0	2	2	3	3	1.0	3.0	0	0	2	1	0

19 19: Liver

19	M	47010	Hepatotomy; for open drainage of abscess or cyst, on	90	10.28	16.01	56%	4	75	100	30	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47015	Laparotomy, with aspiration and/or injection of hepatic	90	9.70	15.11	56%	4	75	120	30	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47100	Biopsy of liver, wedge	90	7.49	11.67	56%	4	75	60	30	4.0	0	0	1	2	1.0	3.0	0	0	2	1	0
19	F	47120	Hepatectomy, resection of liver; partial lobectomy	90	22.79	35.50	56%	1	75	225	30	9.0	1	2	3	2	1.0	4.0	0	1	1	2	0
19	M	47122	Hepatectomy, resection of liver; trisegmentectomy	90	35.39	55.13	56%	4	75	300	45	11.0	3	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47125	Hepatectomy, resection of liver; total left lobectomy	90	31.58	49.19	56%	4	75	225	45	10.0	2	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47130	Hepatectomy, resection of liver; total right lobectomy	90	34.25	53.35	56%	4	75	240	45	10.0	2	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47300	Marsupialization of cyst or abscess of liver	90	9.68	15.08	56%	4	75	100	30	8.0	1	2	2	2	1.0	3.0	0	0	2	1	0
19	M	47350	Management of liver hemorrhage; simple suture of live	90	12.56	19.56	56%	4	75	90	30	7.0	1	2	2	1	1.0	3.0	0	0	2	1	0
19	M	47360	Management of liver hemorrhage; complex suture of li	90	17.28	26.92	56%	4	75	158	45	11.0	3	2	3	2	1.0	3.0	0	0	2	1	0
19	M	47361	Management of liver hemorrhage; exploration of hepa	90	30.25	47.12	56%	4	75	190	45	14.0	4	3	3	3	1.0	3.0	0	0	2	1	0
19	M	47362	Management of liver hemorrhage; re-exploration of he	90	11.88	18.51	56%	4	75	90	45	13.0	4	2	3	3	1.0	3.0	0	0	2	1	0
19	M	47400	Hepaticotomy or hepaticostomy with exploration, drain	90	20.86	32.49	56%	4	75	180	45	10.0	2	2	3	2	1.0	3.0	0	0	2	1	0

20a 20A: Spleen - Incision/Excision/Repair

20a	F	38100	Splenectomy; total (separate procedure)	90	13.01	14.50	11%	4	55	90	30	6.0	0	0	1	4	1.0	2.0	0	0	1	1	0
20a	M	38101	Splenectomy; partial (separate procedure)	90	13.74	15.31	11%	4	83	120	30	6.0	0	0	2	3	1.0	2.0	0	0	1	1	0
20a	M	38115	Repair of ruptured spleen (splenorhaphy) with or with	90	14.19	15.82	11%	4	83	120	30	7.0	1	0	2	3	1.0	2.0	0	0	1	1	0

20b 20B: Pancreatitis management

20b	M	48000	Placement of drains, peripancreatic, for acute pancrea	90	14.91	28.07	88%	4	83	120	30	10.0	2	2	3	2	1.0	3.0	0	0	2	1	0
20b	M	48001	Placement of drains, peripancreatic, for acute pancrea	90	18.83	35.45	88%	4	83	143	45	10.0	2	3	3	1	1.0	3.0	0	0	2	1	0
20b	F	48005	Resection or debridement of pancreas and peripancre	90	22.40	42.17	88%	4	83	180	38	20.5	3	4	5	8	1.0	4.0	0	1	2	1	0

21 21: Pancreatectomy

21	M	48020	Removal of pancreatic calculus	90	14.22	15.70	10%	4	83	125	30	9.0	1	2	3	2	1.0	3.0	0	0	2	1	0
21	M	48100	Biopsy of pancreas, open, any method (eg, fine needle	90	11.08	12.23	10%	4	83	78	30	7.0	0	2	2	2	1.0	2.0	0	0	1	1	0
21	M	48120	Excision of lesion of pancreas (eg, cyst, adenoma)	90	14.36	15.85	10%	4	83	135	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0
21	M	48500	Marsupialization of cyst of pancreas	90	13.84	15.28	10%	4	83	120	30	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0
21	M	48510	External drainage, pseudocyst of pancreas; open	90	12.96	14.31	10%	4	83	98	30	8.0	0	2	3	2	1.0	3.0	0	0	2	1	0
21	M	48520	Internal anastomosis of pancreatic cyst to gastrointest	90	14.12	15.59	10%	4	83	120	30	8.0	0	2	3	2	1.0	2.0	0	0	1	1	0

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21	M	48540	Internal anastomosis of pancreatic cyst to gastrointest	90	17.86	19.72	10%	4	83	140	30	7.0	0 2 2 2 1.0	2.0	0 0 1 1 0
21	M	48545	Pancreatorrhaphy for trauma	90	16.47	18.18	10%	4	83	120	45	10.0	2 3 2 2 1.0	3.0	0 0 2 1 0
21	M	48547	Duodenal exclusion with gastrojejunostomy for pancre	90	23.40	25.83	10%	4	83	180	45	11.0	3 3 2 2 1.0	3.0	0 0 2 1 0
21	M	48140	Pancreatectomy, distal subtotal, with or without splene	90	20.78	22.94	10%	4	90	150	45	9.0	1 2 3 2 1.0	3.0	0 0 2 1 0
21	M	48145	Pancreatectomy, distal subtotal, with or without splene	90	21.76	24.02	10%	4	90	188	45	9.0	1 2 3 2 1.0	3.0	0 0 2 1 0
21	M	48146	Pancreatectomy, distal, near-total with preservation of	90	23.91	26.40	10%	4	90	225	45	10.0	2 2 3 2 1.0	4.0	0 0 3 1 0
21	M	48148	Excision of ampulla of Vater	90	15.71	17.34	10%	4	90	165	45	8.0	1 2 2 2 1.0	3.0	0 0 2 1 0
21	F	48150	Pancreatectomy, proximal subtotal with total duodene	90	43.48	48.00	10%	4	90	345	45	13.0	2 2 4 4 1.0	4.0	0 1 2 1 0
21	M	48152	Pancreatectomy, proximal subtotal with total duodene	90	39.63	43.75	10%	4	90	300	45	13.0	2 3 3 4 1.0	4.0	0 0 3 1 0
21	M	48153	Pancreatectomy, proximal subtotal with near-total duo	90	43.38	47.89	10%	4	90	315	45	13.0	2 3 3 4 1.0	4.0	0 0 3 1 0
21	M	48154	Pancreatectomy, proximal subtotal with near-total duo	90	39.95	44.10	10%	4	90	290	45	12.0	2 3 3 3 1.0	4.0	0 0 3 1 0
21	M	48155	Pancreatectomy, total	90	22.32	24.64	10%	4	90	300	45	12.0	2 3 3 3 1.0	4.0	0 0 3 1 0
21	M	48180	Pancreaticojejunostomy, side-to-side anastomosis (Pu	90	22.39	24.72	10%	4	90	190	45	9.0	1 2 3 2 1.0	3.0	0 0 2 1 0

22 22: Laparoscopy

22	M	49320	Laparoscopy, surgical, abdomen, peritoneum, and om	10	5.10	5.10	0%	2							
22	F	47562	Laparoscopy, surgical; cholecystectomy	90	11.09	11.09	0%	2							
22	M	47563	Laparoscopy, surgical; cholecystectomy with cholangi	90	11.94	11.94	0%	2							
22	M	47564	Laparoscopy, surgical; cholecystectomy with explorati	90	14.23	14.23	0%	2							
22	M	47570	Laparoscopy, surgical; cholecystoenterostomy	90	12.58	12.58	0%	2							
22	M	44970	Laparoscopy, surgical, appendectomy	90	8.70	8.70	0%	2							
22	M	43651	Laparoscopy, surgical; transection of vagus nerves, tr	90	10.15	10.15	0%	2							
22	M	43652	Laparoscopy, surgical; transection of vagus nerves, se	90	12.15	12.15	0%	2							
22	M	44200	Laparoscopy, surgical; enterolysis (freeing of intestinal	90	14.44	14.44	0%	2							
22	M	49650	Laparoscopy, surgical; repair initial inguinal hernia	90	6.27	6.27	0%	2							
22	M	49651	Laparoscopy, surgical; repair recurrent inguinal hernia	90	8.24	8.24	0%	2							

CPT Code: 60220

Current RVW: 10.53
Survey Median RVW: 12.50
ACS Recommended RVW: 12.50
RUC Recommended RVW: 11.90

CPT Descriptor: Total thyroid lobectomy, unilateral; with or without isthmusectomy

Global Period: 90 days

Typical Patient: A 37-year-old female presents with dysphagia and a 1.5 cm palpable thyroid nodule in the lower pole of the right lobe that is cold on radionuclide scan, solid by sonography, and fine needle aspiration cytology is non-diagnostic. The esophagus is deviated by the nodule on barium swallow. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a neck exploration is performed, with exposure and examination of both sides of the thyroid. The right lobe is carefully dissected and appropriate nerves and parathyroid glands identified and preserved. The right lobe of the thyroid and a portion of the isthmus is resected. Frozen section reveals thyroid adenoma. The neck is closed in a standard fashion, with drainage of the neck included as indicated. Postoperatively, the patient is advanced to a diet and intravenous fluids and injectable pain medications are tapered as tolerated. The patient is discharged from the hospital when the calcium level is stable, phonating well, tolerating a diet, and comfortable on oral pain medications. Office visits are conducted as necessary during the 90-day global period to ensure that no wound complications or infections occur. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for Ambulatory Surgery Unit admission and for pre-operative medications
- Review pre-operative work-up, with particular attention to cytopathology reports
- Review pre-operative work-up with regards to laryngotracheal or esophageal compression
- Review pre-operative work-up with attention to adequacy thyroid function
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent

Intra-service work - Skin to skin:

- The neck is opened through a collar incision.
- Both thyroid lobes are palpated through the strap muscles and the presence of a single right-sided nodule confirmed.
- The strap muscles are elevated and rotated laterally to expose the right lobe and isthmus.
- The gross features of the nodule are consistent with colloid nodule.
- The lobe is meticulously dissected free from its attachments, with ligature control of branch vessels near the lobe in order to preserve parathyroid blood supply.
- The recurrent laryngeal nerve is identified near its intersection with the inferior thyroid artery, and the nerve is traced carefully to its laryngeal entry.

- The external branch of the superior laryngeal nerve is sought during division of the superior pole vessels.
- The isthmus is freed from the trachea and divided near its junction with the left lobe.
- The lobe and isthmus are sent to surgical pathology, where frozen section discloses a right colloid nodule.
- Parathyroid viability is re-confirmed, and hemostasis assured.
- The strap muscles are sutured in layers, the platysma is closed, and skin is reapproximated. A sterile dressing is applied

Post-op Same day work through discharge from recovery

- Apply dressings
- Write brief operative note
- Write orders for post-op medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate operative report
- Discuss procedure findings and outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress, with particular attention to airway and voice
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work

- The patient's diet is rapidly advanced and parenteral analgesics are stopped
- Patient is discharged with wound care, activity, and follow-up instructions.

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Review follow-up plans with patient/family
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- At the first postoperative visit, the final pathology report is reviewed with the patient and family.
- Patient is seen back one or more visits to ensure that neck range of motion, phonation, respiration, and swallowing have returned to their pre-morbid state.
- The surgeon periodically updates the patient's primary care physician about the operative findings and the patient's status.
- Answer patient/family questions
- Answer insurance staff questions

- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS
 Charles P. Shoemaker, MD, FACS

Specialty(s): American College of Surgeons
 American Society of General Surgeons

Type of Sample: 90% Random (mail/fax) and 10% Convenience (specialty meeting)

Survey CPT Code: 60220

Sample Size:	290	Response: 69 24%			
	Low	25th pctl	Median	75th pctl	High
Survey RVW	9.09	11.90	12.50	14.14	22.59
Pre-Service	63				
Intra-Service	60	90	90	120	240

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	25	
Critical Care	0	
Other Hospital	19	99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	10.88	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>60220</u>	<u>60210</u>
Survey response	69	31
Pre-service time	63	60
Intra-service time	90	90
Immediate Post-service time	25	25
Total critical care time	0	0
Total other hospital visit time	19	19
Discharge management time	36	36
Total office visit time	38	38
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.48	3.39
Intra-service	4.04	3.97
Post-service	3.16	3.03
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.51	3.42
Urgency of medical decision making	2.94	2.81
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.28	4.13
Physical effort required	3.43	3.43
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.10	3.94
Outcome depends on the skill and judgment of physician	4.26	4.13
Estimated risk of malpractice suit with poor outcome	4.09	4.06

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
60220			
Pre-service total	63	0.0224	1.40
Intra-service	90	0.075	6.75
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	1	0.64	0.64
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			3.56
Total RVW by Building Block Method =			11.71

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

2,971	general surgery	5	ophthalmology
1,359	otolaryngology	3	endocrinology
138	clinic or group practice (not gppp)	3	hematology/oncology
90	thoracic surgery	3	internal medicine
81	vascular surgery	2	allergy/immunology
61	surgical oncology	2	cardiology
23	general practice	2	emergency medicine
20	plastic & reconstructive surgery	2	orthopaedic surgery
13	cardiac surgery	1	anesthesiology
12	family practice	1	medical oncology
9	maxillofacial surgery	1	oral surgery (dentists only)
7	colorectal surgery	1	urology
6	peripheral vascular disease		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 6 Yes
- 63 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 6 I do not agree

c. Patients requiring this service are now:

- 5 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 1 from inpatient to outpatient
- 5 no change

CPT Code: 38745

Current RVW: 8.84
Survey Median RVW: 13.10
ACS Recommended RVW: 13.10
RUC Recommended RVW: 11.00

CPT Descriptor: Axillary lymphadenectomy; complete

Global Period: 90 days

Typical Patient: A 65-year-old female presents with enlarged lymph nodes in her left axilla, five years post-excision of a melanoma of the left arm. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. The patient undergoes a complete axillary lymphadenectomy of the left axilla to remove all nodes present in the area. A closed system suction drain is inserted into the operative site. After a routine postoperative hospital stay and wound/drain care instructions have been given, the patient is discharged to be followed up in the office on a regular basis to check the wound and drainage levels. The drain is removed after the volume of drainage has decreased to acceptable levels. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect further care of the patient through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Care must be taken to ensure the complete surgical preparation/scrub of the entire ipsilateral chest/breast, arm including fingers.
- Supervise the draping of the entire arm to ensure sterility as well as to prevent undue tension on the brachial plexus, yet allowing the arm to be carefully moved and re-positioned in enhance exposure of higher axillary structures.
- Scrub and gown

Intra-service work – Skin to Skin:

- The skin incision is made in a transverse axillary line, caudal to the axillary hair-bearing skin, in the usual fashion.
- The incision is carried down through the subcutaneous tissue, carefully identifying the lateral edge of the pectoral major muscle and the anterior edge of the latissimus dorsi muscle.
- The dissection identifies the clavipectoral fascia, which is the antero-lateral border of the axillary envelop.

- The infero-medial aspect of the axilla, at its junction/confluence with the axillary tail of the breast is dissected out, down to the chest wall.
- Superiorly the anterior border of the axillary vessels is identified.
- The clavipectoral fascia is incised and the axilla identified.
- The lymphatic tissue is removed from beneath the pectoral minor, at the superior extent, infero-laterally, off of the axillary vein, and including the nodal tissue between the latissimus dorsi muscle and the chest wall.
- The long thoracic nerve of Bell and the thoraco-dorsal nerve, as well as the thoraco-dorsal artery and vein are identified dissected free and preserved intact throughout this procedure.
- The lymphatic tissue is dissected from superiorly and medially, inferiorly to the previous landmarks.
- Bridging vessels and lymphatics are ligated with fine ties or by cautery; meticulous hemostasis must be obtained.
- The specimen is oriented and delivered to the pathologist for permanent histological examination.
- A closed suction drain tube is placed through a separate stab incision, placed medial and along the latissimus dorsi muscle, extending superiorly to but not contacting the brachial plexus. It is secured to the skin with a nylon suture.
- The wound is copiously irrigated, and once again hemostasis is assured.
- The wound is closed in layers, using absorbable sutures to re-approximate the subcutaneous tissues, and the skin is closed in the usual fashion.

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
Paul E. Collicott, MD, FACS
Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 85% Random (mail/fax) and 15% Convenience (specialty meeting)

Survey CPT Code: 38745

Sample Size:	140	Response:	40	29%	
	Low	25th pctl	Median	75th pctl	High
Survey RVW	9.00	12.15	13.10	14.29	23.91
Pre-Service			58		
Intra-Service	30	75	90	94	180
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	18	99238 x .5			
Office Visits	76	99214x1 99213x1 99212x1			

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	10.88	90

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

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

	<u>Svy CPT</u> 38745	<u>Ref CPT</u> 60210
<u>TIME ESTIMATES (MEDIAN)</u>		
Survey response	40	12
Pre-service time	58	50
Intra-service time	90	90
Immediate Post-service time	25	25
Total critical care time	0	0
Total other hospital visit time	19	19
Discharge management time	18	18
Total office visit time	76	38
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.36	3.25
Intra-service	3.66	3.64
Post-service	3.18	3.09
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.23	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.42
Urgency of medical decision making	3.18	2.75
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.82	3.75
Physical effort required	3.49	3.08
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.64	3.75
Outcome depends on the skill and judgment of physician	3.77	4.08
Estimated risk of malpractice suit with poor outcome	3.59	4.08

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:			Work RVU
38745	Time	Intensity	(=time x intensity)
Pre-service total	58	0.0224	1.29
Intra-service	90	0.070	6.30
Post-service			
Immediate post	25	0.0224	0.56
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	.5	1.28	0.64
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			3.36
Total RVW by Building Block Method =			10.95

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

4,555	general surgery	4	emergency medicine
335	surgical oncology	4	medical oncology
152	clinic or group practice (not gppp)	3	critical care (intensivists)
87	vascular surgery	3	hand surgery
84	plastic & reconstructive surgery	3	hematology/oncology
62	thoracic surgery	3	peripheral vascular disease
32	general practice	2	pathology
18	maxillofacial surgery	2	pediatric medicine
10	family practice	2	physician assistant
10	obstetrics/gynecology	1	anesthesiology
10	urology	1	cardiology
6	cardiac surgery	1	internal medicine
5	infectious disease	1	nurse practitioner
5	orthopaedic surgery	1	ophthalmology
4	colorectal surgery	1	osteopathic manipulative therapy

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 11 Yes
- 29 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 3 I agree
- 8 I do not agree

c. Patients requiring this service are now:

- 9 more complex (more work)
- 0 less complex (less work)
- 2 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 6 from inpatient to outpatient
- 5 no change

CPT Code: 38500Current RVW: 2.88
Survey Median RVW: 5.00
ACS Recommended RVW: 3.75
RUC Recommended RVW: 3.75**CPT Descriptor:** Biopsy or excision of lymph node(s); superficial (separate procedure)**Global Period:** 10 days

Typical Patient: A 60-year-old female is referred with persistently enlarged superficial axillary nodes. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, under local anesthesia, an incision is made, the nodes are mobilized and vessels ligated. After discharge, the patient is seen for suture removal. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient. [Note: the global period for this codes is 10 days.]

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):**Pre-service work - Day before surgery:**

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to mammogram, chest x-ray, and other films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with patient and nursing staff
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- Xylocaine with epinephrine is injected along the proposed skin incision to provide hemostasis and local anesthesia.
- A skin incision is made and the subcutaneous tissues are carefully incised.
- A Gelpi or Wheatlander self-retaining retractor is placed to maintain exposure.
- The claviopectoral fascia is carefully incised overlying the pathological lymph node
- By careful blunt, sharp, monopolar/bipolar electrocautery dissection, the pathological lymph node is dissected free circumferentially.
- The small lymphatics and bridging blood vessels are carefully dissected out and ligated with fine ties or cautery.
- The pathological lymph node is removed bisected, submitting a portion for cultures, and delivering the remainder to the pathologist for histological examination.
- The wound is carefully inspected for hemostasis; additional ligation or cautery is performed.

- The wound is irrigated; no drain is placed.
- The subcutaneous tissue is carefully reapproximated using individual sutures; the skin is separately reapproximated.

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS
 Charles P. Shoemaker, MD, FACS

Specialty(s): American College of Surgeons
 American Society of General Surgeons

Type of Sample: 90% Random (mail/fax) and 10% Convenience (specialty meeting)

Survey CPT Code: 38500

Sample Size:	150	Response:	41	27%	
	Low	25th pctl	Median	75th pctl	High
Survey RWW	2.50	3.75	5.00	5.61	11.40
Pre-Service			35		
Intra-Service	20	30	30	40	60

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	15	
Critical Care	0	
Other Hospital	0	
Discharge Day Mgmt	18	99238 x .5
Office Visits	15	99212x1

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

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

<u>TIME ESTIMATES (MEDIAN)</u>	<u>Svy CPT</u> <u>38500</u>	<u>Ref CPT</u> <u>36533</u>
Survey response	41	8
Pre-service time	35	33
Intra-service time	30	38
Immediate Post-service time	18	18
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	18	18
Total office visit time	15	53
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.49	2.63
Intra-service	2.49	2.63
Post-service	2.27	2.75
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.73	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.00
Urgency of medical decision making	2.20	2.00
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	2.76	2.38
Physical effort required	2.20	2.50
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	2.44	2.38
Outcome depends on the skill and judgment of physician	2.60	2.63
Estimated risk of malpractice suit with poor outcome	2.25	2.25

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Although we believe the total work for this procedure was underestimated by the Harvard study, we believe the survey respondents overestimated the work RVU for the total work of this service. This is supported by the building block analysis of the survey data as shown below. Therefore, we recommend the 25th percentile RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:			Work RVU
38500			(=time x intensity)
Pre-service total	Time	Intensity	0.78
Intra-service	35	0.0224	1.50
Post-service	30	0.050	
Immediate post	15	0.0224	0.34
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	.5	1.28	0.64
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	0	0.65	0.00
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			1.41
Total RVW by Building Block Method =			3.69

FREQUENCY INFORMATION

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

General Surgery Commonly

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

7,164	general surgery	12	maxillofacial surgery
465	otolaryngology	12	orthopaedic surgery
330	clinic or group practice (not gppp)	11	medical oncology
261	thoracic surgery	11	peripheral vascular disease
203	vascular surgery	7	emergency medicine
182	plastic & reconstructive surgery	6	critical care (intensivists)
177	surgical oncology	5	hematology/oncology
162	anesthesiology	5	oral surgery (dentists only)
118	urology	4	pediatric medicine
83	diagnostic radiology	2	neurosurgery
77	cardiac surgery	2	ophthalmology
70	obstetrics/gynecology	2	osteopathic manipulative therapy
60	family practice	1	allergy/immunology
57	general practice	1	cna, anesthesia assistant
43	colorectal surgery	1	endocrinology
31	gynecology/oncology	1	gastroenterology
24	cardiology	1	geriatric medicine
22	interventional radiology	1	hand surgery
20	pathology	1	physical medicine and rehabilitation
18	internal medicine	1	physician assistant
13	dermatology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 5 Yes
- 36 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 4 I do not agree

c. Patients requiring this service are now:

- 3 more complex (more work)
- 0 less complex (less work)
- 2 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 4 from inpatient to outpatient
- 1 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 38510

Current RVW: 4.14
Survey Median RVW: 7.71
ACS Recommended RVW: 7.71
RUC Recommended RVW: 6.43

CPT Descriptor: Biopsy or excision of lymph node(s); deep cervical node(s)

Global Period: 90 days

Typical Patient: A 68-year-old male is referred by an oncologist, with an enlarged deep cervical node and a prior fine-needle aspirate suspicious for lymphoma. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. The patient undergoes complete excision of the lymph node, located in the internal jugular lymph node chain, with frozen section confirming abnormal cells consistent with lymphoma. He has a routine postoperative course and is discharged to be followed up in-office through the 90-day global period, including checking the wound for signs of infection and fluid accumulation. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- Xylocaine with epinephrine is injected along the proposed skin incision to provide hemostasis.
- A skin incision is made and the platysma carefully incised.
- Flaps are developed immediately beneath the platysma, using sharp dissection.
- Care is taken to identify the marginal mandibular branch of the facial nerve.
- A Gelpi or Wheatlander self-retaining retractor is placed to maintain exposure.
- The deep cervical fascia is carefully incised overlying the pathological lymph node
- By careful blunt, sharp, monopolar/bipolar electrocautery dissection, the pathological lymph node is dissected free circumferentially.
- Care is taken to identify and protect the hypoglossal (CNN XII) and spinal accessory (CNN XI) nerves.
- The small lymphatics and bridging blood vessels are carefully dissected out and ligated with fine ties or cautery.

- The pathological lymph node is removed bisected, submitting a portion for cultures, and delivering the remainder to the pathologist for histological examination.
- The wound is carefully inspected for hemostasis; additional ligation or cautery is performed.
- The wound is irrigated; no drain is placed.
- The platysma is carefully reapproximated using individual sutures; the skin is separately reapproximated.

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications

- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 85% Random (mail/fax) and 15% Convenience (specialty meeting)

Survey CPT Code: 38510

Sample Size: 140 **Response:** 32 23%

	Low	25th pctl	Median	75th pctl	High
Survey RWV	4.50	6.25	7.71	9.53	10.88

Pre-Service 45

Intra-Service 25 40 45 60 80

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	20	
Critical Care	0	
Other Hospital	0	
Discharge Day Mgmt	18	99238x.5
Office Visits	23	99213x1

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	10.88	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>38510</u>	<u>60210</u>
Survey response	32	11
Pre-service time	45	60
Intra-service time	45	75
Immediate Post-service time	20	25
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	18	18
Total office visit time	23	23
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.59	3.13
Intra-service	2.97	3.50
Post-service	2.55	2.88
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.75	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.97	3.10
Urgency of medical decision making	2.78	3.10
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.22	3.60
Physical effort required	2.78	3.30
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.06	3.20
Outcome depends on the skill and judgment of physician	3.00	3.30
Estimated risk of malpractice suit with poor outcome	2.88	3.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
38510				
Pre-service total		45	0.0224	1.01
Intra-service		45	0.065	2.93
Post-service				
Immediate post		20	0.0224	0.45
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	0	0.64	0.00
	99232	0	1.06	0.00
	99233	0	1.51	0.00
	99238	.5	1.28	0.64
	99211	0	0.17	0.00
	99212	0	0.43	0.00
	99213	1	0.65	0.65
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				1.64
Total RVW by Building Block Method =				5.67

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

4,819	general surgery	9	cardiology
2,593	otolaryngology	9	ophthalmology
255	clinic or group practice (not gppp)	8	obstetrics/gynecology
238	thoracic surgery	8	orthopaedic surgery
205	plastic & reconstructive surgery	6	hand surgery
146	vascular surgery	5	anesthesiology
143	surgical oncology	5	gynecology/oncology
60	diagnostic radiology	5	oral surgery (dentists only)
56	general practice	3	ASC
48	cardiac surgery	3	hematology/oncology
28	family practice	3	infectious disease
22	colorectal surgery	2	dermatology
19	maxillofacial surgery	2	medical oncology
15	internal medicine	1	crna, anesthesia assistant
14	urology	1	gastroenterology
13	peripheral vascular disease	1	neurosurgery
11	emergency medicine	1	pediatric medicine
10	interventional radiology	1	radiation oncology

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 3 Yes
- 29 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 3 I do not agree

c. Patients requiring this service are now:

- 3 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 1 from inpatient to outpatient
- 2 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44050

Current RVW: 11.40
Survey Median RVW: 15.90
ACS Recommended RVW: 15.90
RUC Recommended RVW: 14.03

CPT Descriptor: Reduction of volvulus, intussusception, internal hernia, by laparotomy

Global Period: 90 days

Typical Patient: An 80-year-old male presents to the ER with abdominal cramps and vomiting. He had a previous appendectomy. Abdominal x-rays confirm small bowel obstruction. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the exploratory procedure with the patient, and obtains informed consent. At operation, a midline incision is made. Exploration finds small bowel obstruction with an internal hernia secondary to adhesions. Once the adhesions are lysed, the bowel regained normal color and the wound closed. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, hematologic status, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous fluids are discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet. Office visits are conducted as necessary through the 90-day global period to ensure that no delayed abdominal, gastrointestinal problems, wound complications or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

Because this is an emergency procedure, there is no Day before surgery work to describe.

Pre-service work - Day of surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to abdominal x-ray films
- Review planned incisions and procedure
- Confirm OR start time – notify pt. and family
- Arrange for surgical asst.
- Change into scrub clothes
- Check with lab – make certain blood and/or x-match is available
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- Skin incision is made and anterior abdominal wall is carefully divided.
- The peritoneal cavity is entered and the bowel protected.
- A self-retaining retractor is inserted to facilitate exposure
- Adhesions are carefully divided freeing the small intestine from the abdominal incision and other viscera
- A complete exploration is carried out to determine extent of disease, and biopsies of suspicious areas or lymph nodes taken and appropriate frozen sections requested if necessary.
- Cultures are taken of any potentially infected peritoneal fluid
- A volvulus point around adhesions to the cecum is identified and freed up
- The obstructed segment of small bowel is released, any additional adhesions divided
- The bowel is wrapped in warm sterile towels and observed; palpation and observation of the associated mesenteric vessels is carried out.
- Pathology is contacted to be certain that no unsuspected findings are present if indicated
- Any fluid or material for culture is placed in appropriate culture containers/media and sent for microbiological exam
- The abdominal cavity is checked meticulously for bleeding and copiously irrigated with sterile saline
- The abdominal wall is closed in the usual fashion
- The skin is closed

Post-op Same day work through discharge from recovery

- Apply dressings
- Write an op note in the patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed, and fill out pathology and bacteriology/microbiology forms
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of abdominal dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Check function of NG tube, fluid and electrolyte status and urine output
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Determine when NG tube can be removed and oral intake started
- Carefully evaluate return of bowel function, any temperature elevation, and any wound drainage
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions

- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check final pathology report and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	11.23	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>44050</u>	<u>44800</u>
Survey response	36	9
Pre-service time	60	55
Intra-service time	83	60
Immediate Post-service time	30	25
Total critical care time	0	0
Total other hospital visit time	136	87
Discharge management time	36	36
Total office visit time	38	46
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.97	3.33
Intra-service	3.67	3.17
Post-service	3.61	3.17
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.14	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.33
Urgency of medical decision making	4.36	3.50
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.78	3.33
Physical effort required	3.63	3.00
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.17	3.33
Outcome depends on the skill and judgment of physician	4.11	3.67
Estimated risk of malpractice suit with poor outcome	3.47	3.33

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
44050				
Pre-service total		60	0.0224	1.34
Intra-service		83	0.080	6.60
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	4	0.64	2.56
	99232	2	1.06	2.12
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	1	0.65	0.65
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				7.71
Total RVW by Building Block Method =				15.66

FREQUENCY INFORMATION

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

General Surgery Commonly

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,947	general surgery	4	gynecology/oncology
84	clinic or group practice (not gppp)	3	ophthalmology
50	colorectal surgery	2	cardiac surgery
48	vascular surgery	2	maxillofacial surgery
42	thoracic surgery	2	orthopaedic surgery
18	general practice	1	anesthesiology
15	surgical oncology	1	emergency medicine
11	unknown supplier/provider specialty	1	internal medicine
10	obstetrics/gynecology	1	neurosurgery
10	urology	1	peripheral vascular disease
8	family practice	1	plastic & reconstructive surgery
4	critical care (intensivists)		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 10 Yes
- 26 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 10 I do not agree

c. Patients requiring this service are now:

- 9 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 10 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44120

Current RVW: 14.50
Survey Median RVW: 17.00
ACS Recommended RVW: 17.00
RUC Recommended RVW: 17.00

CTP Descriptor: Enterectomy, resection of small intestine; single resection and anastomosis

Global Period: 90 days

Typical Patient: A 67-year-old female presents with a prior history of abdominal surgery and a strictured segment of small bowel evident on small bowel follow-through radiographs. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. At operation, dissection of the small bowel is performed. The strictured segment is mobilized and resected, and bowel continuity is reestablished. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after she is afebrile, the wound is satisfactory, and she is tolerating an adequate diet. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed gastric problems, wound complications or infections occur. The nutritional status of the patient is also monitored to ensure that adequate nutritional intake occurs.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure
- Confirm OR start time – notify pt. and family
- Arrange for surgical asst.

Pre-service work - Day of surgery:

- Change into scrub clothes
- Check with lab – make certain blood and/or x-match is available
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- Skin incision is made and anterior abdominal wall is carefully divided.
- The peritoneal cavity is entered and the bowel protected.
- A self-retaining retractor is inserted to facilitate exposure

- Adhesions are lysed freeing the small intestine
- A complete exploration is carried out to determine extent of disease, and biopsies of suspicious areas or lymph nodes taken and appropriate frozen sections requested if necessary.
- The involved segment of intestine is isolated a determination is made of the extent of resection necessary.
- The mesentery is divided between clamps and the vessels carefully ligated.
- A small portion of the mesentery is cleared on either side of the lesion at the proper distance and a stapler is applied to each limb and fired, dividing the bowel proximally and distally.
- The involved segment is removed and sent to pathology for evaluation and possibly microscopic examination.
- The segments to be anastomosed are carefully cleaned of fat without compromising the blood supply
- A suture is placed to hold the limbs in approximation while a small segment of the antimesenteric border is removed
- The limbs of the stapler are placed into each segment, carefully approximated and fired
- The anastomosis is checked for bleeding and patency
- Bleeding points are oversewn with fine sutures
- The open sections of the bowel through which the stapler was placed are now closed using a stapler
- The anastomosis is examined to be sure that no fat was interposed and any questionable areas are oversewn with interrupted sutures
- The mesentery is then sutured to close any defects
- Pathology is contacted to be certain that no unsuspected findings are present.
- The abdominal cavity is checked meticulously for bleeding and irrigated
- The abdominal wall is closed in the usual fashion
- The skin is closed

Post-op Same day work through discharge from recovery

- Apply dressings
- Write an op note in the patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed, and fill out pathology forms
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of abdominal dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Check function of NG tube, fluid and electrolyte status and urine output
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Determine when NG tube can be removed and oral intake started
- Carefully evaluate return of bowel function, any temperature elevation, and any wound drainage
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check final pathology report and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
35656	Bypass graft, with other than vein; femoral-popliteal	19.53	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>44120</u>	<u>35656</u>
Survey response	59	15
Pre-service time	60	60
Intra-service time	90	135
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	117	106
Discharge management time	36	36
Total office visit time	46	38
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.29	3.57
Intra-service	3.50	4.29
Post-service	3.12	3.14
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.49	4.00
Urgency of medical decision making	3.31	3.86
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.54	4.29
Physical effort required	3.40	4.00
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.56	4.29
Outcome depends on the skill and judgment of physician	3.59	4.00
Estimated risk of malpractice suit with poor outcome	3.39	4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
44120			
Pre-service total	60	0.0224	1.34
Intra-service	90	0.081	7.25
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	0	1.51	0.00
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	0	0.43	0.00
99213	2	0.65	1.30
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			7.29
Total RVW by Building Block Method =			15.88

FREQUENCY INFORMATION

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

General Surgery **Commonly**
Colon and Rectal Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

23,446	general surgery	15	maxillofacial surgery
835	clinic or group practice (not gppp)	10	anesthesiology
791	colorectal surgery	10	orthopaedic surgery
658	vascular surgery	9	cardiology
351	thoracic surgery	8	gastroenterology
316	obstetrics/gynecology	7	unknown supplier/provider specialty
311	surgical oncology	4	medical oncology
171	gynecology/oncology	4	osteopathic manipulative therapy
161	general practice	4	pathology
103	urology	2	infectious disease
73	family practice	2	psychiatry
51	peripheral vascular disease	1	allergy/immunology
35	internal medicine	1	crna, anesthesia assistant
34	critical care (intensivists)	1	diagnostic radiology
27	emergency medicine	1	nurse practitioner
26	ophthalmology	1	pediatric medicine
22	plastic & reconstructive surgery	1	physician assistant
21	hand surgery	1	pulmonary disease
16	cardiac surgery	1	radiation oncology
16	hematology/oncology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

7 Yes
52 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree
7 I do not agree

c. Patients requiring this service are now:

6 more complex (more work)
0 less complex (less work)
1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
0 from inpatient to outpatient
7 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44320

Current RVW: 12.94
Survey Median RVW: 20.00
ACS Recommended RVW: 17.64
RUC Recommended RVW: 17.64

CPT Descriptor: Colostomy or skin level cecostomy;

Global Period: 90 days

Typical Patient: A 67-year-old male presents with a history of rectal bleeding and a biopsy proven sigmoid carcinoma at 35 cm. from the anal verge. The lesion is completely obstructing the patient, and because of multiple medical problems, the decision is made to perform a diverting colostomy to decompress the colon, and to allow time for proper medical stabilization of the patient, prior to definitive resection. After the decision to operate has been made, the surgeon reviews laboratory and radiologic studies, and assesses need for further diagnostic procedures prior to surgery. The surgeon discusses the procedure with the patient, and obtains informed consent. At operation, a dissection of the left colon is performed. The left colon is mobilized and brought out as a colostomy and drains are placed as indicated. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Drains are removed as indicated. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and the nutritional status of the patient is also monitored to ensure that adequate nutritional intake occurs. The medical status of the patient is reviewed with other consultants, discussed with the patient and family, and appropriate decisions are then made for further care of the patient. A decision is made to discharge the patient to allow further stabilization of their medical status, prior to definitive resection. The patient is followed in the office as needed to monitor for wound complications or infection until cleared for surgery by the medical consultants.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- A skin incision is made, and the anterior abdominal wall is carefully divided

- The peritoneum is entered and a thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including bladder and rectum
- Adhesions are lysed by sharp and blunt dissection
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The small bowel is mobilized and isolated with laparotomy packs
- An incision of the muco-cutaneous junction of the previously constructed ileostomy is incised and the ileostomy is carefully separated from the subcutaneous fat and fascia / muscle of the abdominal wall, taking care to preserve the blood supply of the ileum
- The distal bowel is measured for the appropriate length to create a pouch
- A point chosen proximal to the distal end is isolated from its mesenteric blood supply for future use as an intussuscepted nipple valve
- The pouch components are folded into the appropriate pouch configuration and held in place with sutures
- The common wall anastomosis is then performed
- The valve component is then intussuscepted and secured in place with suture or staples
- The prior ileostomy site is then assessed for suitability for placement of the pouch nipple, and if adequate is then prepared for a pouch nipple-mucocutaneous anastomosis
- Then the pouch is delivered through the abdominal wall into the ileostomy site and carefully secured in place with sutures
- The position of the nasogastric tube is adjusted and ascertained to be in the correct place for drainage
- The abdominal cavity is then irrigated with saline, and another inspection of the abdomen is made for other abnormalities
- A closed-system suction drain may be inserted for drainage of a localized area
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The anterior abdominal wall is closed with standard technique, and subcutaneous tissue is irrigated and drained with a closed-suction drain when indicated
- The skin is then closed in a standard fashion
- After the skin is closed and dressed, a special pouch intubation catheter is then selected and placed into the nipple valve and the pouch

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient

- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Review laboratory and x-ray data
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	44320	44626
Survey response	53	24
Pre-service time	75	70
Intra-service time	90	160
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	158	177
Discharge management time	36	36
Total office visit time	76	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.87	3.39
Intra-service	3.67	3.87
Post-service	3.65	3.39
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.65
Urgency of medical decision making	4.15	3.22
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.62	3.87
Physical effort required	3.66	3.70
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.12	4.00
Outcome depends on the skill and judgment of physician	3.96	4.00
Estimated risk of malpractice suit with poor outcome	3.48	3.73

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
44320			
Pre-service total	75	0.0224	1.68
Intra-service	90	0.070	6.30
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	3	0.64	1.92
99232	2	1.06	2.12
99233	1	1.51	1.51
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			9.66
Total RVW by Building Block Method =			17.64

FREQUENCY INFORMATION

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

General Surgery Commonly

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

6,683	general surgery	4	hematology/oncology
531	colorectal surgery	4	orthopaedic surgery
274	clinic or group practice (not gppp)	4	plastic & reconstructive surgery
152	vascular surgery	3	anesthesiology
106	obstetrics/gynecology	3	cardiac surgery
103	thoracic surgery	3	critical care (intensivists)
85	surgical oncology	2	cardiology
69	gynecology/oncology	2	diagnostic radiology
48	general practice	2	psychiatry
22	family practice	1	certified clinical nurse specialist
22	urology	1	hand surgery
20	emergency medicine	1	osteopathic manipulative therapy
14	ophthalmology	1	otolaryngology
11	peripheral vascular disease	1	pediatric medicine
10	maxillofacial surgery	1	physician assistant
6	internal medicine	1	pulmonary disease
6	medical oncology	1	radiation oncology
4	gastroenterology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

8 Yes

45 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

8 I do not agree

c. Patients requiring this service are now:

7 more complex (more work)

0 less complex (less work)

1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

7 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44604

Current RVW: 14.28
Survey Median RVW: 20.85
ACS Recommended RVW: 16.03
RUC Recommended RVW: 16.03

CPT Descriptor: Suture of large intestine for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy

Global Period: 90 days

Typical Patient: A 22-year-old male presents to the emergency room with a single 22 caliber gun shot wound to the abdomen. Once a decision to operate has been made, the surgeon stabilizes and prepares the patient for emergent surgery, including assessment of pre-existing medical problems, reviewing laboratory and x-ray/imaging studies, assuring adequate ventilation and intravenous fluid administration, ordering pre-operative antibiotics, and communicating and obtaining informed consent from the patient and/or family. Further diagnostic tests are obtained and reviewed, as indicated, prior to surgery, in order to rule out other injury and to plan the operative approach. At operation, the patient is explored through a midline incision and a tangential injury to the right colon is found. The patient is felt to be a candidate for suture repair of the colon, and this is done in a routine fashion. Careful exploration of the entire abdomen is also performed to rule out other injury, and copious lavage is also accomplished of the abdomen. The entrance wound is debrided as needed and drains are placed as indicated. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Drains are removed as indicated. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed gastric problems, wound complications or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work :

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure
- 44605 is performed usually as an emergency, and extra work is usually involved to ensure that the patient has had adequate pre-operative fluid administration to offset third space fluid losses, antibiotic administration after blood cultures are obtained, and other stabilization of the cardiovascular and respiratory system as these patients may require. Additionally, if the injury to the colon is due to trauma, the patient may have other injuries that must be assessed and frequently treated prior to taking the patient to the operating room.
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite

- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- A skin incision is made, and the anterior abdominal wall is carefully divided
- The peritoneum is entered and a thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including bladder and rectum
- Adhesions are lysed by sharp and blunt dissection
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The small bowel and colon are mobilized and isolated with laparotomy packs, in order to contain any fecal contamination.
- The site of colon leakage is identified and usually isolated with non-crushing bowel clamps or vessel loops to prevent further peritoneal contamination.
- The leakage site is debrided and then carefully repaired, taking care that the approximation is both water tight as well as perfused to ensure viability of the repair.
- The local area of the perforation is carefully debrided and irrigated to remove as much contamination as possible.
- A closed system suction drain may be inserted into the area for drainage, and brought out through a separate stab incision
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The anterior abdominal wall is closed with standard technique, and subcutaneous tissue is irrigated and drained with a closed-suction drain when indicated or packed open with antibiotic soaked gauze.

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity

- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS
 Anthony J. Senagore, MD, FACS

Specialty(s): American College of Surgeons
 American Society of Colon and Rectal Surgeons

Type of Sample: 95% Random (mail/fax) and 5% Convenience (specialty meeting)

Survey CPT Code: 44604

Sample Size: 165 **Response:** 46 28%

Low 25th pctl Median 75th pctl High

Survey RVW 12.00 16.03 **20.85** 24.00 50.00

Pre-Service 60

Intra-Service 60 90 **90** 120 210

Post-Service:	Total Time	CPT code / # of visits		
Immed. Post-Service	30			
Critical Care	0			
Other Hospital	158	99233x1	99232x2	99231x3
Discharge Day Mgmt	36	99238		
Office Visits	46	99213x2		

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	44604	44626
Survey response	46	31
Pre-service time	60	75
Intra-service time	90	165
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	158	147
Discharge management time	36	36
Total office visit time	46	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.33	3.41
Intra-service	4.12	4.00
Post-service	3.56	3.48
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.23	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.02	3.72
Urgency of medical decision making	4.67	3.28
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.98	4.10
Physical effort required	3.88	3.97
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.30	4.00
Outcome depends on the skill and judgment of physician	4.30	4.14
Estimated risk of malpractice suit with poor outcome	4.17	3.86

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the pre- and post-operative EM work (which includes ICU care) for this procedure was not valued appropriately by the RUC in 1993. The following building block analysis (i.e., valuing the increment), applied to the current RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
44604				
Pre-service total		60	0.0224	1.34
Intra-service		90	0.080	7.16
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	3	0.64	1.92
	99232	2	1.06	2.12
	99233	1	1.51	1.51
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	0	0.43	0.00
	99213	2	0.65	1.30
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				8.80
Total RVW by Building Block Method =				17.30

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,430	general surgery	3	emergency medicine
55	vascular surgery	2	anesthesiology
50	colorectal surgery	2	cardiac surgery
49	clinic or group practice (not gppp)	2	cardiology
27	obstetrics/gynecology	2	critical care (intensivists)
20	family practice	2	physician assistant
20	thoracic surgery	1	gastroenterology
16	gynecology/oncology	1	medical oncology
16	surgical oncology	1	nurse practitioner
15	internal medicine	1	orthopaedic surgery
10	urology	1	pathology
7	general practice	1	peripheral vascular disease
4	ophthalmology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 6 Yes
- 40 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 5 I do not agree

c. Patients requiring this service are now:

- 5 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 6 no change

CPT Code: 46262

Current RVW: 8.73
Survey Median RVW: 7.50
ACS Recommended RVW: 7.50
RUC Recommended RVW: 7.50

CPT Descriptor: Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy

Global Period: 90 days

Typical Patient: A 27-year-old male presents with a long history of bright red rectal bleeding due to enlarged internal and external hemorrhoids and a chronically draining fistula in ano. After the decision is made to operate, the surgeon reviews all previous laboratory, radiologic, and endoscopic studies and informed consent is obtained. At operation, each of three enlarged internal-external hemorrhoidal complexes is identified and excised. The fistula tract is identified at another location in the anal canal and both the internal and external openings are located with a fistula probe, and a fistulotomy is performed. Postoperative facility and office visits are conducted as necessary during the 90-day global period to assure normal recovery and the absence of any complications.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

- **Pre-service work-Day before surgery:**
- Write pre-operative orders for peri-operative medications and enemas
- Review pre-operative work-up, Routine labs
- Review planned incisions and procedure
- Counsel patient and obtain informed consent

- **Pre-service work - Day of surgery:**
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome (s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning, prepping and draping, and assist with positioning as needed
- Scrub and gown.

- **Intra-service work - Skin to skin:**
- Inspect and do anorectal exam under anesthesia to include visual inspection, digital examination.
- Examine the anorectal area with appropriate anorectal retractors to view the pathology
- Assess hemorrhoidal complexes and fistula location and plan appropriate incisions for hemorrhoidectomy and fistulotomy/fistulectomy (keeping in mind canal sparing so as not to contribute to anal stenosis)
- Control and ligate the hemorrhoidal pedicle on the first mass.
- Incise and excise the hemorrhoidal complex from the underlying anal sphincter so as not to injure it.
- Undermine wound edges and remove additional hemorrhoid tissue in the proximity as necessary
- As these hemorrhoids frequently have rectal mucosal prolapse, it must be reduced

- appropriately with sutures.
- When mucosal prolapse is reduced the hemorrhoidal wound may be closed as in a Ferguson hemorrhoidectomy or other appropriate sutures placed and the wound left partially open
 - This is accomplished in the area of the other hemorrhoid piles also with great care not to narrow the anal canal.
 - The fistula present had to be localized. It is probed from the external opening to try to follow the tract without creating a tract.
 - If the tract cannot be followed with a probe injecting it with a liquid material to identify the internal opening may be accomplished.
 - Should you identify the whole tract, fistulotomy is then performed.
 - If the tract could not totally be identified, fistulotomy is performed gradually down over a probe identifying the tract as you proceed.
 - Once the complete fistulotomy is performed excision/debridement of the fistulous tract is carried out with sharp curetment and excision as necessary.
 - Once the fistulotomy/fistulectomy is complete, marsupialization of the wound edges to the edges of the fistulous fibrous tract is carried out as desired.
 - Remove all instruments at completion to observe, digitalize, and evaluate the outcome
 - Insert small retractor to evaluate for hemostasis.
 - Once satisfied with results, procedure can be completed by injecting some local anesthetic if it was not done at initiation of procedure. This is for postop analgesia. Sometimes it is injected at initiation of procedure to possibly aid in hemostasis from the Epinephrine effect.
- **Post-Op Same day work through discharge from recovery**
 - Apply dressings
 - Write orders for post-op labs, films, medication, diet, and patient activity
 - Review recovery room care and medications with staff.
 - Discuss procedure outcome with family
 - Discuss procedure outcome with patient after emergence from anesthesia
 - Dictate post-op report
 - Discuss procedure outcome with referring physician
 - Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- **Post-op Office work - after discharge from hospital**
 - Telephone inquiries answered to patient and family, quite frequent in first 7-10 days.
 - Obtain history and examine patient during each visit, at least one visit includes anoscopy
 - Check wounds for inflammation/delayed healing, partial impaction and patient functional progress
 - Answer patient/family questions
 - Discuss patient progress with referring physician (verbal/written)
 - Write return to work letter
 - Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
46255	Hemorrhoidectomy, internal and external, simple;	5.36	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>46262</u>	<u>46255</u>
Survey response	31	14
Pre-service time	40	25
Intra-service time	45	30
Immediate Post-service time	20	20
Total critical care time	0	0
Total other hospital visit time	19	0
Discharge management time	18	18
Total office visit time	53	38
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.83	2.46
Intra-service	3.27	2.92
Post-service	2.97	2.69
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.94	2.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.54
Urgency of medical decision making	2.65	2.46
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.32	3.00
Physical effort required	2.84	2.77
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.35	2.62
Outcome depends on the skill and judgment of physician	3.42	3.08
Estimated risk of malpractice suit with poor outcome	3.32	2.92

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
46262			
Pre-service total	40	0.0224	0.90
Intra-service	45	0.053	2.39
Post-service			
Immediate post	20	0.0224	0.45
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	.5	1.28	0.64
99211	0	0.17	0.00
99212	2	0.43	0.86
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			2.60
Total RVW by Building Block Method =			5.88

FREQUENCY INFORMATION

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

General Surgery and Colon and Rectal Surgery 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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

184	general surgery	4	vascular surgery
113	colorectal surgery	3	ophthalmology
12	gastroenterology	2	family practice
7	general practice	2	internal medicine
5	thoracic surgery	1	anesthesiology

Do many physicians perform this service across the United States?

No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

8 Yes
23 No

b. This service represents new technology that has become more familiar (i.e., less work).

3 I agree
5 I do not agree

c. Patients requiring this service are now:

1 more complex (more work)
1 less complex (less work)
6 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
6 from inpatient to outpatient
2 no change

CPT Code: 46221

Current RVW: 1.43
Survey Median RVW: 3.75
ACS Recommended RVW: 2.58
RUC Recommended RVW: 2.04

CPT Descriptor: Hemorrhoidectomy, by simple ligature (eg, rubber band)

Global Period: 10 days

Typical Patient: A 32-year-old male with a long history of bright red rectal bleeding due to enlarged internal hemorrhoids requires banding of his internal hemorrhoids. The surgeon reviews all previous laboratory, radiologic, and endoscopic studies and determines that no further evaluation is required, and informed consent is obtained. The patient is administered cleansing enemas and then placed in the left lateral position. The anoscope is inserted and all three hemorrhoidal plexi are inspected. The enlarged plexus is isolated and the rubber band is applied. The patient is observed for pain and any vasovagal reaction. He is instructed to call immediately if any symptoms of post-banding sepsis occur, which include increasing pain, fever, or dysuria. Dietary and analgesic instructions are reviewed with the patient. Postoperative visits during the 10-day global period are made as necessary. The care plan is communicated to the other health care providers involved with the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day of surgery:

- Please take note that implemented payment policy does not typically allow for separately billable E/M events, such as -Take a history, limited review of systems, PMHx, Medications, Allergies – yet these are always performed
- Anorectal physical exam (Inspect, palpate, digital assessment for sphincter length, tone and “squeeze”)
- Insert Anoscope and establish diagnosis of hemorrhoids and their grade (I-IV) and patient's discomfort level/tolerance
- Answer patient and family questions and obtain informed consent
- Position and drape patient
- Verify that all necessary surgical instruments and supplies are readily available in exam room

Intra-service work - Skin to skin:

- Re-insert anoscope
- Through anoscope, the surgeon will prolapse the hemorrhoidal complexes for banding
- Apply Bands and assess patient tolerance, pain and bleeding
- Rotate anoscope and re-assess the complex for banding
- Apply Bands and assess patient tolerance, pain and bleeding
- Remove anoscope

Post-op Office work – same day

- Write prescriptions for medication, diet, and patient activity, including sitz baths
- Discuss procedure outcome with patient regarding urinary retention, postbanding sepsis
- Dictate procedure outcome and expected recovery letter for referring physician
- Usually one phone call with patient during global period regarding pain, bleeding and/or constipation
- Talk with patient in office
- Answer patient/family questions
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
46255	Hemorrhoidectomy, internal and external, simple;	5.36	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>46221</u>	<u>46255</u>
Survey response	27	13
Pre-service time	15	30
Intra-service time	15	30
Immediate Post-service time	15	20
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	0	18
Total office visit time	23	30
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.04	2.25
Intra-service	2.19	2.58
Post-service	1.96	2.33
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.19	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.07	2.33
Urgency of medical decision making	1.93	1.83
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	2.22	2.67
Physical effort required	2.04	2.33
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	2.11	2.50
Outcome depends on the skill and judgment of physician	2.44	2.83
Estimated risk of malpractice suit with poor outcome	2.15	2.75

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Although, we believe the total work for this procedure was not valued appropriately by the Harvard study, the survey respondents overestimated the work RVU. The survey respondents indicated a discharge management service, but this procedure is performed typically in an office. Subtracting the RVW for the discharge management work from the median results in approximately the 25th percentile. Therefore, we recommend the 25th percentile RVW of 2.58 for 46221.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
46221				
Pre-service total		15	0.0224	0.34
Intra-service		15	0.040	0.60
Post-service				
Immediate post		15	0.0224	0.34
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	0	0.64	0.00
	99232	0	1.06	0.00
	99233	0	1.51	0.00
	99238	0	1.28	0.00
	99211	0	0.17	0.00
	99212	0	0.43	0.00
	99213	1	0.65	0.65
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				0.99
Total RVW by Building Block Method =				1.93

FREQUENCY INFORMATION

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

General Surgery and Colon and Rectal Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

16,547	general surgery	10	emergency medicine
14,702	colorectal surgery	8	obstetrics/gynecology
1,016	clinic or group practice (not gppp)	7	diagnostic radiology
822	gastroenterology	4	peripheral vascular disease
494	internal medicine	2	ASC
437	family practice	2	anesthesiology
221	general practice	2	dermatology
162	vascular surgery	2	hematology/oncology
121	thoracic surgery	2	maxillofacial surgery
79	ophthalmology	1	hand surgery
42	surgical oncology	1	osteopathic manipulative therapy
20	critical care (intensivists)	1	otolaryngology
20	urology	1	physician assistant
16	infectious disease	1	plastic & reconstructive surgery

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 5 Yes
- 22 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 2 I agree
- 3 I do not agree

c. Patients requiring this service are now:

- 1 more complex (more work)
- 1 less complex (less work)
- 3 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 2 from inpatient to outpatient
- 3 no change

CPT Code: 45550

Current RVW: 18.26
Survey Median RVW: 23.00
ACS Recommended RVW: 23.00
RUC Recommended RVW: 23.00

CPT Descriptor: Proctopexy combined with sigmoid resection, abdominal approach

Global Period: 90 days

Typical Patient: A 75-year-old female presents with a long history of chronic constipation and recent onset of full thickness rectal prolapse. After the decision to operate has been made, the surgeon reviews all laboratory and radiologic studies, and determines that no further evaluation is required. The surgeon reviews the intended procedure with the patient and her spouse and informed consent is obtained. A preoperative mechanical and antibiotic bowel preparation is performed. At operation a complete rectosigmoid mobilization is performed down to the pelvic floor posteriorly. The redundant sigmoid colon is resected and a primary anastomosis is performed. The mobilized rectum is sutured fixated to the sacral promontory with 4 permanent sutures. The wound is closed in layers. Postoperative care includes all necessary hospital and office visits during the 90-day global period to assure normal recovery and the absence of any complications.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work—day before surgery

- Write preoperative orders.
- Review preoperative workup, attention to toxicology reports and lab reports
- Review preoperative workup reviewing any possible x-rays.
- Review planned procedure.

Pre-service work - day of surgery

- Change into scrub clothes.
- Review procedure postop recovery and expected outcomes and course with patient and family.
- Answer patient/family questions and obtain informed consent.
- Review anesthesia type and length of anesthesiologist.
- Review planned procedure and positioning, draping of patient, verify all necessary surgery instruments and supplies readily available.
- Monitor patient positioning and draping, may assist with it.
- Scrub and gown.

Intra-service work - skin to skin

- Patient is prepped and draped under anesthesia, supine position, ready for the abdominal incision.
- Abdominal incision is made (incision of choice by surgeon).
- Incision is carried through the subcutaneous tissues and other layers of tissue individually entering the peritoneal cavity.
- The peritoneal cavity is thoroughly explored for other abnormalities.
- The peritoneal cavity is appropriately packed.
- The self-retaining retractor is secured to the operating table and appropriate appendages attached to provide visualization.
- Packs are repositioned as needed to mobilize the distal descending colon and the sigmoid colon. Once that is done rectal mobilization must be accomplished to the level of the lateral stocks of the rectum.

- Rectopexy sutures are placed appropriately to the rectum at the upper level of the lateral stocks and the presacral fascia. The sutures are tagged and not tied at this time. Appropriate length of bowel for resection is determined.
- Mesentery to that part of the bowel is divided to devascularize it. The resection is then carried out controlling the distal rectal stump and proximal colon site of resection so there is no leakage appropriately.
- Anastomosis is made in fashion of choice by the operating surgeon.
- Rectopexy sutures are tied down securing the rectum to the presacral fascia.
- Abdominal cavity is irrigated with saline solution assuring hemostasis and cleansing.
- Exploration for foreign bodies such as sponges, instruments and needles is carried out. All are removed and counts are correct. Retractor is removed and disassembled.
- Anterior abdominal wall is closed in standard technique irrigating the subcutaneous tissue.
- Skin is closed in fashion of choice.

Post-Op Same day work through discharge from recovery

- Apply dressings
- Write orders for postop labs, x-rays, medications, diet and activity.
- Review orders with recovery room care and staff.
- Discuss the procedure, findings and outcome with family.
- Discuss procedure with patient after emergence from anesthesia.
- Dictate postop report.
- Discuss outcome with referring physician.
- Dictate procedure, outcome, and expected recovery letter as needed for referring physician or insurance company.

Post-Op Same day work after discharge from recovery

- Patient, check wounds, patient progress.
- Review chart information, vital signs and nursing notes.
- Answer and review questions with family and patient.
- Review progress with nursing and other staff.
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes.

Post-op Other Hospital work-Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (written and verbal)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work

- Examine and talk with patient
- Check wounds and patient progress.
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Frank G. Opelka, MD, FACS
 Anthony J. Senagore, MD, FACS
 Charles P. Shoemaker, MD, FACS

Specialty(s): American College of Surgeons
 American Society of General Surgeons
 American Society of Colon and Rectal Surgeons

Type of Sample: 100% Random (mail/fax)

Survey CPT Code: 45550

Sample Size:	90		Response:	29	32%
	Low	25th pctl	Median	75th pctl	High
Survey RVW	19.00	22.00	23.00	26.11	31.63
Pre-Service			70		
Intra-Service	90	150	180	220	240
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	136	99232x2 99231x4			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	45550	44626
Survey response	29	18
Pre-service time	70	60
Intra-service time	180	175
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	136	177
Discharge management time	36	36
Total office visit time	61	53
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.78	3.50
Intra-service	3.96	4.13
Post-service	3.78	3.75
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.81
Urgency of medical decision making	3.64	3.38
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.11	4.31
Physical effort required	4.04	4.38
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.14	4.13
Outcome depends on the skill and judgment of physician	4.11	4.13
Estimated risk of malpractice suit with poor outcome	4.00	4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

CPT 44140 is an integral part of this operation. The recommended value for 44140 is 22.50 work RVUs (survey median). There is approximately one hour additional intraoperative work over 44140 to perform the proctopexy portion of this procedure. This is consistent with 4.00 work RVUs and therefore, we recommend the 75th percentile RVW of 26.11 for 45550.

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
45550				
	Pre-service total	70	0.0224	1.57
	Intra-service	180	0.088	15.84
	Post-service			
	Immediate post	30	0.0224	0.67
	Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	4	0.64	2.56
	99232	2	1.06	2.12
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	0	1.08	0.00
	99215	0	1.73	0.00
	Post-service total			8.36
	Total RVW by Building Block Method =			25.77

FREQUENCY INFORMATION

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

General Surgery and Colon and Rectal Surgery **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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

286	general surgery	2	anesthesiology
146	colorectal surgery	2	general practice
18	clinic or group practice (not gppp)	2	gynecology/oncology
9	vascular surgery	2	thoracic surgery
4	ophthalmology	2	urology
3	obstetrics/gynecology	1	internal medicine
3	surgical oncology	1	peripheral vascular disease

Do many physicians perform this service across the United States?

No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

10 Yes

19 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

10 I do not agree

c. Patients requiring this service are now:

8 more complex (more work)

0 less complex (less work)

2 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

10 no change

CPT Code: 49505Current RVW: 6.49
Survey Median RVW: 8.24
ACS Recommended RVW: 8.24
RUC Recommended RVW: 7.60**CPT Descriptor:** Repair initial inguinal hernia, age 5 years or over; reducible**Global Period:** 90 days

Typical Patient: A 70-year-old overweight male smoker referred because of a symptomatic reducible inguinal hernia. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory studies, discusses the procedure with the patient, and obtains informed consent. At operation, under local anesthesia and sedation, a large hernia sac and a large fascial defect are present. The sac is ligated and an on-lay mesh is sutured to cover the fascial defect. Postoperatively, at discharge, the patient is prescribed pain medication and provided instructions for care of the wound and diet. Office visits are conducted as necessary through the 90-day global period to monitor for wound complications and/or infection.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):**Pre-service work - Day before surgery:**

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- An incision is made, hemostasis obtained, and the external oblique fascia identified and cleaned
- The external oblique fascia is opened into the external inguinal ring, taking care to avoid the ilioinguinal nerve
- Fascial flaps are developed to expose the inguinal canal
- A self retaining retractor is inserted to provide exposure
- The ilioinguinal nerve is identified, mobilized, and retracted out of harms way
- The spermatic cord is mobilized, encircled with a penrose drain, and dissected up to the internal inguinal ring
- The spermatic cord is then explored for a indirect hernia sac, taking care to avoid injury to the vas deferens or the testicle's blood supply
- If an indirect sac is discovered, it is ligated at or above the level of the internal inguinal ring
- The proper tissue needed is identified to allow the planned repair
- The repair is completed with suture or mesh implant (reported separated), ensuring an adequate internal ring around the cord

- After ensuring hemostasis, the ilioinguinal nerve is returned to its former position and the external oblique fascia is closed
- Scarpa's fascia is then approximated, the wound is irrigated, and the skin is closed

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family
- Review activity limitations with patient
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Review post-discharge labs
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	8.24	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>49505</u>	<u>49651</u>
Survey response	37	13
Pre-service time	37	35
Intra-service time	60	60
Immediate Post-service time	20	20
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	18	18
Total office visit time	38	38
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.44	2.69
Intra-service	2.94	3.46
Post-service	2.28	2.38
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.51	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.30	2.31
Urgency of medical decision making	2.16	2.31
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.11	3.92
Physical effort required	2.76	3.08
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	2.62	3.23
Outcome depends on the skill and judgment of physician	3.19	3.54
Estimated risk of malpractice suit with poor outcome	2.84	3.31

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
49505			
Pre-service total	37	0.0224	0.82
Intra-service	60	0.070	4.20
Post-service			
Immediate post	20	0.0224	0.45
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	0	4.00	0.00
99231	0	0.64	0.00
99232	0	1.06	0.00
99233	0	1.51	0.00
99238	.5	1.28	0.64
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	0	1.08	0.00
99215	0	1.73	0.00
Post-service total			2.17
Total RVW by Building Block Method =			7.19

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

89,067	general surgery	36	hand surgery
2,877	clinic or group practice (not gppp)	35	ASC
2,271	urology	24	gastroenterology
2,200	vascular surgery	15	pediatric medicine
1,322	thoracic surgery	14	gynecology/oncology
679	general practice	10	cma, anesthesia assistant
634	family practice	10	pathology
598	colorectal surgery	9	infectious disease
321	surgical oncology	9	nurse practitioner
131	internal medicine	9	osteopathic manipulative therapy
106	emergency medicine	9	radiation oncology
105	peripheral vascular disease	8	diagnostic radiology
82	critical care (intensivists)	8	hematology/oncology
54	orthopaedic surgery	8	medical oncology
52	obstetrics/gynecology	6	physician assistant
52	ophthalmology	5	allergy/immunology
51	cardiac surgery	4	otolaryngology
47	cardiology	1	dermatology
46	maxillofacial surgery		
45	plastic & reconstructive surgery		
40	anesthesiology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

14 Yes

23 No

b. This service represents new technology that has become more familiar (i.e., less work).

6 I agree

8 I do not agree

c. Patients requiring this service are now:

9 more complex (more work)

0 less complex (less work)

5 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

5 from inpatient to outpatient

9 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 43638

Current RVW: 21.76
Survey Median RVW: 29.00
ACS Recommended RVW: 35.00
RUC Recommended RVW: 29.00

CPT Descriptor: Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrotomy, with vagotomy;

Global Period: 90 days

Typical Patient: A 55-year-old male requires a partial gastrectomy after a UGI endoscopy biopsy-proven adenocarcinoma of the fundus has been diagnosed. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. At operation, an en-bloc resection is carried out of the proximal stomach, including the distal esophagus. This includes a careful dissection of the stomach, associated lymph node bearing areas, and surrounding organs. After the tumor and proximal stomach are resected, the distal stomach is anastomosed to the esophagus, and the area is widely drained. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after return of bowel function, and after review of a Gastrografin study confirms the absence of an anastomotic leak. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed anastomotic strictures, wound complications, or infections occur. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect further care of the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

-
- A skin incision is made, and the anterior abdominal wall is carefully divided
- The peritoneum is entered and a thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including bladder and rectum
- Adhesions are taken down by sharp and blunt dissection
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The stomach is mobilized and carefully palpated to identify, if possible, the source of bleeding (e.g. penetrating ulcer of the lesser curve) or malignancy.
- A vagotomy is then performed by mobilizing the left lobe of the liver, taking care to not injure the liver.
- The esophagus is then mobilized and encircled with a penrose drain, and the vagus nerves are then identified.
- They are then each sequentially ligated and hemoclipped and resected with samples of each sent for pathologic resection.
- The stomach is isolated with laparotomy packs, and mobilized by taking down the gastroepiploic arcade and right gastric artery and then suture ligating and dividing them.
- The lesion and ulcer crater is identified, and a biopsy is sometimes performed to rule out malignancy
- The proximal stomach is then resected from the esophagus down to an area below the stomach lesion.
- An anastomosis is then constructed between the stomach and the distal esophagus with sutures &/or staples
- The position of the nasogastric tube is adjusted and ascertained to be in the correct place for drainage
- The abdominal cavity is then irrigated with saline, and another inspection of the abdomen is made for other abnormalities
- A closed-system suction drain may be inserted for drainage of a localized area
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The anterior abdominal wall is closed with standard technique, and subcutaneous tissue is irrigated and drained with a closed-suction drain when indicated
- The skin is then closed in a standard fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta	28.01	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	43638	35081
Survey response	31	10
Pre-service time	75	60
Intra-service time	210	195
Immediate Post-service time	30	30
Total critical care time	0	60
Total other hospital visit time	237	158
Discharge management time	36	36
Total office visit time	99	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.23	4.00
Intra-service	4.63	4.89
Post-service	4.13	4.11
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	4.33
Urgency of medical decision making	4.00	4.11
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.57	4.78
Physical effort required	4.53	4.33
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.63	4.89
Outcome depends on the skill and judgment of physician	4.60	4.89
Estimated risk of malpractice suit with poor outcome	4.10	4.44

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the survey respondents did not take into account the critical nature of the patients and that they almost always require at least one day of ICU care (99291). For that reason, we recommend the survey 75th percentile RVW 35.00. The significantly greater postoperative time and additional intraoperative time compared with 35081 also validates the survey 75th percentile.

Building Block Method

Intra-service Intensity is based on ACS consensus panel survey.

Other Intensity factors from the original Harvard / Stone formula

All other time and visit data from RUC survey (median)

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43638				
Pre-service total		75	0.0224	1.68
Intra-service		210	0.095	19.95
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	5	0.64	3.20
	99232	2	1.06	2.12
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				13.10
Total RVW by Building Block Method =				34.73

FREQUENCY INFORMATION

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

General Surgery Sometimes

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

327	general surgery	1	anesthesiology
25	thoracic surgery	1	cardiac surgery
12	clinic or group practice (not gppp)	1	emergency medicine
10	vascular surgery	1	internal medicine
3	surgical oncology	1	pediatric medicine
2	colorectal surgery	1	urology

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 4 Yes
- 27 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 4 I do not agree

c. Patients requiring this service are now:

- 3 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 4 no change

CPT Code: 43631

Current RVW: 19.66
Survey Median RVW: 23.70
ACS Recommended RVW: 23.70
RUC Recommended RVW: 22.59

CPT Descriptor: Gastrectomy, partial, distal; with gastroduodenostomy

Global Period: 90 days

Typical Patient: A 68-year-old retired salesman (50 pack per year history) presents with gastric outlet obstruction. He has had a 20 pound weight loss in the last three months, known peptic ulcer disease, and has been treated with H2 blockers. Despite medical advice, he has continued to smoke and drink socially until this past week when he was unable to keep anything down. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. Initial lab studies reveal: K+ 3.0 mEq/L; total protein 5.0 gm/dl; albumin 2.5 gm/dl; and Hgb 10.8 gm/dl. ABG's reveal metabolic alkalosis. Pulmonary function tests reveal mild COPD. At operation, a large pre-pyloric anterior/superior benign ulcer is found. A careful dissection of the chronically scarred and inflamed area around the ulcer is performed, including the duodenum, common bile duct, pancreas, and stomach. An antrectomy with gastroduodenostomy is performed. Drains are placed in the operative area as needed. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, blood loss, and fluid balance. Wound checks and dressing changes are made to assure an absence of hematoma, infection, and drainage. Communication occurs with the patient and family and coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, he is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed anastomotic strictures, wound complications, or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- A skin incision is made, and the anterior abdominal wall is carefully divided

- The peritoneum is entered and a thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including bladder and rectum
- Adhesions are taken down by sharp and blunt dissection
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The stomach is mobilized and carefully palpated to identify, if possible, the ulcer or lesion (e.g. penetrating ulcer of the antrum)
- The stomach is freed from the omentum, and gastroepiploic arcade with clamps and suture ligation.
- A Kocher maneuver is then done to mobilize the duodenum from the first to the third portions, with care taken to not injure the blood supply to the duodenum or the common bile duct
- The stomach is isolated with laparotomy packs, and sutures are used to secure the stomach wall in preparation for resection.
- The stomach is then opened with electrocautery
- The lesion and ulcer crater is identified, and a biopsy is sometimes performed to rule out malignancy
- The antrum of the stomach is then identified and the gastric arterial arcade is ligated with clamps and sutures and then divided.
- The antrum is then resected from the remaining stomach with a stapling device, and then from the duodenum, taking care not to injure the common bile duct or pancreas.
- An anastomosis is then constructed between the stomach and duodenum, taking care to not impair the blood supply of the duodenum and to assure a water tight closure of the anastomosis
- The position of the nasogastric tube is adjusted and ascertained to be in the correct place for drainage
- The abdominal cavity is then irrigated with saline, and another inspection of the abdomen is made for other abnormalities
- A closed-system suction drain may be inserted for drainage of a localized area
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The anterior abdominal wall is closed with standard technique, and subcutaneous tissue is irrigated and drained with a closed-suction drain when indicated
- The skin is then closed in a standard fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient

- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 85% Random (mail/fax) and 15% Convenience (specialty meeting)

Survey CPT Code: 43631

Sample Size:	140		Response:	40	29%
	Low	25th pctl	Median	75th pctl	High
Survey RVW	15.30	22.00	23.70	27.33	34.90
Pre-Service			75		
Intra-Service	120	148	150	180	300
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	155	99232x2	99231x5		
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	43631	44626
Survey response	40	17
Pre-service time	75	70
Intra-service time	150	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	155	158
Discharge management time	36	36
Total office visit time	61	76
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.80	3.41
Intra-service	4.30	4.00
Post-service	3.79	3.35
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.59
Urgency of medical decision making	3.80	3.12
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.35	4.00
Physical effort required	4.15	4.06
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.35	4.18
Outcome depends on the skill and judgment of physician	4.38	4.24
Estimated risk of malpractice suit with poor outcome	3.95	4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the pre- and post-operative EM work for this procedure was not valued appropriately by the RUC in 1993. The following building block analysis (i.e., valuing the increment), applied to the current RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43631				
Pre-service total		75	0.0224	1.68
Intra-service		150	0.088	13.20
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>		<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00	0.00
	99231	5	0.64	3.20
	99232	2	1.06	2.12
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				9.00
Total RVW by Building Block Method =				23.88

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national frequency, however, procedure performed more often outside the Medicare population.

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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,826	general surgery	3	peripheral vascular disease
43	thoracic surgery	2	family practice
43	vascular surgery	2	hand surgery
42	clinic or group practice (not gppp)	2	internal medicine
15	surgical oncology	2	obstetrics/gynecology
14	general practice	2	urology
12	colorectal surgery	1	gastroenterology
3	cardiac surgery	1	maxillofacial surgery
3	cardiology	1	orthopaedic surgery
3	critical care (intensivists)	1	plastic & reconstructive surgery
3	emergency medicine		
3	hematology/oncology		
3	ophthalmology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 12 Yes
- 28 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 11 I do not agree

c. Patients requiring this service are now:

- 11 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 11 no change

CPT Code: 43830

Current RVW: 7.28
Survey Median RVW: 11.00
ACS Recommended RVW: 11.00
RUC Recommended RVW: 9.53

CPT Descriptor: Gastrostomy, temporary (tube, rubber or plastic) (separate procedure);

Global Period: 90 days

Typical Patient: An elderly female presents with a massive CVA and is unable to eat. An open gastrostomy is necessary because of multiple prior surgeries, contraindicating a percutaneous gastrostomy tube placement. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. The patient is taken to the operating room, where a gastrostomy and placement of a gastrostomy tube is performed. Postoperatively, the patient has tube feedings started when bowel function returns, and the surgeon advances the feedings to an appropriate level of nutritional intake, as well as monitors the surgical wound for signs of infection or leakage. Office visits are conducted as necessary during the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to chemistries
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin

- Local anesthesia is injected into the proposed skin incision
- A skin incision is made, and the anterior abdominal wall is carefully divided
- The peritoneum is entered and a thorough exploration of the area is undertaken, albeit in limited fashion
- Adhesions are taken down by sharp and blunt dissection
- A self-retaining retractor, where appropriate, is secured to the operating table, or is a Weisslander retractor
- The stomach is identified and mobilized, and carefully palpated to identify any abnormalities
- The stomach is freed from the omentum and gastroepiploic arcade with sutures and suture ligature, and grasped with a Babcock clamp
- Two stay sutures of nonabsorbable material are then used to secure the stomach

- A pursestring absorbable suture is then placed and cautery used to open the gastric wall within the pursestring
- Two hemostats then grasp the mucosa; the stomach is entered, the hemostats are tied, and the edges of the mucosa are examined for bleeding
- A #20 French whistle-tip catheter in which extra holes have been cut is then placed through the gastrostomy incision
- The pursestring suture is tied
- The suture is then placed through the wall of the gastrostomy tube, making certain it does not traverse the lumen of the tube
- A second pursestring suture is then placed; however, with the orientation that the place where the suture is tied is the most difficult to get to after the gastrostomy has been drawn up through the abdominal wall
- The gastrostomy tube is then brought out laterally to a separate stab wound carried out under local anesthesia
- The gastrostomy tube is then sutured in place, both above and on the anterior abdominal wall
- The area around the gastrostomy tube is then inspected for hemostasis; in addition to putting the absorbable suture back against the anterior abdominal wall, the most difficult area to achieve, the other sides of the gastrostomy are tacked to the anterior abdominal wall
- The gloves and gowns are then changed
- The wound is closed in layers
- Irrigation of the operative site, and sponge, needle, and instrument counts are obtained and confirmed prior to closure
- The subcutaneous tissue and skin are irrigated with Kantrex, and additional local anesthesia is injected
- The subcutaneous tissue and skin are closed
- A dry sterile dressing is placed and the gastrostomy tube is secured

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Review laboratory and radiologic tests and data
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions

- Write orders for post-op labs, films (where appropriate), medications, diet, and patient activity
- Chart patient progress notes
- Assess and remove drains when present
- Order and monitor tube feedings

Discharge day work

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Arrange for home health visits, tube feedings and monitoring

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Assess care of tube
- Dictate patient progress notes for medical chart
- Adjust tube feedings where necessary

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)	11.92	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	43830	43832
Survey response	37	23
Pre-service time	50	50
Intra-service time	60	70
Immediate Post-service time	25	30
Total critical care time	0	0
Total other hospital visit time	87	106
Discharge management time	36	36
Total office visit time	46	46
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	2.69	2.70
Intra-service	2.83	2.83
Post-service	2.71	2.65
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	2.49	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.73
Urgency of medical decision making	2.57	2.50
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	2.89	3.04
Physical effort required	2.77	2.65
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.09	3.00
Outcome depends on the skill and judgment of physician	3.00	2.96
Estimated risk of malpractice suit with poor outcome	2.69	2.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43830				
Pre-service total		50	0.0224	1.12
Intra-service		60	0.073	4.35
Post-service				
Immediate post		25	0.0224	0.56
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	3	0.64	1.92
	99232	1	1.06	1.06
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	0	0.43	0.00
	99213	2	0.65	1.30
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				6.12
Total RVW by Building Block Method =				11.59

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

5,856	general surgery	5	plastic & reconstructive surgery
481	gastroenterology	4	anesthesiology
223	clinic or group practice (not gppp)	4	pediatric medicine
171	internal medicine	3	nuclear medicine
154	colorectal surgery	3	maxillofacial surgery
150	vascular surgery	2	unknown supplier/provider specialty
137	thoracic surgery	2	cardiology
94	urology	2	hand surgery
64	general practice	2	medical oncology
48	surgical oncology	1	infectious disease
38	obstetrics/gynecology	1	pulmonary disease
29	diagnostic radiology	1	hematology/oncology
26	family practice	1	allergy/immunology
18	gynecology/oncology	1	interventional radiology
17	cardiac surgery	1	neurosurgery
14	emergency medicine	1	nurse practitioner
13	critical care (intensivists)	1	osteopathic manipulative therapy
10	orthopaedic surgery	1	pathology
10	ophthalmology	1	physician assistant
9	peripheral vascular disease	1	rheumatology
6	otolaryngology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 7 Yes
30 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
7 I do not agree

c. Patients requiring this service are now:

- 7 more complex (more work)
0 less complex (less work)
0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
0 from inpatient to outpatient
7 no change

CPT Code: 43860

Current RVW: 19.91
Survey Median RVW: 25.00
ACS Recommended RVW: 25.00
RUC Recommended RVW: 25.00

CPT Descriptor: Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; without vagotomy

Global Period: 90 days

Typical Patient: A 65-year-old female presents with a history of a previous vagotomy and antrectomy, with a gastrojejunostomy for drainage. She has developed recurrent anastomotic strictures, resulting in a chronically distended stomach, and gastric ulcerations. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. At operation, a careful dissection of the stomach and previously constructed gastrojejunostomy is performed. This includes a careful dissection of the anastomosis, mobilization of the scarred stomach and jejunum, along with the pancreas, duodenum, and liver and bile ducts. The previously constructed anastomosis is taken down, the distended stomach is resected to an appropriate size, and a new gastrojejunostomy is constructed. The area is drained, as appropriate. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after she is afebrile, the wound is satisfactory, and she is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed gastric problems, wound complications or infections occur. The nutritional status of the patient is also monitored to ensure that adequate nutritional intake occurs.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to endoscopy and pathology reports and blood-work
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin

- A sponge is placed over the loran over the previous incision
- The sponge is resected and the loran applied to the wound
- Local anesthesia is injected into the anterior abdominal wall over the site of the previous incision
- The old incision is excised
- The abdominal wall is carefully divided and the peritoneum is entered
- A thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including the bladder and rectum
- Wound towels dipped in Kantrex are sewn onto the wound, or a vinyl wound protector is placed
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The stomach is mobilized and carefully palpated to identify the anatomy
- The stomach is dissected free from the liver
- Any bleeding from the liver from stripping of Glisson's capsule is coagulated and sutured
- If necessary, an argon-beam coagulator is utilized to make certain that hemostasis is secure
- The gastrojejunostomy is dissected free from underneath the transverse mesocolon, and the sutures holding the transverse mesocolon to the previous gastrojejunostomy are divided
- The stomach is isolated with laparotomy packs, and sutures are used to secure the gastric wall in preparation for resection
- The nasogastric tube is irrigated with Kantrex and drawn back so as not to cut across the nasogastric tube
- A partial gastrectomy is then carried out with two passes of a TA-90 stapler, the first along the lesser curve and subsequently along the greater curve
- The two limbs of the gastrojejunostomy are freed up by dividing the mesentery and placing Allen-Kocher clamps across the limbs of the gastrojejunostomy distally and Kocher clamps proximally
- The gastrojejunostomy is then resected between the staples of the TA-90 and the Allen-Kocher clamps distally
- The two ends of the gastrojejunostomy are then reanastomosed with a two-layer anastomosis
- A Hoffmeister turn-in is then fashioned
- An initial layer of absorbable suture in over-and-over hemostatic fashion is then placed across the lesser curve
- This layer is then run back with running Lembert sutures to tie with the initial layer
- A fine layer of interrupted nonabsorbable Lembert sutures is then placed on the lesser curve
- A gastrojejunostomy is then carried out in retrocolic fashion, assuming that this has not been done in retrocolic fashion; if it has been done in retrocolic fashion, the transverse mesocolon is then sutured to the stomach with interrupted nonabsorbable sutures
- A gastrojejunostomy is then carried out; great care is exercised so that the corners are not constricted
- Care is taken to ensure vascular viability of the anastomosis as well as hemostasis and water tight construction
- The position of the nasogastric tube is adjusted and ascertained to be in the correct place for drainage
- Depending on the patient's condition, retrograde gastrostomy and/or feeding catheter jejunostomy (separate codes) may be carried out if the patient is believed to be at poor nutritional risk
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The abdominal wall is then irrigated with saline or Kantrex, and another inspection is made for other abnormalities and hemostasis
- A closed-system suction drain may be inserted to drain localized areas
- The anterior abdominal wall is then closed with standard technique, and subcutaneous tissue is irrigated and may be drained with a closed-suction drain when indicated
- The skin is then closed in a standard fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Check nasogastric tube position and drainage

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Review laboratory and radiologic tests and data
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Remove the nasogastric tube when drainage has decreased to an extent where post-removal emesis will not be a problem
- Remove the Foley catheter and watch for adequate voiding; check urinary residual where appropriate

Discharge day work

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	43860	44626
Survey response	29	13
Pre-service time	75	75
Intra-service time	180	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	237	136
Discharge management time	36	36
Total office visit time	61	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.79	3.31
Intra-service	4.39	4.08
Post-service	3.79	3.46
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.21	3.46
Urgency of medical decision making	3.69	3.15
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.38	4.15
Physical effort required	4.17	4.00
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.38	4.00
Outcome depends on the skill and judgment of physician	4.45	4.23
Estimated risk of malpractice suit with poor outcome	4.00	4.08

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43860				
Pre-service total		75	0.0224	1.68
Intra-service		180	0.088	15.84
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	5	0.64	3.20
	99232	2	1.06	2.12
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				12.02
Total RVW by Building Block Method =				29.54

FREQUENCY INFORMATION

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

General Surgery **Sometimes**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

702	general surgery	2	urology
23	clinic or group practice (not gppp)	1	cardiac surgery
23	vascular surgery	1	critical care (intensivists)
11	surgical oncology	1	family practice
10	thoracic surgery	1	internal medicine
2	colorectal surgery	1	orthopaedic surgery
2	general practice	1	plastic & reconstructive surgery
2	peripheral vascular disease		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 3 Yes
- 26 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 3 I do not agree

c. Patients requiring this service are now:

- 3 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 3 no change

CPT Code: 49020

Current RVW: 16.79
Survey Median RVW: 22.84
ACS Recommended RVW: 27.76
RUC Recommended RVW: 20.73

CPT Description: Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal

Global Period: 90 days

Typical Patient: A 58-year-old hospitalized male patient has a history of undergoing a Hartmann procedure for perforated sigmoid diverticulum with gross intraperitoneal contamination and soilage approximately one month ago; followed by low- and then high-grade fevers; and CT-scan-confirmed multiple intraperitoneal abscesses throughout the entire range of the mesentery, with at least three separate obvious collections of pus, as well as a questionable subhepatic collections on the right and left side. Because of the extensive nature of the disease and the lack of accessibility to drain these abscesses with a catheter percutaneously, he requires surgery to drain these multiple abscesses via the open approach. Preoperatively, once the decision to operate has been made, the surgeon reviews laboratory and radiologic studies in order to plan the operative approach. Communication with the patient and family are done, and informed consent is obtained. At operation, a complete abdominal re-exploration is performed, including interruption of all of the abscessed cavities, irrigation with saline, and subsequent antibiotic solution. Careful re-exploration of the entire abdomen is also performed to rule out other abscess collections. Closure of the abdominal wall is undertaken and the subcutaneous tissue and skin are packed open with antibiotic-soaked gauze. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, necrotizing fasciitis, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous fluids are discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet. Office visits are conducted as necessary during the 90-day global period for continued wound care, and to ensure that no delayed gastrointestinal problems, wound complications or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-Service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-Service work -Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family.
- Answer patient and family questions and obtain informed consent,
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all-necessary surgical instruments and supplies are readily available in the operative suite.
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work -Skin to skin:

- A midline incision is made entering the peritoneal cavity in standard fashion.
- Exploration carried out manually for pathology, specifically abscessed cavity (s)
- Other abdominal contents also systemically examined.
- Exploration is carried out using the retractors of choice.
- Once the exploration is complete, the self-retaining retractor is hooked to the table and the appendages applied so as to provide good visualization for the procedure.
- The abscess (es) are localized and drained using sharp incision to incise them and suction apparatus to evacuate.
- When evacuation is complete, irrigation is carried out.
- Following irrigation, re-exploration is carried out to assure that no abscesses are missed.
- In addition, in exploration a source of the infection is examined for.
- Drains are placed appropriately as needed and brought out through a separate stab wound.
- Once it is felt that irrigation is complete, ready for closure.
- Abdominal wall/fascia is carefully closed in the usual fashion.
- Subcutaneous tissue is irrigated with saline.
- Skin is closed in the usual fashion.

Post-Op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff.
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician.
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress.
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes.

Post-op Other Hospital work -Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Remove the abdominal drain when indicated by patient progress and clinical exam, laboratory test findings, etc.
- Chart patient progress notes.

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	22.59	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	49020	44626
Survey response	28	15
Pre-service time	60	60
Intra-service time	120	160
Immediate Post-service time	30	30
Total critical care time	60	0
Total other hospital visit time	237	177
Discharge management time	36	36
Total office visit time	99	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.93	3.40
Intra-service	4.33	4.27
Post-service	4.22	3.53
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.96	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.04	3.73
Urgency of medical decision making	4.23	3.40
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.11	4.13
Physical effort required	4.22	4.07
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.48	3.93
Outcome depends on the skill and judgment of physician	4.19	4.13
Estimated risk of malpractice suit with poor outcome	3.85	4.13

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe that the survey respondents underestimated the work for postoperative care (including ICU), that is necessary and typical for these patients, when they estimated the work RVU. These patients are quite ill and require ICU bedside care by the surgeon for hemodynamic monitoring and medication adjustments. We recommend the 75th percentile RVW 27.76 which is supported by the building block analysis of the survey data. This analysis captures the correct incremental value for one ICU day as indicated by the survey respondents.

Additionally, we believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Time	Intensity	Work RVU (=time x intensity)
49020			
Pre-service total	60	0.0224	1.34
Intra-service	120	0.075	9.00
Post-service			
Immediate post	30	0.0224	0.67
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	1	4.00	4.00
99231	5	0.64	3.20
99232	2	1.06	2.12
99233	2	1.51	3.02
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			17.10
Total RVW by Building Block Method =			27.45

FREQUENCY INFORMATION

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

General Surgery Commonly

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,243	general surgery	4	gynecology/oncology
1,077	diagnostic radiology	4	plastic & reconstructive surgery
139	interventional radiology	3	peripheral vascular disease
124	clinic or group practice (not gppp)	2	hematology/oncology
35	colorectal surgery	2	critical care (intensivists)
34	vascular surgery	2	radiation oncology
25	thoracic surgery	1	cardiac surgery
22	urology	1	cardiology
19	general practice	1	nuclear medicine
14	surgical oncology	1	orthopaedic surgery
10	obstetrics/gynecology	1	psychiatry
9	internal medicine	1	anesthesiology
8	family practice	1	neurosurgery
6	emergency medicine	1	pediatric medicine
4	gastroenterology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 4 Yes
- 24 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 4 I do not agree

c. Patients requiring this service are now:

- 4 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 4 no change

CPT Code: 49428

Current RVW: 2.38
Survey Median RVW: 7.00
ACS Recommended RVW: 6.06
RUC Recommended RVW: 6.06

CPT Descriptor: Ligation of peritoneal-venous shunt

Global Period: 10 days

Typical Patient: A 68-year-old hospitalized male requires ligation of a peritoneal-venous shunt (e.g. LeVeen, Denver) that was placed five days previously for chronic refractory ascites. His has extensive bleeding and coagulopathy. Preoperatively, once the decision to operate has been made, the surgeon reviews laboratory, hematologic and radiologic studies. Communication with the patient and family are done, and informed consent is obtained. At operation, the shunt is exposed and ligated temporarily in anticipation of the defect resolving and allowing resumption of shunt function. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, hematologic status, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous fluids are discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet. Office visits are conducted as necessary through the 10-day global period to ensure that no delayed abdominal, gastrointestinal problems, ascitic wound complications or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work – Day before procedure:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to coagulation studies
- Order blood transfusion type and cross-match to include fresh frozen plasma and platelets
- Review planned incisions and procedure

Pre-service work – Day of Procedure:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to coagulation studies
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure
- Assure that the patient is adequately stabilized and hydrated prior to surgery
- Assure that transfusion blood products are available
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Obtain transfusion consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- The skin incision is made sharply over the subcutaneous course of the previously placed peritoneovenous shunt
- The shunt is doubly-ligated with 2-0 non-absorbable suture
- The operative site is inspected for hemostasis.
- The subcutaneous tissue is carefully reapproximated with 3-0 absorbable suture
- The skin is closed in the usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress, with special attention to abnormal bleeding
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs (especially related to coagulation studies), diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions

- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 90% Random (mail/fax) and 10% Convenience (specialty meeting)

Survey CPT Code: 49428

Sample Size: 140 **Response:** 22 16%

	Low	25th pctl	Median	75th pctl	High
Survey RVW	3.40	6.06	7.00	9.28	18.00

Pre-Service 45

Intra-Service 15 30 **35** 45 60

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	23	
Critical Care	0	
Other Hospital	49	99232x1 99231x1
Discharge Day Mgmt	36	99238
Office Visits	38	99213x1 99212x1

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
49422	Removal of permanent intraperitoneal cannula or catheter	6.25	10

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>49428</u>	<u>49422</u>
Survey response	22	11
Pre-service time	45	45
Intra-service time	35	45
Immediate Post-service time	23	20
Total critical care time	0	0
Total other hospital visit time	49	19
Discharge management time	36	36
Total office visit time	38	15
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.35	2.73
Intra-service	2.80	2.91
Post-service	3.35	2.82
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.24	2.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.73
Urgency of medical decision making	3.71	2.73
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	2.67	2.82
Physical effort required	2.57	2.73
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.57	3.09
Outcome depends on the skill and judgment of physician	3.38	2.91
Estimated risk of malpractice suit with poor outcome	3.00	2.91

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The survey respondents indicated two post-discharge office visits, which we believe is not correct for this 10-day global procedure. Therefore, we recommend the 25th percentile RVW of 6.06. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW [6.69 minus 99212 RVW of 0.43 = 6.26].

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:	Work RVU		
49428	Time	Intensity	(=time x intensity)
Pre-service total	45	0.0224	1.01
Intra-service	35	0.032	1.12
Post-service			
Immediate post	23	0.0224	0.50
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	0	4.00
	99231	1	0.64
	99232	1	1.06
	99233	0	1.51
	99238	1	1.28
	99211	0	0.17
	99212	1	0.43
	99213	1	0.65
	99214	0	1.08
	99215	0	1.73
Post-service total			4.56
Total RVW by Building Block Method =			6.69

FREQUENCY INFORMATION

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

General Surgery 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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

8	general surgery	1	clinic or group practice (not gppp)
8	neurosurgery	1	thoracic surgery
7	vascular surgery		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

2 Yes

20 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

2 I do not agree

c. Patients requiring this service are now:

2 more complex (more work)

0 less complex (less work)

0 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

2 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44950

Current RVW: 8.70
Survey Median RVW: 10.00
ACS Recommended RVW: 10.00
RUC Recommended RVW: 10.00

CPT Descriptor: Appendectomy;

Global Period: 90 days

Typical Patient: A 21-year-old female presents in the emergency department with findings consistent with appendicitis. Once a decision to operate has been made, the surgeon stabilizes and prepares the patient for emergent surgery, including assessment of pre-existing medical problems, reviewing laboratory and x-ray/imaging studies, assuring adequate ventilation and intravenous fluid administration, ordering pre-operative antibiotics, and communicating and obtaining informed consent from the patient and/or family. At operation, an inflamed (non-perforated) appendix is resected. Postoperative care of the patient includes monitoring of intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after she is afebrile, the wound is satisfactory, and she is tolerating an adequate diet. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed gastric problems, wound complications or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- The skin incision is made and the dissection is carried down through the subcutaneous tissue
- Muscles of the anterior abdominal wall are divided along the line of muscle fibers
- The peritoneum is divided and opened and the local peritoneal cavity is inspected and palpated
- Aerobic and anaerobic cultures may be taken if active infection is noted
- The cecum is mobilized and the omentum is likewise removed from the inflamed appendix
- The appendiceal mesentery is divided with clamps and suture ligated

- The base of the appendix is tied with suture in two places and the appendix is divided
- The appendix is removed and the stump is invaginated with suture in many cases
- The local peritoneal cavity is re-inspected and irrigated with saline
- The peritoneum and muscle layers are then closed with suture
- The skin is usually closed, and may be drained with a closed system suction drain, or left open and packed with antibiotic soaked gauze

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Review laboratory and x-ray data and results
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes



Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 85% Random (mail/fax) and 15% Convenience (specialty meeting)

Survey CPT Code: 44950

Sample Size:	140		Response:	42	30%
	Low	25th pctl	Median	75th pctl	High
Survey RVW	7.31	9.02	10.00	11.00	14.56
Pre-Service			50		
Intra-Service	30	45	60	60	120
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	25				
Critical Care	0				
Other Hospital	38	99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1 99212x1			

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	11.23	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>44950</u>	<u>44800</u>
Survey response	42	13
Pre-service time	50	60
Intra-service time	60	70
Immediate Post-service time	25	30
Total critical care time	0	0
Total other hospital visit time	38	117
Discharge management time	36	36
Total office visit time	38	38
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	3.59	3.08
Intra-service	3.15	2.77
Post-service	2.74	2.69
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.15
Urgency of medical decision making	3.88	3.23
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	3.25	2.92
Physical effort required	3.10	2.85
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	3.35	2.69
Outcome depends on the skill and judgment of physician	3.38	2.85
Estimated risk of malpractice suit with poor outcome	3.23	3.15

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
44950				
Pre-service total		50	0.0224	1.12
Intra-service		60	0.073	4.35
Post-service				
Immediate post		25	0.0224	0.56
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	2	0.64	1.28
	99232	0	1.06	0.00
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	1	0.65	0.65
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				4.20
Total RVW by Building Block Method =				9.67

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

5,452	general surgery	7	emergency medicine
209	clinic or group practice (not gppp)	6	gynecology/oncology
187	vascular surgery	5	plastic & reconstructive surgery
103	thoracic surgery	4	ophthalmology
68	urology	3	hand surgery
62	general practice	2	cardiology
49	colorectal surgery	2	maxillofacial surgery
42	obstetrics/gynecology	1	cardiac surgery
39	family practice	1	endocrinology
26	surgical oncology	1	hematology/oncology
20	internal medicine	1	medical oncology
12	peripheral vascular disease	1	osteopathic manipulative therapy
8	anesthesiology	1	pediatric medicine
8	critical care (intensivists)	1	physician assistant
8	orthopaedic surgery	1	pulmonary disease

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

5 Yes

37 No

b. This service represents new technology that has become more familiar (i.e., less work).

1 I agree

4 I do not agree

c. Patients requiring this service are now:

3 more complex (more work)

0 less complex (less work)

2 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

2 from inpatient to outpatient

3 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 45110

Current RVW: 23.80
Survey Median RVW: 28.00
ACS Recommended RVW: 28.00
RUC Recommended RVW: 28.00

CPT Descriptor: Proctectomy; complete, combined abdominoperineal, with colostomy

Global Period: 90 days

Typical Patient: A 66-year-old female presents with a history of rectal bleeding and a biopsy proven 5cm adenocarcinoma. The distal margin is located at the dentate line. A chest x-ray and CT scans of the abdomen and pelvis are negative for metastatic disease. The surgeon reviews the intended procedure with the patient and her spouse, including the need for a permanent colostomy and informed consent is obtained. At operation, the entire left colon is mobilized and a high ligation of the inferior mesenteric artery is performed. The rectal dissection is performed circumferentially down to the pelvic floor. The bowel is divided proximally in the descending colon and an end colostomy is constructed. The abdomen is closed after placing drains. The patient is placed in lithotomy position and re-prepped and draped to allow the perineal dissection to be completed. The wound is closed in layers. Postoperative care includes all necessary hospital and office visits during the 90-day global period to assure normal recovery and the absence of any complications. [Note: When completing this survey, do not consider the work of the splenic flexure take-down because this is separately billable with a difference CPT code.]

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- The patient's anus is sutured closed
- A skin incision is made and the anterior abdominal wall is carefully divided
- The peritoneum is entered and adhesions are taken down by blunt and sharp dissection
- A through abdominal exploration is performed, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small and large bowel, kidneys, uterus, ovaries, bladder and rectum to access the extent and clinical stage of the clinical tumor
- A self-retaining retractor is secured to the operating table; rings and blades are selected and inserted along with packs to obtain appropriate visualization of the pelvis

- The descending and sigmoid colon along with their mesenteries are mobilized with electrocautery, sharp and blunt dissection, taking extreme care to avoid injury to the ureters, iliac arteries and veins, ovarian or spermatic vessels and sympathetic nerves (to avoid impotence or reverse ejaculation)
- The presacral space is opened with careful dissection beginning at the sacral promontory posterior to the upper rectum and extended inferiorly through Waldier's fascia to the levator muscles
- The lateral stocks to the rectum are serially divided and ligated
- The dissection proceeds anteriorly between the rectum and bladder just behind Devonier's fascia and is continued distally below the prostate gland to the anus
- The mesentery of the sigmoid colon then divided at the origin of the left colic artery from the inferior mesenteric artery
- The colon is skeletonized at the point of anticipated proximal transection and divided utilizing stapling devices
- The abdomen is then packed and attention is directed to the perineal area
- The perineal dissection is initiated with an elliptical skin incision around the anus which had been previously sutured closed
- Electrocautery dissection is utilized through the fatty perirectal tissue to the levator muscles
- The posterior coccygeal raphe is incised and the previously developed presacral space is entered from below
- The levator muscles are then divided carefully maintaining hemostasis at all times
- The rectum is subsequently freed from its remaining attachments to the prostate gland and the fibroareolar and muscular tissues
- The pelvis and resultant space is thoroughly irrigated with normotonic saline
- A closed suction drain is placed and brought out from the pelvis through a separate stab wound
- The remaining levator muscles are then approximated along with the perineal subcutaneous tissue and skin
- The colostomy site is now developed using a preoperatively marked and selected site as a guide
- The previously transected proximal colon is brought out through the wound and carefully secured to the abdominal wall fascia
- If necessary, the colon is further mobilized in order to avoid any tension on the colostomy and the vascular pedicles
- The self-retaining retractor is then removed and disassembled along with confirmation of the sponge, needle and instrument counts prior to closure of the abdomen
- The anterior abdominal wall and the peritoneum are closed with standard technique
- The subcutaneous tissues are thoroughly irrigated with normotonic saline
- The skin is closed in standard fashion
- The abdominal incision is then isolated and the closed end of the proximal bowel is opened
- The colostomy is then matured carefully avoiding any vascular embarrassment to the end colostomy segment
- The colostomy appliance is applied

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Discuss with patient any further treatments (chemoradiation)
- Ensure patient understands colostomy management
- Review pathology report and enter clinical stage of tumor in hospital tumor registry
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress and prognosis with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	20.89	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	45110	45116
Survey response	32	14
Pre-service time	80	80
Intra-service time	180	140
Immediate Post-service time	30	35
Total critical care time	0	0
Total other hospital visit time	207	136
Discharge management time	36	36
Total office visit time	91	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.32	4.17
Intra-service	4.61	4.17
Post-service	4.10	3.50
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.22	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	4.17
Urgency of medical decision making	4.09	3.83
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.63	5.00
Physical effort required	4.56	4.17
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.47	4.83
Outcome depends on the skill and judgment of physician	4.53	4.67
Estimated risk of malpractice suit with poor outcome	4.26	4.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
45110				
Pre-service total		80	0.0224	1.79
Intra-service		180	0.093	16.65
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	4	0.64	2.56
	99232	3	1.06	3.18
	99233	1	1.51	1.51
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	2	0.43	0.86
	99213	1	0.65	0.65
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				11.79
Total RVW by Building Block Method =				30.23

FREQUENCY INFORMATION

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

General Surgery and Colon and Rectal Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

3,477	general surgery	5	family practice
669	colorectal surgery	5	peripheral vascular disease
147	clinic or group practice (not gppp)	4	obstetrics/gynecology
85	vascular surgery	3	cardiac surgery
71	surgical oncology	3	emergency medicine
53	thoracic surgery	2	hand surgery
23	general practice	2	plastic & reconstructive surgery
17	ophthalmology	1	anesthesiology
10	maxillofacial surgery	1	critical care (intensivists)
9	urology	1	gastroenterology
6	internal medicine	1	physician assistant

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

7 Yes

25 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

7 I do not agree

c. Patients requiring this service are now:

6 more complex (more work)

0 less complex (less work)

1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

7 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 47780

Current RVW: 22.29
Survey Median RVW: 26.50
ACS Recommended RVW: 26.50
RUC Recommended RVW: 26.50

CPT Code: 47780

CPT Descriptor: Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract

Global Period: 90 days

Typical Patient: A 50-year-old female presents with a history of a previous laparoscopic cholecystectomy, followed two months later by re-operation for jaundice which revealed a narrowing of the common bile duct. A resection and primary anastomosis of the common bile duct was performed. It is now two years later and she reappears with recurrent jaundice, cholangitis, and ERCP-confirmed obstruction of the common bile duct. Preoperatively, once the decision to operate has been made, the surgeon reviews laboratory and radiologic studies. Preoperative instructions and bowel prep orders are given. Communication with the patient and family are done, and informed consent is obtained. At operation, a dissection of the common bile is performed, including dissection of the prior anastomosis, mobilization of the scarred stomach and duodenum, along with the pancreas, small bowel and colon. The small bowel is divided and mobilized in order to bring a loop of small bowel into apposition with the structured bile duct. The bile duct is then opened and a suitable area is prepared and then sewn to the jejunum. The distal small bowel is then anastomosed to remaining small bowel in a Roux-en-Y. The area is widely drained as appropriate, including a T-tube as necessary. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after she is afebrile, the wound is satisfactory, she is tolerating an adequate diet, and some drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no biliary tract problems, wound / drain complications or infections occur. Drains are further removed as indicated. A T-tube cholangiogram is ordered and reviewed and the T-tube is removed when appropriate.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

- **Pre-service work - Day before surgery**
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports and nutritional status
- Review pre-operative work-up, with particular attention to films
- Review biliary cultures and sensitivities with specific attention to drug allergies and the most appropriate perioperative antibiotics
- Review planned incisions and procedure, especially in view of the possibility of malignancy

- **Pre-service work - Day of surgery**
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent

- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Review x-rays, making certain that all x-rays are available and appropriately hung on the operating room wall on view-boxes so that they may be referred to intra-operatively
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning and draping as needed
- Scrub and gown
- Place or supervise subclavian lines (if necessary) and Foley catheters

- **Intra-service work – Skin to skin**
- A sponge is placed under the loban over the previous incision
- Local anesthesia is injected into the path of the presumed incision
- A skin incision is made and the old excision is excised
- The abdominal wall is carefully divided and hemostasis is secured with cautery and ligation
- The peritoneum is entered
- Numerous adhesions in the right upper quadrant of the previous incision(s) are taken down
- Areas of bleeding from the liver where the capsule may have been stripped are coagulated and/or sutured
- The spleen, liver, stomach, duodenum, pancreas, small bowel, kidneys, adrenals, and pelvic organs including the bladder and rectum are either visualized or palpated
- Wound towels are sewn in place or a plastic wound protector is placed
- A self-retaining retractor is secured to the operating room table
- The various attachments are inserted and secured so that adequate exposure can be obtained
- The stomach and duodenum especially are carefully mobilized and adhesions are taken down
- Areas of bleeding from the liver are coagulated and/or sutured
- The foramen of Winslow is identified and palpated
- The duodenum is Kocherized
- The common duct is identified and its blood supply is carefully protected while it is dissected free
- If the common duct is difficult to identify, needle aspiration of the various structures may be required to identify the common duct
- A vein retractor is placed to retract the hepatic artery
- After careful dissection, the common duct is encircled with a vessel loop and freed up from the surrounding structures for a distance of 4 cm
- Silastic loops are placed around the hepatic artery
- The Penrose drain is used to encircle the entire portal triad
- The cystic duct stump from the previous cholecystectomy is inspected; if the stump is too long, it is mobilized, clamped, divided, and tied; the end is oversewn with 3-0 Prolene
- With the common duct and the duodenum being sufficiently mobilized, the distal scarred end of the common duct is divided with an atraumatic clamp and resected
- The distal end is tied with a nonabsorbable suture and its end oversewn with 3-0 Prolene or a similar suture
- Attention is then turned to the ligament of Treitz; the proximal portion of the jejunum is mobilized up to the point where the first major arcade is encountered
- Two vessels on either side of the prospective point of transection are then clamped, divided, and tied with fine nonabsorbable suture
- A GIA 55 mm stapling device is then placed across the jejunum and fired
- The distal end of the transected jejunum is then mobilized and brought up through the transverse mesocolon into the lesser sac
- The end of the transected jejunum is then oversewn with three layers of suture; the first, a hemostatic suture, is then placed underneath the staple line and run back after a U corner stitch to running Lembert sutures to tie with the original end of the suture; a final layer of fine interrupted nonabsorbable Lembert sutures is then placed
- The common duct is transected
- A choledochoscope is then used to inspect the hepatic ducts and the common duct through its open end; suspicious areas are biopsied for question of malignancy

- The bile from the common hepatic duct is aspirated and sent for culture
 - The transected end of the common duct is anastomosed to the Roux-en-Y utilizing two layers of nonabsorbable suture
 - As the anastomosis is being carried out, a long-arm T-tube is inserted through the Roux-en-Y, through the anastomosis, into the common duct
 - Omentum is used to protect the anastomosis
 - Attention is then turned to the distal end of the ligament of Treitz, which is then anastomosed end-to-side to the Roux-Y loop, measuring 60 cm downstream from the biliary anastomosis
 - The position of the nasogastric tube is checked and adjusted, and ascertained to be in the correct place for drainage
 - Depending on the patient's condition, a gastrostomy and catheter jejunostomy is carried out for drainage and tube feeding, respectively, if the patient is in poor general condition
 - The Roux-en-Y is sutured to the transverse mesocolon, and the side-to-end entero-enterostomy is protected by omentum sutured around it
 - The wound towels and the retractor are then removed
 - Gloves, gowns, and drapes are then changed
 - A closed-suction drain may be inserted for drainage of the right upper quadrant
 - The anterior abdominal wall is closed in layered fashion
 - The subcutaneous tissue is irrigated
 - A closed-suction drain may be inserted in the subcutaneous layer
 - Subcutaneous sutures are then placed
 - The skin is closed in standard fashion
 - A dry sterile dressing is placed
- **Post-op Same day work through discharge from recovery**
 - Apply dressings
 - Write orders for post-op labs, films, medications, diet, and patient activity
 - Review recovery room care and medications with staff
 - Discuss procedure outcome with family
 - Discuss procedure outcome with patient after emergence from anesthesia
 - Dictate post-op report
 - Discuss procedure outcome with referring physician
 - Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- **Post-op Same day work after discharge from recovery**
 - Examine patient, check wounds and patient progress
 - Review nursing/other staff patient chart notes
 - Answer patient family questions
 - Answer nursing/other staff questions
 - Write orders for following day's labs, films, medications, diet, and patient activity
 - Chart patient progress notes
- **Post-op Other Hospital work - Beginning on post-op day 1, until discharge day**
 - Check wounds and abdomen
 - Listen to chest
 - Check legs for thrombophlebitis
 - Remove Foley catheter; check for voiding and/or urinary residuals
 - Remove nasogastric tube when appropriate
 - Examine and talk with patient
 - Check wounds and patient progress
 - Discuss patient progress with referring physician (verbal and written)
 - Review nursing/other staff patient chart notes
 - Answer patient/family questions
 - Answer nursing/other staff questions (verbal and written)
 - Answer insurance staff questions
 - Write orders for post-op labs, films, medications, diet, and patient activity

- Chart patient progress notes
- **Discharge day work**
- Arrange for outpatient cholangiogram
- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Give patient typed instructions for diet, activity, etc.
- **Post-op Office work - After discharge from hospital**
- Examine and talk with patient
- Review t-tube cholangiogram
- Remove t-tube when appropriate
- Remove drain when appropriate
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	21.74	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>47780</u>	<u>47760</u>
Survey response	28	19
Pre-service time	75	75
Intra-service time	190	135
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	199	166
Discharge management time	36	36
Total office visit time	76	61
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.11	4.11
Intra-service	4.61	4.56
Post-service	4.14	4.06
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.22	4.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.52	4.33
Urgency of medical decision making	4.11	4.06
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.78	4.71
Physical effort required	4.63	4.53
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.67	4.53
Outcome depends on the skill and judgment of physician	4.67	4.47
Estimated risk of malpractice suit with poor outcome	4.48	4.24

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
47780				
Pre-service total		75	0.0224	1.68
Intra-service		190	0.083	15.68
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	3	0.64	1.92
	99232	2	1.06	2.12
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	1	0.65	0.65
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				11.17
Total RVW by Building Block Method =				28.53

FREQUENCY INFORMATION

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

General Surgery **Commonly**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,063	general surgery	3	urology
37	clinic or group practice (not gppp)	2	maxillofacial surgery
35	surgical oncology	1	allergy/immunology
19	thoracic surgery	1	infectious disease
19	vascular surgery	1	internal medicine
9	general practice	1	medical oncology
6	family practice	1	ophthalmology
3	colorectal surgery	1	orthopaedic surgery
3	emergency medicine	1	peripheral vascular disease
3	plastic & reconstructive surgery		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

5 Yes
23 No

b. This service represents new technology that has become more familiar (i.e., less work).

1 I agree
4 I do not agree

c. Patients requiring this service are now:

4 more complex (more work)
0 less complex (less work)
1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
0 from inpatient to outpatient
5 no change

CPT Code: 43360

Current RVW: 28.78
Survey Median RVW: 35.70
ACS Recommended RVW: 40.00
RUC Recommended RVW 35.70

CPT Descriptor: Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty

Global Period: 90 days

Typical Patient: A 38-year-old male requires gastrointestinal reconstruction for a previous esophageal exclusion for an esophageal perforation. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At laparotomy, the stomach is mobilized. Through a separate neck incision, the proximal esophagus is also mobilized. A tunnel is made substernally. The stomach is transposed through the tunnel into the neck and anastomosed to the esophagus (ie, esophagogastrostomy). The neck is drained. Postoperative hospital care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, and fluid balance. Wound checks and dressing changes are made to assure an absence of hematoma and drainage. Communication occurs with the patient and family and coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after return of bowel function, and after review of a Gastrograffin study confirms the absence of an anastomotic leak. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet. Post-discharge office visits are scheduled as necessary (through the 90-day global period) to ensure that no delayed anastomotic strictures, wound complications, or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to CT scans of the abdomen and chest, and barium swallow
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- The patient is positioned in a semi-left lateral position.
- All nerve and pressure points are carefully padded to avoid neuropraxia.
- The right arm is specifically draped and padded and supported on a Mayo stand with pillows.
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed

- Scrub and gown

Intra-service work - Skin to skin:

- A semi-left lateral position incision is made in the 6th or 7th interspace, using standard technique.
- The pleural space is entered and the right lung is cautiously retracted.
- The inferior pulmonary ligament is divided, and the mediastinum is entered.
- The pleura is opened between the inferior vena cava and the pericardium; thus the esophagus is identified.
- The esophagus is freed up, from above the superior aspect of the diseased area, down to the esophago-gastric junction.
- The phrenicoesophageal ligament is opened anteriorly to expose the cardia of the stomach.
- The table is partially rotated to place the patient in the semi-supine position
- A laparotomy is performed
- The gastroesophageal junction is mobilized at the hiatus
- The stomach and duodenum are mobilized, ligating the left gastric artery, preserving the right gastroepiploic arcade, and dividing and ligating the short gastric vessels between the spleen and the stomach
- A pyloroplasty is performed
- The stomach is then delivered through the hiatus in to the right chest; here it is divided from the GE junction
- The patient is then rotated back in to the original left lateral position
- The esophagus is divided above the diseased area
- The esophagus is anastomosed to the gastric pouch with two layers of interrupted 4-0 suture
- The wound is carefully inspected for hemostasis.
- The pleura is loosely reapproximated.
- A chest tube is placed through a separate incision inferior to the thoracotomy incision; it is secured to the skin in the usual manner.
- The chest is closed in the usual fashion.
- The abdominal wound is closed in the usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Order a postoperative chest x-ray to ensure normal expansion of the lung; review the films.
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Monitor pulmonary function and chest tube function.
- Order and review a Gastrografin swallow on post operative day seven to check for a leak and anastomotic patency
- Remove nasogastric tube
- Order a liquid diet
- Progress diet to solids, instruct patient in anti-reflux positioning for eating and in anti-dumping dietary selections
- Remove chest tube when the pleural space is adequately sealed and the lung is normally expanded.
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review anti-reflux and anti-dumping dietary guidelines
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Order postoperative chest x-ray.
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
35091	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels	35.40	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	43360	35091
Survey response	30	11
Pre-service time	90	100
Intra-service time	270	240
Immediate Post-service time	40	45
Total critical care time	0	120
Total other hospital visit time	229	229
Discharge management time	36	36
Total office visit time	99	99
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.40	4.45
Intra-service	4.83	5.00
Post-service	4.33	4.36
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.30	4.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	4.55
Urgency of medical decision making	3.97	4.45
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.83	4.91
Physical effort required	4.80	5.00
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.83	5.00
Outcome depends on the skill and judgment of physician	4.73	4.91
Estimated risk of malpractice suit with poor outcome	4.43	4.64

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

For those 10 surgeons who performed this operation in the past 12 months (based on the survey's experience question), the median intraoperative time was 300 minutes, which is higher than the survey median. Additionally, the median length of stay for these same "experienced" surgeons was 14 days and included at least one day of ICU care (99291). For this rarely performed service, we believe that the survey median work RVU (based on "estimates") does not capture the correct postoperative EM RVU information. For this reason, we recommended the 75th percentile RVW of 40.00. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43360				
Pre-service total		90	0.0224	2.02
Intra-service		270	0.100	27.00
Post-service				
Immediate post		40	0.0224	0.90
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>	
	99291	0	4.00	0.00
	99231	3	0.64	1.92
	99232	3	1.06	3.18
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				13.11
Total RVW by Building Block Method =				42.12

FREQUENCY INFORMATION

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

General Surgery 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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

18	general surgery	1	clinic or group practice (not gppp)
9	thoracic surgery	1	internal medicine
3	cardiac surgery	1	surgical oncology
2	gastroenterology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

6 Yes
24 No

b. This service represents new technology that has become more familiar (i.e., less work).

1 I agree
5 I do not agree

c. Patients requiring this service are now:

6 more complex (more work)
0 less complex (less work)
0 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
0 from inpatient to outpatient
6 no change

CPT Code: 43415

Current RVW: 17.06
Survey Median RVW: 25.00
ACS Recommended RVW: 31.99
RUC Recommended RVW: 25.00

CPT Descriptor: Suture of esophageal wound or injury; transthoracic or transabdominal approach

Global Period: 90 days

Typical Patient: A 64-year-old male requires esophageal repair after his esophagus was inadvertently ruptured at a distal esophageal stricture site while undergoing an EGD at an outpatient endoscopy center. Once a decision to operate has been made, the surgeon stabilizes and prepares the patient for emergent surgery, including assessment of pre-existing medical problems, reviewing laboratory and x-ray/imaging studies, assuring adequate ventilation and intravenous fluid administration, ordering pre-operative antibiotics, and communicating and obtaining informed consent from the patient and/or family. At thoracotomy, the esophageal perforation is carefully dissected from surrounding scar tissue and repaired. The surrounding area is debrided and widely drained. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma, and drainage. Communication occurs with the patient and family, and coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after return of bowel function, and after a Gastrografin study confirms the absence of an esophageal leak. The patient's diet is advanced, intravenous feeding is discontinued, and discharge plans are completed, with the patient being discharged after he is afebrile, the wound and chest are satisfactory, he is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed anastomotic strictures, wound complications, or infections occur.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- PLEASE NOTE THAT BECAUSE THIS IS AN URGENT/EMERGENT PROCEDURE, NO DAY BEFORE SURGERY PRE-SERVICE WORK IS INCLUDED**

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- The patient is positioned in the right lateral position.
- The left arm is specifically draped and padded and supported on a Mayo stand with pillow
- All nerve and pressure points are carefully padded to avoid neuropraxia.
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- A left postero-lateral incision is made in the 6th or 7th interspace, using standard technique.
- The pleural space is entered and the left lung is cautiously retracted.
- The inferior pulmonary ligament is divided, and the mediastinum is entered.
- The pleura is opened between the aorta and the pericardium; thus the esophagus is identified.
- The esophagus is freed up, from above the superior aspect of the perforated area, down to the esophago-gastric junction.
- The area of esophageal perforation is identified; the edges of the wound are carefully debrided
- The perforation is carefully reapproximated in two layers with interrupted monofilament suture
- A pleural flap is created from local pleura and sutured over the perforation repair site
- The area is copiously irrigated with sterile saline
- The wound is carefully inspected for hemostasis.
- A naso-gastric tube is carefully positioned and secured
- The pleura is loosely reapproximated.
- A chest tube is placed through a separate incision inferior to the thoracotomy incision; it is secured to the skin in the usual manner; it is positioned close to but not touching the esophageal repair site
- The chest is closed in the usual fashion.

Post-op Same day work through discharge from ICU

- Apply dressings
- Write orders for post-op labs, films, medications, diet (NPO), and patient activity
- Review ICU care and medications with staff
- Discuss procedure outcome with family
- Order a postoperative chest x-ray to ensure normal expansion of the lung; review the films.
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from ICU

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Monitor pulmonary function and chest tube function.
- Order and review a Gastrografin esophagram on post operative day five
- Remove chest tube when the pleural space is adequately sealed and the lung is normally expanded, and no evidence of leakage at perforation site is found.
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient

- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Order postoperative chest x-ray.
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS

Specialty(s): American College of Surgeons

Type of Sample: 85% Random (mail/fax) and 15% Convenience (specialty meeting)

Survey CPT Code: 43415

Sample Size: 140 **Response:** 30 21%

	Low	25th pctl	Median	75th pctl	High
Survey RVW	15.00	20.71	25.00	31.99	80.00
Pre-Service			75		
Intra-Service	105	125	150	208	240
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	45				
Critical Care	60	99291x1			
Other Hospital	229	99233x2	99232x3	99231x3	
Discharge Day Mgmt	36	99238			
Office Visits	99	99214x1	99213x2	99212x1	

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
43331	Esophagomyotomy (Heller type); thoracic approach	16.23	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	<u>43415</u>	<u>43331</u>
Survey response	30	9
Pre-service time	75	90
Intra-service time	150	120
Immediate Post-service time	45	30
Total critical care time	60	0
Total other hospital visit time	229	139
Discharge management time	36	36
Total office visit time	99	38
 <u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.45	3.38
Intra-service	4.63	3.88
Post-service	4.40	3.50
 <u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	4.25
Urgency of medical decision making	4.87	2.63
 <u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.63	4.14
Physical effort required	4.53	3.71
 <u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.83	3.88
Outcome depends on the skill and judgment of physician	4.67	4.13
Estimated risk of malpractice suit with poor outcome	4.50	3.75

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

When you subtract preoperative and postoperative EM equivalent RVWs from the RUC survey median, the result is 6.89 RVU's. This is equal to an IWP/UT of 0.046 for 150 minutes of intra-operative work (6.89/150). This is less than intensive care intensity. This infrequently performed procedure (survey median experience is 0; range 0 to 2), which is always emergent, should have an intra-intensity higher than 0.046. Therefore, we recommend the 75th percentile RVW of 31.99. This results in an intraoperative intensity of 0.08 that is slightly higher than intensive care (99291).

Additionally, we believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
43415				
Pre-service total		75	0.0224	1.68
Intra-service		150	0.085	12.75
Post-service				
Immediate post		45	0.0224	1.01
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	1	4.00	4.00
	99231	3	0.64	1.92
	99232	3	1.06	3.18
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	2	0.65	1.30
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				17.22
Total RVW by Building Block Method =				31.65

FREQUENCY INFORMATION

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

General Surgery 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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

177	general surgery	4	general practice
91	thoracic surgery	2	medical oncology
17	cardiac surgery	2	otolaryngology
15	clinic or group practice (not gppp)	1	colorectal surgery
6	cardiology	1	gastroenterology
6	vascular surgery	1	surgical oncology

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

4 Yes
26 No

b. This service represents new technology that has become more familiar (i.e., less work).

1 I agree
3 I do not agree

c. Patients requiring this service are now:

3 more complex (more work)
0 less complex (less work)
1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
1 from inpatient to outpatient
3 no change

CPT Code: 47120Current RVW: 22.79
Survey Median RVW: 33.43
ACS Recommended RVW: 35.50
RUC Recommended RVW: 35.50**CPT Descriptor:** Hepatectomy, resection of liver; partial lobectomy**Global Period:** 90 days

Typical Patient: A 67-year-old male, who two years previously had a right colon resection for carcinoma, presents now with a 6 cm. mass in the right lobe of his liver that a CT directed biopsy revealed to be adenocarcinoma consistent with metastatic disease of the colon. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach; discusses the procedure with the patient, and obtains informed consent. At operation, the liver and lesion are dissected from the surrounding adhesions and scar tissue, including the colon, stomach and duodenum. A careful exam is made of the entire liver and abdomen to rule out other sites of metastatic disease. A partial resection of the right lobe of the liver is performed, removing the lesion and a surrounding zone of normal liver. The area is widely drained as necessary. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, blood loss, coagulation status and fluid balance. Wound checks and dressing changes are made to assure an absence of hematoma, infection, and drainage. Communication occurs with the patient and family and coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced and intravenous feeding is discontinued. Drains are removed as appropriate. Discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet via the GI tract. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed wound complications or infections occur, and that adequate nutrition is being tolerated. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):**Pre-service work - Day before surgery**

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports and "liver chemistries"
- Review pre-operative work-up, with particular attention to films and scans
- Review planned incisions and procedure

Pre-service work - Day of surgery

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

- The patient is positioned with the right side up approximately 10° on a roll
- The chest and upper thighs are prepped, as well as the abdomen

Intra-service work - Skin to skin

- A skin incision is made and extended across the midline in a bilateral chevron incision
- The anterior abdominal wall is carefully divided
- The peritoneum is entered
- Thorough exploration of the area around the liver is undertaken, including palpation and visualization where possible
- The liver, stomach, duodenum, and lymph nodes in the preaortic and pancreatic area are visualized
- The duodenum is Kocherized and the pancreas carefully inspected for tumors
- The small bowel, large bowel, kidneys, pelvis, and adrenals including the bladder and rectum are carefully palpated
- Several slightly enlarged portal lymph nodes are dissected free, biopsied, and sent for frozen section
- Any adhesions present are taken down by sharp and blunt dissection
- The falciform ligament is divided and the attachments between the liver and the diaphragm are dissected free
- The right lobe of the liver is dissected from the lateral abdominal wall so that it may be mobilized anteriorly
- The porta hepatis is isolated and encircled with a Penrose drain
- Specifically, the hepatic artery and portal vein are dissected free from the biliary tree and looped with different color vessel loops
- The common hepatic duct is identified, a vessel loop is placed around it, and it is dissected free from the hepatic artery and the portal vein
- The gallbladder is identified, and the peritoneum over the gallbladder is opened
- A Reinhof clamp is then used to grasp the peritoneum of the gallbladder
- The gallbladder is dissected free using sharp and blunt dissection, as well as sutures and cautery where appropriate
- The cystic duct is identified and encircled with a nonabsorbable suture such as silk, as is the cystic artery
- The gallbladder is removed from the fundus downward until the only structures remaining are at the porta hepatis
- The cystic duct is carefully ligated and divided, and the stump of the cystic duct oversewn
- The cystic artery is doubly ligated with nonabsorbable suture and divided
- The gallbladder is removed
- The hepatic plate is lowered at the portal bifurcation as described by Blumgart
- The extension of Glisson's capsule is divided and both hepatic arteries and both branches of the common duct are exposed
- Vessel loops are placed around all of these structures
- With the porta and the right lobe mobilized, intraoperative ultrasound is undertaken to make certain that no additional hepatic tumors are present, even if they are not palpable, and to identify the middle hepatic vein
- To determine whether the tumor in the right lobe extends across the segments, segments IV and VI are carefully evaluated and palpated
- Wound towels, whose edges are dipped in Kantrex, are sewn in place (or vinyl ring drapes may be used)
- The self-retaining mechanical retractor is secured to the operating room table and the various attachments are utilized and exposure obtained for the hepatic resection
- Once it is ascertained that the tumor is resectable, the prospective area for resection is identified
- The ultrasonic dissector is then grasped; the presumed area for resection is then marked with a cautery
- The ultrasonic dissector is then used to outline the area for dissection

- Individual vessels and bile ducts are identified in the depths of the ultrasonic dissection, and are ligated with fine silk suture and divided
- Hemostasis within the liver is secured with nonabsorbable silk suture ties as well as Prolene to repair vessels which one wishes to preserve
- A 2-cm margin is obtained from the edges of the tumor
- Intraoperative ultrasound is used to detect the presence of hepatic veins in the area of dissection, as well as any other unsuspected anatomical features
- The specimen is then removed
- Hemostasis is secured, making certain that there are no bile leaks
- The remaining left lobe of the liver is once again inspected for residual tumor or tumors which may have been missed both by palpation and the ultrasonic examination
- The cut edge of the area where the tumor has been resected is then inspected for hemostasis and biliary leakage
- An argon-beam coagulator is then utilized on the closed surface of the resected liver for meticulous hemostasis
- The omentum may or may not be mobilized and placed against with the defect and against the cut edge of the liver to decrease biliary leakage and bleeding
- Two closed-suction drains are then placed in the immediate vicinity of the resection, towards the edge of the cut liver, as well as in the foramen of Winslow
- The right upper quadrant and the surrounding area, as well as the liver, are copiously irrigated with Kantrex
- The position of the nasogastric tube is checked
- Perioperative antibiotics are given preoperatively, but are repeated as necessary, depending on time intraoperatively; thus, if a first-generation cephalosporin is utilized, a redosing occurs at three hours following the initial dose
- Wound towels and the retractor are then removed
- The abdominal wall is closed in layered fashion with meticulous attention to hemostasis
- A drain may be left in the subcutaneous tissue if the surgeon desires
- The skin is closed in the usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Drainage from the two right upper quadrant drains is checked and their volume recorded
- Abdominal girth is measured every six hours to make certain that bile and/or ascites is not accumulating
- Check position and function of nasogastric tube
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Check the drainage from right upper quadrant and record
- Record abdominal girth
- Continue antibiotics for 24 hours at most, then discontinue
- Check liver chemistries every other day
- Check urine output and measure urine sodium, potassium, and osmolality
- If ascites supervenes, place on diuretics
- Make certain that serum albumin exceeds 3.0 gr/dl
- Remove nasogastric tube at appropriate time
- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Remove Foley catheter; check for voiding

Discharge day work

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta	28.01	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	47120	35081
Survey response	28	8
Pre-service time	75	75
Intra-service time	200	180
Immediate Post-service time	30	30
Total critical care time	60	60
Total other hospital visit time	210	158
Discharge management time	36	36
Total office visit time	91	76
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.32	4.00
Intra-service	4.86	4.88
Post-service	4.21	4.25
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.39	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.70	4.50
Urgency of medical decision making	4.26	4.00
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.89	4.88
Physical effort required	4.63	4.25
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.85	4.75
Outcome depends on the skill and judgment of physician	4.89	4.88
Estimated risk of malpractice suit with poor outcome	4.37	4.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

The consensus committee believes the survey respondents (who only infrequently performed this service) underestimated the intensity of this operation and the length of stay for patients requiring this service when estimating their work RVU. We therefore recommend the 75th percentile RVW of 35.50. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Additionally, we believe the total work for this procedure was not valued appropriately by the Harvard study. Again, the building block analysis shown below, applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study
 Intra-service Intensity is based on ACS consensus panel survey
 Post-service subsequent visits utilize EM work RVUs
 All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
47120				
Pre-service total		75	0.0224	1.68
Intra-service		225	0.090	20.25
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	1	4.00	4.00
	99231	2	0.64	1.28
	99232	3	1.06	3.18
	99233	2	1.51	3.02
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	2	0.43	0.86
	99213	1	0.65	0.65
	99214	1	1.08	1.08
	99215	0	1.73	0.00
Post-service total				16.02
Total RVW by Building Block Method =				37.95

FREQUENCY INFORMATION

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

General Surgery **Sometimes**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,094	general surgery	3	family practice
98	surgical oncology	3	internal medicine
70	clinic or group practice (not gppp)	3	urology
27	vascular surgery	2	peripheral vascular disease
21	colorectal surgery	1	cardiac surgery
20	general practice	1	certified clinical nurse specialist
16	thoracic surgery	1	hematology/oncology
9	maxillofacial surgery	1	medical oncology
8	obstetrics/gynecology	1	pediatric medicine
5	gynecology/oncology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 4 Yes
- 24 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 4 I do not agree

c. Patients requiring this service are now:

- 4 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 4 no change

CPT Code: 38100

Current RVW: 13.01
Survey Median RVW: 16.00
ACS Recommended RVW: 16.00
RUC Recommended RVW: 14.50

CPT Descriptor: Splenectomy; total (separate procedure)

Global Period: 90 days

Typical Patient: A 60-year-old male with an enlarged spleen and past history of Hodgkin's disease presents for a splenectomy. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. Medical and anesthesiology consults are requested. At operation, a subcostal incision is performed, the spleen mobilized, and the vessels doubly ligated. Postoperatively, the wound is monitored for infection and injectable pain medications are tapered as tolerated. The patient is discharged from the hospital when stable and comfortable on oral pain medications. Office visits are conducted as necessary during the 90-day global period to ensure that no wound complications or infections occur. Discussions are conducted with the patient, family, and other health care providers with respect to further care of the patient

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to pathology reports
- Review pre-operative work-up, with particular attention to films
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:

- A skin incision is made, and the anterior abdominal wall is carefully divided
- The peritoneum is entered and a thorough exploration of the abdomen is undertaken, including palpating and visualizing (where possible) the spleen, liver, stomach, duodenum, pancreas, small bowel, large bowel, kidneys, and pelvis, including bladder and rectum
- Adhesions are taken down by sharp and blunt dissection
- A self-retaining retractor is secured to the operating table, and rings and blades are selected and inserted to obtain adequate visualization of the operative site
- The attachments to the splenic flexure of the colon are divided in order to avoid splenic injury,
- In some cases (e.g. significant splenomegaly), the gastrocolic ligament is divided, allowing entry into the lesser sac. In these circumstances, the splenic vessels are identified above the

superior pancreatic border. Once dissected free, these vessels are clamped and doubly ligated being careful to avoid injury to the pancreas, while ensuring hemostasis

- The short gastric vessels are identified, divided, and suture ligated incorporating the gastric wall to ensure adequate hemostasis
- The spleen is then mobilized by dividing the attachments to the lateral abdominal wall and the diaphragm, allowing the spleen and the pancreatic tail to be elevated into the wound
- The splenic vasculature are then identified and doubly ligated to ensure hemostasis. Care is taken to avoid injury to the pancreatic tail
- Any remaining attachments are divided and the spleen is removed
- The position of the nasogastric tube is adjusted and ascertained to be in the correct place for drainage
- The abdominal cavity is then irrigated with saline, and another inspection of the abdomen is made for other abnormalities
- A closed-system suction drain may be inserted for drainage of the area
- The self-retaining retractor is then removed and disassembled, and sponge, needle, and instrument counts are obtained and confirmed, prior to closure of the abdomen
- The anterior abdominal wall is closed with standard technique, and subcutaneous tissue is irrigated and drained with a closed-suction drain when indicated
- The skin is then closed in the standard fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient
- Check wounds and patient progress
- Check drains (if present) and discontinue when appropriate
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Check surgical pathology reports

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress

- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Charles D. Mabry, MD, FACS
 Paul E. Collicott, MD, FACS
 Frank G. Opelka, MD, FACS
 Charles P. Shoemaker, MD, FACS

Specialty(s): American College of Surgeons
 American Society of General Surgeons

Type of Sample: 90% Random (mail/fax) and 10% Convenience (specialty meeting)

Survey CPT Code: 38100

Sample Size: 150 **Response:** 41 27%

	Low	25th pctl	Median	75th pctl	High
Survey RVW	11.42	14.50	16.00	17.00	25.00
Pre-Service			55		
Intra-Service	45	75	90	90	150
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	106	99231x1	99231x4		
Discharge Day Mgmt	36	99238			
Office Visits	38	99213x1	99212x1		

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	16.58	90

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

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

<u>TIME ESTIMATES (MEDIAN)</u>	<u>Svy CPT</u>	<u>Ref CPT</u>
	38100	43324
Survey response	41	9
Pre-service time	55	75
Intra-service time	90	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	106	87
Discharge management time	36	36
Total office visit time	38	30

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

Pre-service	3.66	4.13
Intra-service	3.97	4.00
Post-service	3.37	3.75

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.50	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	4.00
Urgency of medical decision making	3.18	3.22

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.93	4.00
Physical effort required	3.80	3.89

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.98	3.89
Outcome depends on the skill and judgment of physician	3.90	4.22
Estimated risk of malpractice suit with poor outcome	3.58	3.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study

Intra-service Intensity is based on ACS consensus panel survey

Post-service subsequent visits utilize EM work RVUs

All time and visit data are RUC survey medians

Survey CPT Code:		Time	Intensity	Work RVU (=time x intensity)
38100				
Pre-service total		55	0.0224	1.23
Intra-service		90	0.075	6.75
Post-service				
Immediate post		30	0.0224	0.67
Subsequent visits:	Visit n		E/M RVU	(=n x E/M RVU)
	99291	0	4.00	0.00
	99231	4	0.64	2.56
	99232	1	1.06	1.06
	99233	0	1.51	0.00
	99238	1	1.28	1.28
	99211	0	0.17	0.00
	99212	1	0.43	0.43
	99213	1	0.65	0.65
	99214	0	1.08	0.00
	99215	0	1.73	0.00
Post-service total				6.65
Total RVW by Building Block Method =				14.63

FREQUENCY INFORMATION

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

General Surgery Commonly

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

3,382	general surgery	4	emergency medicine
147	vascular surgery	3	plastic & reconstructive surgery
127	clinic or group practice (not gppp)	2	orthopaedic surgery
101	thoracic surgery	2	anesthesiology
57	surgical oncology	2	diagnostic radiology
37	colorectal surgery	2	gastroenterology
29	general practice	2	medical oncology
17	obstetrics/gynecology	2	osteopathic manipulative therapy
16	urology	1	allergy/immunology
15	critical care (intensivists)	1	hand surgery
14	peripheral vascular disease	1	hematology/oncology
13	family practice	1	nurse practitioner
8	cardiac surgery	1	otolaryngology
8	internal medicine	1	pediatric medicine
6	gynecology/oncology	1	psychiatry
5	maxillofacial surgery	1	radiation oncology
4	cardiology		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 11 Yes
- 30 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 10 I do not agree

c. Patients requiring this service are now:

- 9 more complex (more work)
- 0 less complex (less work)
- 3 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 11 no change

CPT Code: 48005

Current RVW: 22.40
Survey Median RVW: 42.16
ACS Recommended RVW: 52.54
RUC Recommended RVW: 42.17

CPT Descriptor: Resection or debridement of pancreas or peripancreatic tissue for pancreatitis

Global Period: 90 days

Typical Patient: A 65-year-old hospitalized male patient with a history of abdominal pain, alcohol abuse, and pancreatitis requires surgery because he has worsened clinically on medical management (N/G suction, fluid replacement, and IV antibiotics) and has changes on CT scan suggestive of necrosis of the pancreas. Once the decision to operate has been made, the surgeon reviews laboratory and radiologic studies in order to plan the operative approach. Communication with the patient and family are done, and informed consent is obtained. At operation, a careful exploration of the abdomen is undertaken, including dissection of the pancreas and associated pseudocysts, mobilization of the stomach, duodenum, and jejunum. All necrotic material is debrided and non-viable pancreas resected. Hemostasis is maintained as needed with the area then being drained as appropriate. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, coagulation status and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Intravenous nutrition is continued until the acute inflammation and pancreatitis has subsided. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced, intravenous feeding is discontinued, when feeding is tolerated without worsening the pancreatitis. Discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary during the 90-day global period to ensure that no delayed gastrointestinal problems, wound complications or infections occur. Repeat ultrasounds or CT scans are ordered and reviewed as needed to help detect recurrent abscess or pseudocyst formation. The nutritional status of the patient is also monitored to ensure that adequate nutritional intake occurs.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review any culture reports and current anti-microbial agents for appropriateness
- Review pre-operative work-up, with particular attention to sonography and CT imaging
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Review patient's pulmonary and hemodynamic status with the anesthesiologist; discuss anesthetic options since intraoperative hemodynamic instability is likely, as are also significant blood loss, "third-space" sequestration of fluid, and bowel edema
- Review the indications for and goals of operation with the patient/family including the high morbidity and mortality associated with management of pancreatic necrosis/abscess; discuss the possibility of an extended ICU stay including mechanical ventilatory and vasoactive drug support, prolonged convalescence, and possibility of long-term pancreatic exocrine and endocrine insufficiency
- Answer patient/family questions and obtain informed consent
- Confirm postoperative ICU bed availability

- Assure availability of blood products with the Blood Bank
- Change into scrub clothes
- Review planned procedure and positioning and draping of patient with the anesthesiologist and OR staff
- Verify that major abdominal and vascular procedure instruments and supplies are open or readily available in the operative suite
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, assisting OR staff as needed
- Verify with anesthesiologist that intravenous access and monitoring devices are in place and functioning properly with patient in position
- Review extent and type of abdominal prep with circulating nurse
- Select and hang appropriate imaging studies for intraoperative review; finalize planned incision(s)
- Don and pre-focus fiberoptic headlight
- Scrub and gown
- Drape operative field including possible sites of additional/extended incisions for drain placement

Intra-service work - Skin to skin:

- The skin is incised and the anterior abdominal wall divided; soft tissue perfusion is assessed and hemostasis is obtained
- The peritoneum is carefully entered
- Peritoneal fluid is obtained for culture as indicated
- The abdomen is thoroughly explored by inspection and palpation, with particular reference to the possibility of abscess sites outside the field of the proposed resection or debridement; cultures, biopsies and frozen sections are obtained as required
- Self-retaining retractors and their attachments are placed
- The stomach, duodenum, and jejunum are mobilized as indicated; the lesser sac is entered if possible
- All portions of the pancreas and associated phlegmon are assessed by inspection and palpation
- Intra-operative needle aspiration is performed if necessary to identify occult abscesses
- The surgeon opens tissue planes as necessary to expose the necrotic tissue
- All cystic, liquefied, and necrotic or non-viable pancreatic tissue is carefully resected or debrided as indicated.
- Immediate gram stain and culture of fluid is ordered and placed in appropriate containers/media for the laboratory examination
- A sponge forcep is used to gently withdraw/remove any necrotic material within the pancreatic abscess
- Gentle, copious irrigation with sterile saline is used to remove any remaining debris
- Multiple closed suction drains are placed through separate stab incisions
- The abdominal cavity is also copiously irrigated and hemostasis is assured
- The abdominal wall fascia is closed
- The skin and subcutaneous tissues are irrigated and closed in layers

Post-op Same day work through discharge from recovery (note that patient may be taken directly to ICU rather than to Post-Anesthesia Care Unit then ICU)

- Apply dressings
- Write orders for post-op labs, films, medications, ICU care, and wound and drain management
- Write brief operative note with diagrams of reconstruction and drains
- Review immediate postoperative care with Post-Anesthesia Care Unit/ICU staff
- Discuss operative findings and postoperative plans with family
- Discuss procedure outcome with patient, condition permitting, after emergence from anesthesia
- Dictate operative report
- Discuss operative findings and postoperative expectations with referring physician, coordinate care
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review immediate postoperative laboratory and radiological studies

Post-op Same day work after discharge from recovery (after immediate post-op period if patient taken directly to ICU post-op)

- Examine patient, check wounds, drains, and patient progress
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions
- Adjust intravenous fluids and medications as indicated by postoperative events; special attention is given to any additional culture information; any immediate gram stain examinations are reviewed
- Write orders for following day's labs and films; verify patient parameters for physician notification with nursing staff
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient/family
- Check wounds, drain outputs, and patient progress
- Remove drain tubes as appropriate
- Review any culture reports and antibiotic sensitivity reports; verify adequacy of antibiotic/anti-microbial coverage; monitor any associated laboratory values (e.g., BUN, creatinine, Liver function tests)
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rww</u>	<u>GLOB</u>
35091	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels	35.40	90

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

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

	<u>Svy CPT</u> 48005	<u>Ref CPT</u> 35091
<u>TIME ESTIMATES (MEDIAN)</u>		
Survey response	24	6
Pre-service time	83	83
Intra-service time	180	180
Immediate Post-service time	38	30
Total critical care time	180	120
Total other hospital visit time	457	199
Discharge management time	36	36
Total office visit time	99	76
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.39	3.60
Intra-service	4.65	4.80
Post-service	4.65	4.00
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.65	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.70	4.40
Urgency of medical decision making	4.61	4.20
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	4.57	5.00
Physical effort required	4.52	4.60
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.96	4.80
Outcome depends on the skill and judgment of physician	4.70	4.80
Estimated risk of malpractice suit with poor outcome	4.26	4.40

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

If you subtract the EM RVWs that correspond to the survey data for preoperative and postoperative care from the survey median RVW, the resulting intraoperative RVW is 6.41 for 180 minutes. This IWPUT of 0.035 is similar to an office visit which is an inappropriate intensity for this procedure. We recommend the 75th percentile RVW of 52.54 for this code as this better reflects the total work for this procedure, which has extensive postoperative care.

Additionally, we note that this code was reviewed by the RUC in 1993 and that the RUC recommendation to HCFA included the following information:

The RUC determined that the general surgeons had presented compelling evidence changing the global period for the codes for treatment of pancreatitis from 90 days to zero days ("090" to "000"). As this letter explains, the operative treatment of pancreatitis, while extremely difficult, is a relatively small part of the overall management of the patient with acute necrotizing pancreatitis.

In the December 1993 Final Rule, HCFA responded to the RUC's recommendation with the following statement:

(c) Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis (CPT code 48005).

RUC recommended 13.42 RVUs with no postoperative period for new CPT code 48005. We have increased these work RVUs to 18.00 and established a global period of 90 days. We believe the procedure is a more extensive procedure than that represented by CPT code 48000 during a single hospitalization, is seldom done by itself, and is apt to be done multiple times. Subsequent surgeries should be reported as staged procedures with modifier -58. We also note that CPT code 48000 is bundled into CPT code 48005 and should not be reported separately if performed on the same day.

We reemphasize that the overall management of a patient with acute necrotizing pancreatitis includes extensive postoperative care. Some of the survey respondents indicated a length of stay as long as 35 days. HCFA's adjustment to the RUC recommendation (4.58 RVUs) to account for work in the 90-day global period does not accurately account for the work required postoperatively for these patients. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW for the 90-day global period.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study
 Intra-service Intensity is based on ACS consensus panel survey
 Post-service subsequent visits utilize EM work RVUs
 All time and visit data are RUC survey medians

Survey CPT Code:			Work RVU
48005	Time	Intensity	(=time x intensity)
Pre-service total	83	0.0224	1.85
Intra-service	180	0.095	17.10
Post-service			
Immediate post	38	0.0224	0.84
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	3	4.00	12.00
99231	8	0.64	4.80
99232	5	1.06	5.30
99233	4	1.51	6.04
99238	1	1.28	1.28
99211	0	0.17	0.00
99212	1	0.43	0.43
99213	2	0.65	1.30
99214	1	1.08	1.08
99215	0	1.73	0.00
Post-service total			33.07
Total RVW by Building Block Method =			52.02

FREQUENCY INFORMATION

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

General Surgery **Sometimes**

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

499	general surgery	3	cardiology
39	clinic or group practice (not gppp)	3	thoracic surgery
18	interventional radiology	2	emergency medicine
17	diagnostic radiology	2	internal medicine
9	surgical oncology	1	anesthesiology
9	vascular surgery	1	colorectal surgery
5	general practice	1	critical care (intensivists)
		1	plastic & reconstructive surgery

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 3 Yes
- 24 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 3 I do not agree

c. Patients requiring this service are now:

- 3 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 3 no change

CPT Code: 48150

Current RVW: 43.48
Survey Median RVW: 48.00
ACS Recommended RVW: 54.68
RUC Recommended RVW: 48.00

CPT Descriptor: Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy

Global Period: 90 days

Typical Patient: A 63-year-old hospitalized male patient, with a history of painless jaundice, anorexia, 20 lb. weight loss, and CT scan evidence of a 2.5 cm mass in the head of the pancreas requires surgery. There is marked dilatation of the extrahepatic and intrahepatic biliary ductal system with no evidence of cholelithiasis or choledocholithiasis. Preoperatively, once the decision to operate has been made, the surgeon reviews laboratory and radiologic studies in order to plan the operative approach. Communication with the patient and family are done, and informed consent is obtained. At operation, exploration of the abdomen is undertaken and dissection of the pancreas and mobilization of the stomach, duodenum, and jejunum is performed. There is no evidence of lymphadenopathy or hepatic metastasis. Intraoperative biopsy of the head of the pancreas (separately billable using the multiple procedure modifier -51) confirms the diagnosis of carcinoma of the head of the pancreas. There is no evidence of nodal or hepatic metastasis. A classic Whipple procedure is performed, including resection of the head of the pancreas, distal stomach, duodenum, and associated lymph nodes. Gastrointestinal continuity is re-established by a gastro-jejunostomy, choledocho-jejunostomy, and pancreatico-jejunostomy. The area is drained widely with closed system suction drains. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, intravenous nutrition, antibiotics, coagulation and fluid balance. Wound checks and dressing changes are made to assure an absence of infection, hematoma and drainage. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. The patient is extubated when ventilation returns to an acceptable level. Oral feeding is resumed after a return of bowel function. The patient's diet is advanced and intravenous feeding is discontinued when oral feeding is tolerated in adequate amounts. Diabetes is managed as appropriate with insulin orders. Discharge plans are completed, with the patient being discharged after he is afebrile, the wound is satisfactory, and he is tolerating an adequate diet, and all drains have been removed. Office visits are conducted as necessary through the 90-day global period to ensure that no delayed gastrointestinal problems, wound complications or infections occur. Repeat ultrasounds or CT scans are ordered and reviewed as needed to help detect recurrent abscess or pseudocyst formation. The nutritional status of the patient is also monitored to ensure that adequate nutritional intake occurs. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work - Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to imaging and endoscopic studies and to pathology reports
- Review planned incisions and procedure

Pre-service work - Day of surgery:

- Review patient's pulmonary and hemodynamic status with the anesthesiologist; discuss anesthetic options since intraoperative hemodynamic instability is likely, as are also significant blood loss, "third-space" sequestration of fluid, and bowel edema
- Review the indications for and goals of operation with the patient/family including the high morbidity and mortality associated with management of pancreatic cancer; discuss the possibility of an extended Intensive Care Unit stay including mechanical ventilatory and vasocactive drug support, prolonged convalescence, and possibility of long-term pancreatic exocrine and endocrine insufficiency
- Answer patient/family questions and obtain informed consent
- Confirm postoperative ICU bed availability
- Assure availability of blood products with the Blood Bank
- Change into scrub clothes
- Review planned procedure and positioning and draping of patient with the anesthesiologist and OR staff
- Verify that major abdominal and vascular procedure instruments and supplies are open or readily available in the operative suite
- Monitor patient positioning and draping, assisting OR staff as needed
- Verify with anesthesiologist that intravenous access and monitoring devices are in place and functioning properly with patient in position
- Review extent and type of abdominal prep with circulating nurse
- Select and hang appropriate imaging studies for intraoperative review; finalize planned incision(s)
- Don and pre-focus fiberoptic headlight
- Scrub and gown
- Drape operative field including possible sites of additional/extended incisions for drain placement

Intra-service work - Skin to skin:

- The skin is incised and the anterior abdominal wall divided; soft tissue perfusion is assessed and hemostasis is obtained
- The peritoneum is carefully entered
- Peritoneal fluid is obtained for cytology as indicated
- The abdomen is thoroughly explored by inspection and palpation, with particular reference to the possibility of metastatic disease outside the field of the proposed resection ; biopsies and frozen sections are obtained as required to exclude metastases
- Self-retaining retractors and their attachments are placed
- The duodenum is extensively mobilized from lateral to medial
- The distal half of the stomach is mobilized by dividing the neurovascular bundles along the greater and lesser curvatures
- The lymph-node bearing tissues of the lesser omentum and hepatoduodenal ligament are sharply dissected free
- Cholecystectomy is performed
- The common bile duct is dissected free from the hepatic artery and portal vein
- The neck of the pancreas is freed posteriorly from the underlying portal vein
- The third and fourth portions of the duodenum are totally mobilized and the ligament of Treitz divided
- The stomach, proximal jejunum, distal common bile duct, and the neck of the pancreas are divided; the specimen (distal stomach, duodenum, proximal jejunum, head and neck of pancreas, distal common duct, associated lymphatics) is removed; and marking sutures are placed to orient the pathologist; frozen sections are done as needed to evaluate resection margins
- A Roux-en-Y jejunal limb is constructed and brought through the mesocolon
- Gastrojejunostomy, choledochojejunostomy, and pancreatojejunostomy are performed; T-tube^a choledochostomy may be done if indicated
- Jejunojejunostomy at the Roux limb site is performed

- Truncal vagotomy is performed
- The mesocolon is secured to the Roux limb
- Multiple closed suction drains are placed through separate stab incisions
- The abdomen is copiously irrigated and hemostasis is assured
- The abdominal wall fascia is closed
- The skin and subcutaneous tissues are irrigated and closed in layers

Post-op Same day work through discharge from recovery (note that patient may be taken directly to ICU rather than to Post-Anesthesia Care Unit then ICU)

- Apply dressings
- Write orders for post-op labs, films, medications, ICU care, and wound and drain management
- Write brief operative note with diagrams of reconstruction and drains
- Review immediate postoperative care with Post-Anesthesia Care Unit/ICU staff
- Discuss operative findings and postoperative plans with family
- Discuss procedure outcome with patient, condition permitting, after emergence from anesthesia
- Dictate operative report
- Discuss operative findings and postoperative expectations with referring physician, coordinate care
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review immediate postoperative laboratory and radiological studies

Post-op Same day work after discharge from recovery (after immediate post-op period if patient taken directly to ICU post-op)

- Examine patient, check wounds, drains, and patient progress
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions
- Adjust intravenous fluids and medications as indicated by postoperative events
- Write orders for following day's labs and films; verify patient parameters for physician notification with nursing staff
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient/family
- Check wounds, drain outputs, and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work -

- Examine and talk with patient
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	21.74	90

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

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

	<u>Svy CPT</u>	<u>Ref CPT</u>
<u>TIME ESTIMATES (MEDIAN)</u>	48150	47760
Survey response	39	10
Pre-service time	90	75
Intra-service time	345	140
Immediate Post-service time	45	30
Total critical care time	120	0
Total other hospital visit time	278	136
Discharge management time	36	36
Total office visit time	99	38
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
<u>TIME SEGMENTS</u>		
Pre-service	4.76	4.10
Intra-service	4.96	4.30
Post-service	4.82	4.00
<u>MENTAL EFFORT AND JUDGMENT</u>		
The number of possible diagnosis and/or the number of management options that must be considered	4.78	4.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.78	4.00
Urgency of medical decision making	4.51	3.90
<u>TECHNICAL SKILL/PHYSICAL EFFORT</u>		
Technical skill required	5.00	4.60
Physical effort required	4.96	3.80
<u>PSYCHOLOGICAL STRESS</u>		
The risk of significant complications, morbidity and/or mortality	4.98	4.50
Outcome depends on the skill and judgment of physician	4.96	4.80
Estimated risk of malpractice suit with poor outcome	4.31	4.20

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

When you subtract pre- and post-operative RVWs from the survey median, the result is 22.59 rvu's. This is equal to an IWPOT of 0.065 for 345 minutes of intra-operative work. This is slightly less than intensive care intensity. We believe this is an inappropriate comparison for this intense, infrequently performed operation. Therefore, we recommend the 75th percentile RVW of 54.68. This results in an intraoperative intensity of 0.085 that is slightly higher than intensive care.

Additionally, we believe the total work for this procedure was not valued appropriately by the Harvard study. The following building block analysis (i.e., valuing the increment), applied to the RUC survey data, supports the recommended RVW.

Building Block Analysis

Pre-service and immediate post-service intensity factors from the Harvard Study
 Intra-service Intensity is based on ACS consensus panel survey
 Post-service subsequent visits utilize EM work RVUs
 All time and visit data are RUC survey medians

Survey CPT Code:			Work RVU
48150	Time	Intensity	(=time x intensity)
Pre-service total	90	0.0224	2.02
Intra-service	345	0.098	33.64
Post-service			
Immediate post	45	0.0224	1.01
Subsequent visits:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
	99291	2	4.00
	99231	4	0.64
	99232	4	1.06
	99233	2	1.51
	99239	1	1.75
	99211	0	0.17
	99212	1	0.43
	99213	2	0.65
	99214	1	1.08
	99215	0	1.73
Post-service total			23.39
Total RVW by Building Block Method =			59.04

FREQUENCY INFORMATION

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

General Surgery Sometimes

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.

Cannot estimate national 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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,328	general surgery	4	infectious disease
81	surgical oncology	3	plastic & reconstructive surgery
54	clinic or group practice (not gppp)	1	cardiac surgery
31	vascular surgery	1	family practice
18	thoracic surgery	1	gynecology/oncology
15	general practice	1	obstetrics/gynecology
6	urology	1	orthopaedic surgery
5	maxillofacial surgery	1	peripheral vascular disease
4	colorectal surgery		

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 8 Yes
- 36 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 0 I agree
- 8 I do not agree

c. Patients requiring this service are now:

- 8 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 8 no change

**AMA/Specialty Society RVS Update
Committee**

**Five-Year Review Recommendations
October 2000**

Volume 2

**AMA/Specialty Society RVS Update Committee
Five-Year Review Recommendations
October 2000**

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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE FIVE-YEAR REVIEW RECOMMENDATIONS

Anesthesia

The American Society of Anesthesiologists submitted a comment to HCFA requesting revaluation of the approximately 250 anesthesia services to correct undervaluation that has persisted since the implementation of the RBRVS. The ASA proposed a building block methodology to place the anesthesia codes and values on the same scale as the RBRVS. The model relies primarily on a group of E/M codes to be equated to various components of anesthesia services. The total work value of these comparable services are then compared with an imputed value of anesthesia values converted to RBRVS values.

The ASA initially submitted 13 codes for review by the RUC. These codes account for 54% of all Medicare allowed charges, 44% of cases of anesthesia services and each one accounted for at least \$10,000,000 in charges. These codes were also selected to represent a variety of surgical procedure types, and a range of basic unit values ranging from 3 to 20.

For each of the 13 codes, the ASA divided the anesthesia code into five service elements and equated each service element to an E/M or induction procedure code, or an intensity value was assigned. The five service elements are preoperative evaluation, equipment and supply preparation, intra-operative anesthesia care, induction period procedure, and post-operative care. After the RUC reviewed the 13 codes, the RUC concluded that the building block values are between 13% and 49 % higher than the current imputed work values. On average the estimate work values are 28% higher than the current work values.

The original five-year review workgroup had a number of concerns with making a specific recommendation to increase the anesthesiology conversion factor. These concerns included the lack of survey data to determine the high and low intensity values and associated intensity distribution, the use of 1993 HCFA BMAD time data rather than more current data, use of a building block methodology to place ASA values on the same scale as the RBRVS, and blending of values used in the building block. Some RUC members questioned the validity of the entire methodology of placing the ASA values on the same scale of the RBRVS and using 13 codes and then extrapolating the results to all ASA codes. Also, RUC members were concerned that the ASA had not presented any compelling evidence for changes in anesthesia services since the last five-year review that would warrant an increase in the conversion factor.

Facilitation Committee

To reconcile the issues identified in the five-year report before the RUC, a short term facilitation committee was established to work with the ASA to identify new data that ASA might be able to present to the RUC in February, 2001. In response to the October, 2000 meeting, the ASA collected new data outlined below.

1. The ASA selected six additional anesthesia codes to survey, for a total of 19 codes. The survey form was identical to the one used for the original thirteen codes, except that the survey requested specific information on post-induction anesthesia intra-operative time. According to the ASA, the 19 codes represent more than 55% of Medicare allowable payments in anesthesiology. The selection of the additional codes was due to a concern by Workgroup 4 that the original 13 codes were not sufficiently representative of anesthesia codes to allow extrapolation to all anesthesia codes.

2. The ASA presented updated time data. The presentation to Workgroup 4 used 1993 BMAD average time data for the specific "0xxxx" anesthesia codes. The ASA now is using 1998 time data related to the anesthesia reported time for the specific surgical procedures used in the ASA surveys. This time data was obtained from HCFA's 5% sample claim database.
3. The ASA developed more specific data relating to the levels of intensities during the post-induction anesthesia time period. The Facilitation Committee had asked the ASA to divide this service period into 4-5 intensity levels and to obtain survey data to allocate time values based on new HCFA data among these levels. Survey respondents were provided the new time data and asked to distribute the time among the five quintiles listed below.

<u>Intensity Level 1</u>	Monitoring and recording standard physiologic monitors (EKG, ETCO2, SpO2, BP, respiratory parameters) in a stable patient Positioning a patient for surgery (supine)	0.026
<u>Intensity Level 2</u>	Evaluating and managing transient aberrations in hemodynamic or respiratory status such as moderate tachycardia or hypotension. Responding to abrupt changes in surgical activity – e.g. visceral traction, orthopedic cement application, abdominal insufflation Positioning an unconscious patient (prone, sitting, lateral) for surgery	0.036
<u>Intensity Level 3</u>	Inducing intentional hypotension for intracranial aneurysm clipping Evaluation and management of sustained hypertension using vasoactive agents Preparing and evaluating a patient for anesthetic emergence and tracheal extubation	0.051
<u>Intensity Level 4</u>	Evaluating and managing intraoperative myocardial ischemia, sustained hypotension, serious cardiac arrhythmias Initiating single lung ventilation	0.070
<u>Intensity Level 5</u>	Managing separation from cardiopulmonary bypass Managing clamping or unclamping of abdominal aorta Managing massive transfusion for resuscitation of hemorrhagic shock	0.085

Using the survey data showing the quintile distribution of post-induction anesthesia time, a work value for this period was calculated for each respondent by multiplying the time allocated to each quintile by the corresponding work intensity. These quintile work relative values were summed to obtain post-induction anesthesia work values for each respondent. Finally, a median value of the total RVWs for all respondents was calculated.

The new facilitation committee presented its recommendation to the RUC in February, 2001. Although the ASA responded to a number of the concerns raised by the original workgroup, the RUC concluded that there remain a number of concerns that could not be resolved by the five-year review deadline of February, 2001. There are five primary issues with the ASA data.

1. Primarily, the Committee questioned if the surgical codes selected for each anesthesia code are truly representative of all surgical codes associated with each of the 19 anesthesia codes. Given the methodology, it is necessary that the surgical code be representative of the family of surgical codes. For example, code 00210 has 87 surgical codes in the family. The committee felt that the data presented to data was inconclusive given the large number of codes contained in some of the families.
2. The committee questioned the RVUs associated with the Induction Period Procedure (IPP) because in some instances such as with code 00914, the calculated IWPUT approached a value of 1. In addition there was a concern that the cross walked IPP codes contained pre and post service work that needed to be removed prior to including the value in the ASA calculations. The inclusion of this work may lead to a double counting of work.
3. Some of the committee members had remaining concerns regarding the selection of the five levels of IWPUTs and the allocation of time among the five quintiles.
4. The Committee also pointed out that there appeared to be a disconnect between the values associated with the pre-service time period. Although the time varied for some codes the relative values assigned to the time period varied and the Committee needed to discuss this issue further.
5. The primary goal of the five year review is to demonstrate how physician work has changed since the last five year review. During the last five year review the RUC recommended an increase in the anesthesia values that was accepted and implemented by HCFA. HCFA is concerned that sufficient data has not been presented to demonstrate that the work has changed since the last five year review especially since the anesthesia codes received an increase during the last five year review. However, the presenters stated that the purpose of the five year review is to identify codes that are not correctly valued.

Given the number of concerns identified by the original five-year review workgroup as well as the concerns identified by the facilitation committee, the RUC concluded that it was not possible to reach a recommendation on the ASA five year review submission at this time. However, the RUC supported allowing the ASA to continue its work in refining their five-year review recommendation. The RUC therefore agreed to form a new committee to first determine if these concerns can be addressed by a time certain, or whether the methodological differences between the anesthesia payment system and the RBRVS prohibit resolution of the concerns. This committee will also examine whether it is possible to place anesthesia services on the RBRVS scale.

American Medical Association

Physicians dedicated to the health of America



James G. Hoehn, MD
Chairman
AMA/Specialty Society RVS
Update Committee.

515 North State Street
Chicago, Illinois 60610

312 464-5604
312 464-5849 Fax

October 27, 2000

Paul Rudolf, MD, JD
Medical Officer, Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Boulevard, C4-01-26
Baltimore, Maryland 21244

Dear Doctor Rudolf:

On behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), I have enclosed our work relative value recommendations for 870 CPT codes included in the Five-Year Review of the Resource-Based Relative Value System (RBRVS). This submission represents the extraordinary efforts of physician representatives and their staff from many medical specialty societies who devoted significant time and resources in reviewing each of the comments submitted to the Health Care Financing Administration (HCFA) in March of this year.

Our recommendations may be summarized as follows

- For 469 codes, the RUC recommends that the relative values be increased.
- For 311 codes, the RUC recommends that the current relative value be maintained.
- For 27 codes, the RUC recommends that the relative values be decreased.
- The RUC has referred 63 codes to the CPT Editorial Panel to consider coding changes prior to consideration of the work relative value.

In addition to comments on individual codes, HCFA also asked the RUC to review a comment from the American Society of Anesthesiology (ASA) that the work component of their individual conversion factor is currently undervalued. The RUC convened a workgroup to review this issue in August. The RUC report for Anesthesiology, however, is not included at this time as revised data will be reviewed at the February, 2001 RUC meeting. The RUC must first address a number of issues related to the ASA methodology used to place the anesthesiology codes on the same scale as the RBRVS. The ASA has agreed to collect additional data and present a recommendation in February. Therefore, the RUC requests that HCFA defer any action until February when the RUC will submit a recommendation. We hope that this timeline will be reasonable as we understand that HCFA plans to publish a Spring 2001 Rule with any proposed revisions to the work relative values as a result of the Five-Year Review.

Paul Rudolf, MD, JD


October 27, 2000

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Also included in this submission are the RUC recommendations for individual anesthesia CPT 2001 new and revised codes. As you recall, the RUC had submitted interim recommendations to HCFA in May for these services. This latest submission should be considered the finalized RUC recommendations.

The RUC appreciates this opportunity to review the comments submitted in this Five-Year Review. We believe that our recommendations, if implemented, would further improve the RBRVS payment system.

Sincerely,


James G. Hoehn, MD

Enclosures

cc: Terry Kay
Ken Simon, MD
Carolyn Mullen
Rick Ensor

AMA/Specialty Society RVS Update Committee
October 5-8, 2000 RUC Meeting

Facilitation Committees

Facilitation Committee 1
(Vascular Surgery)

Barbara Levy, MD (Chair)
Don Williamson, DO
John Derr, MD
Norman Cohen, MD
Bill Moran, MD
Arthur Traugott, MD

Facilitation Committee 3:
(Cardiothoracic Surgery)

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William Gee, MD
David Hitzeman, DO
James Moorefield, MD
Peter Sawchuk, MD
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Facilitation Committee 5:
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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE FIVE-YEAR REVIEW RECOMMENDATIONS

Thoracic Surgery

The Society of Thoracic Surgeons submitted revised Summary of Work Recommendation Forms for nine codes: three esophageal resection codes (43107, 43112, and 43122), two pulmonary resection codes (32482 and 32500), and four additional general thoracic surgical codes (32100, 32110, 32220, and 32320). The RUC determined during the October, 2000 RUC meeting that these nine codes could be resubmitted to the RUC to prevent rank order anomalies due to the revaluation of codes 32440, 32480, and 43117.

The presenters stated that a concerted effort was made to ensure that the survey respondents included general surgeons and thoracic surgeons outside of academic practice. The STS used a combination of random sample and nominations from respondents to identify additional respondents. The STS also enlisted the help of the American Society of General Surgeons and the American College of Surgeons. These specialties faxed the list of codes to be surveyed to a geographically distributed sample of their membership, asking the surgeons to indicate which procedures they were familiar with and whether they were able to participate in the survey effort. The STS identified 10 general thoracic surgeons that were geographically distributed and asked them to nominate five or more additional general thoracic surgeons in their region from both academic and nonacademic settings.

The RUC examined all nine codes as a group and in relation to the three codes that the RUC approved in October. This allowed the RUC to first obtain a sense of the relativity among the codes before examining each code individually. While 7 of the 9 codes reviewed included critical care visits, the three codes approved in October (32440, 32480, and 43107) did not include these visits. The STS presenters stated that they used a level three hospital visit instead of a critical care visit in their October presentation because they were not aware that critical care could be included. However, for the 7 codes with revised data, as well as the three previously submitted codes, thoracic surgeons stated that they are typically providing the critical care services such as ventilator management for their patients. The RUC agreed with this recommendation and to ensure consistency, the RUC changed the one level three hospital visit to a critical care service for codes 32440, 32480, and 43107.

32100 Thoracotomy, major; with exploration and biopsy

The STS recommended the 25th percentile of 18 RVUs because it was felt that the median survey value of 20 would have created a rank order anomaly with this family of codes, since this code requires less *total* work than a wedge resection 32500 (STS recommended RVW, 22) or control of traumatic lung hemorrhage 32110 (STS recommended RVW, 23). Also, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. Because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). This was verified by the decrease in frequency of this procedure; from 5,306 in 1993 to 3,192 in 1998. Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. However, the RUC felt that even the 25th percentile was not supported based on the resulting IWP/UT of .088 and in comparison with other codes in the family. The RUC then compared this code to the work involved in 58150, *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of*

ovary(s); (Work RVU 15.24) Since the intraperative times, and the number of office and hospital visits were very similar, the RUC felt that this code served as an accurate anchor code. Upon extensive discussion of the work involved in 32100 and in comparison to other codes such as 49000 *Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (Work RVU, 11.68)* The RUC determined that to create the proper rank order within this family of codes, and to ensure the IWPUR is in line with the remainder of codes within the family, the value of 15.24, which is the value assigned to code 58150 is recommended.

The RUC recommends a work relative value of 15.24 for code 32100.

32110 Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear

The STS explained that this procedure is typically performed on an emergent basis with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for 32110 is different, but still as complex as for 32480 *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)*. The patient requiring 32480 (RUC work RVU recommendation, 23.75), is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given the information provided, the RUC felt that the survey results supported the recommendation and created proper rank order within the family by reflecting the difference in work for code 32110 compared code 32480.

The RUC recommends a work relative value of 23.00 for code 32110.

32220 Decortication, pulmonary (separate procedure); total

32320 Decortication and parietal pleurectomy

The intraoperative work for codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, 32320 is slightly more work than 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." Code 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on the survey results and the recommendation for using the median RVU, the RUC felt that the information presented supported the recommendation. Additionally, the recommended work relative values; CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50) would place these two procedures in proper rank order, which is greater than 32480 and less than 32440 (RUC recommended RVW = 25).

The RUC recommends a work relative value of 24.00 for code 32220.

The RUC recommends a work relative value of 24.50 for code 32320.

32482 Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)

This code was compared to 32440 *Removal of lung, total pneumonectomy*; (RUC recommended RVW = 25.00) and 32480 *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)* (RUC recommended RVW = 23.75). The STS data indicates that 32440 is less intraoperative work than 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. Code 32480 is also a large operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The RUC agreed that the correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: 32482 (med RVW = 25.00); 32440 (RUC recommended RVW = 25.00); and 32480 (RUC recommended RVW = 23.75). This would create the proper rank order within the family.

The RUC recommends a work relative value of 25.00 for code 32482.

32500 Removal of lung, other than total pneumonectomy; wedge resection, single or multiple

The STS data indicated that it is typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Given the survey data and the recommended median relative values, the RUC agreed that the survey median RVW of 22.00 reflects the slightly less total work for 32500 compared with the reference codes 32440 and 32480.

The RUC recommends a work relative value of 22.00 for code 32500.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty (transhiatal)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagostomy, with or without pyloroplasty

The STS presenters discussed that while 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. This procedure was described as having greater intensity in comparison with 43117, however, the survey results did not support this conclusion. After considerable discussion by the RUC and obtaining a detailed description of the work involved, as well as a review of the accompanying literature contained in tab 16, the RUC was convinced that the intensity of the approach described was greater than the reference code 43117.

Of the four surveyed esophagectomy codes, 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including repositioning and redraping. The STS explained that the other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to 43112, they each include a gastric drainage

procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both 43117 and 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. Code 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare.

For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The RUC discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.

The RUC recommends a work relative value of 40.00 for code 43107.

The RUC recommends a work relative value of 43.50 for code 43112.

The RUC recommends a work relative value of 40.00 for code 43122.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE RBRVS FIVE-YEAR REVIEW

RUC RECOMMENDATIONS

Thoracic Surgery

The Society of Thoracic Surgeons (STS) submitted comments to HCFA that there have been major changes in the practice of thoracic surgery since the initial development of the RBRVS. Due to advances in surgical technique and of post-surgical care for patients, thoracic surgeons are now frequently performing surgery on patients who are older and who have more comorbid conditions. The STS claims that the changes in surgical technique and in the typical patients have changed the time and intensity of a number of procedures including reference procedures used by STS. The STS undertook to revalue a number of their reference procedures along with other procedures.

The STS grouped its codes into three sections, General Thoracic Surgery, Adult Cardiac Surgery, and Congenital Thoracic Surgery. Within each of these three categories the STS further grouped codes into a total of 23 families. Each family had an anchor code that received a full RUC survey, and each of the remaining codes in a family received a mini-survey. The mini-survey collected time information and the number of post operative visits. The mini-survey also included questions that asked respondents to estimate a relative value for the procedure based on the reference service for the family. Each family used the same reference service and only the vignette for the anchor code was included in the survey. In several families, codes with different global periods were included. For example, an anchor code with a 090 day global period was surveyed, and the same vignette was used for an add on code with a ZZZ global period. The RUC felt that mixing codes with different global periods was inappropriate, and further complicated comparisons with reference codes and anchor codes.

The RUC initially was concerned with the approach used by STS that simultaneously included reference services that were also being reviewed and estimated by the same survey respondents. This issue was even noted by some survey respondents who questioned how to use reference services that were also included in the five-year review. The RUC agreed that the methodology that used reference services that were also in the five year review skewed the resulting data. In several instances a code under review had lower physician time and physician work intensity measures than the reference service as rated by the respondents, yet the recommended RVUs for the procedure under review was higher than the existing reference service. The RUC concluded that since the RUC methodology attempts to set the work RVU of the service under review "relative" to the work RVU of comparable and established reference

services, the inclusion of reference services that are also in the five year review skewed results when respondents felt that the reference service was misvalued. It was clear in many instances that respondents valued the code under review relative to their perception of what the reference relative value should be, not the current value of the reference code. Therefore, when respondents estimated the final RVU for the service under review, it may have been in comparison with a code that respondents may or may not have felt was correctly valued. Normally, the respondents should base their recommendation on a reference service that is correctly valued.

The STS also utilized mini-surveys for the vast majority of codes. While the RUC approved the use of mini-surveys for low volume codes within a family of codes, the RUC questioned the use of mini-surveys for procedures with high Medicare frequency such as CPT Code 32000, *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*, with a 1998 Medicare frequency of over 143,000. The RUC felt that in many instances full RUC surveys performed in conjunction with other specialties were necessary to collect the data needed to present a compelling evidence of a change in work. The STS officials stated that they did not perform full surveys for many codes, including those with high frequencies due to the amount of work required to perform a full RUC survey.

To overcome this substantial methodological problem, reference services that were used for families were first reviewed and the resulting value was compared to the family of codes. For the adult cardiac surgery codes, the RUC developed a building block methodology to validate the survey codes, and for the congenital thoracic surgery codes, the RUC utilized previous RUC reviews of the codes to determine how the work has changed since the last five year review. In addition, the verbal rationale offered by the presenter Doctor Mayer, was critical in demonstrating that for a majority of these codes the patient population has changed, leading to a higher intensity of the intra-service work. Since Doctor Mayer was one of only 100 full time pediatric congenital surgeons in the U.S., his oral testimony was given considerable weight in RUC deliberations.

Overall, the RUC was faced with a very difficult challenge due to a lack of a clear compelling evidence of how the work has changed since the last five year review. The summary of recommendation forms in all but a few instances did not include any written rationale for how a changing patient population translated into increased physician work. The RUC was not presented with data that clearly demonstrated how an aging population with increased comorbidities increased work, in either the pre-operative work, the procedure itself or in post-operative work. The RUC felt that for some families in the adult cardiac surgery group that an increase in work values was warranted but struggled in validating the recommended work values presented.

To validate the adult cardiac STS recommendations, the RUC developed a reverse building block methodology partially based on code 33410 that was reviewed by the RUC in 1999. This code represented a recently valued procedure, although the specialty stated that the RUC did not correctly value this procedure, however, the RUC felt that this was a code that could be used for comparison. The

recommended RVUs were also validated using the building block approach for each code in a family and comparing the building block work RVU to the recommended work RVU. Also, the IWPUTs for all codes in the family were examined.

At the commencement of the August RUC workgroup meeting, the STS presented information from the STS National Cardiac Surgery Database, and the Cleveland Clinic Database that contained data on patient age and comorbidities for CABG procedures and several other procedures. While the RUC utilized the data in some instances, the data was received too late to fully review, and was not presented to easily relate to specific recommendations under consideration. In addition, at the same time the STS provided vignettes for each of the codes that had a mini survey, although these vignettes were not available to the survey respondents. Also, clinical description of the services under review was provided since the RUC workgroup had previously informed the STS that this data was a necessary part of the summary of recommendation form but the STS chose not to include this information in the RUC submission. The absence of clinical descriptions significantly hindered the review of the data presented. The incomplete summary of recommendation forms and the lack of a clear rationale for the use of mini-surveys presented substantial difficulties and forced the RUC to piece together various data in order to make a recommendation on procedures.

To overcome the use of reference codes that were included in the review, the workgroup used a building block methodology to validate the survey results for all of the adult cardiac surgery codes. The specialty first used 33410, *Stentless valve*, (work RVU 32.46) as a reference code since this code was reviewed by the RUC in 1999. The specialty then used the building block methodology to break this code down into its components based on data the RUC reviewed in 1999. While the specialty used time data reviewed by the RUC, the post operative hospital visit time of 100 minutes was attributed to the following services of four 99231 visits, one discharge day visit of 99238, and one critical care visit of 99291. Also, three 99213 office visits were added to account for the office visit time. The specialty felt that his distribution of visits was the best description of the typical post operative care associated with this code. The pre-service and immediate post service times of 30 and 50 minutes respectively were assigned a intensity value of .0224. This value was selected by the specialty to represent a composite of the evaluation and management as well as scrubbing work during these time periods. The resulting non intra-service relative values were totaled and subtracted from the total RVU to arrive at an IWPUT calculation of .102. The calculations are listed below in the attached tables.

Each family anchor code then underwent a building block calculation. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post-operative work was the same as the family anchor code. Each anchor code then underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. If the anchor code value and IWPUT seemed appropriate in comparison to 33410, further analysis of the remaining codes in the family occurred. Although the specialty contended that their description of the post operative visit distribution for 33410 should be used for

all codes, the RUC decided to use the post operative visit data for each of the anchor codes, since the specialty used a full RUC survey for these codes. This assumption that the pre and post-operative work was the same for all codes in a family was necessary since the mini-survey data did not provide sufficient detail to use the building block methodology otherwise.

Since the RUC only had full survey data for the anchor codes, the work RVUs for each code in a family was calculated in two ways. First, the anchor code's intensity was multiplied by the intra-service time for each code in the family to arrive at an intra-service work figure. The intra-service work was added to the pre and post work (assumed to be the same as the anchor code) to arrive at total work RVU. Also, for each code in the family, the pre and post-service work was subtracted from the total specialty recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family as well as the building block RVUs were examined to identify any outliers and rank order anomalies.

Comparing the relative intensities and the total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The RUC took the conservative approach of rejecting proposed increases if the relative intensities within the family did not make clinical sense. In addition, to verifying the survey data via the building block methodology, frequently the codes were compared to codes on the MPC for additional validation. In particular CPT codes 48150 *Partial removal of pancreas*, (work RVU 43.48), CPT code 61530 *Removal of brain lesion* (work RVU 43.86), and CPT code 19364 *Breast reconstruction with free flap* (work RVU 41) were used to compare the appropriateness of the recommended values. This validation process was necessary since the specialty included reference procedures that were also included in the five year review and may have resulted in skewed survey results. Although, the majority of the specialty recommendations for the adult cardiac codes were validated in this manner, three codes, 33425, 33468, and 33945 were not validated and the RUC recommended no change in the work relative values for these codes.

The STS extracted three codes at the RUC October, 2000 meeting and presented revised survey data as well as building block data to support the survey data and also compared these codes with other codes recently approved by the RUC during the five year review. The three extracted codes were 32440, *Removal of lung, total pneumonectomy*; 32480, *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)*, and 43117, *Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastronomy, with or without pyloroplasty (Ivor Lewis)*. The RUC concluded that the revised data presented by STS provided compelling evidence for a change in the work RVU for these three codes. Specifically, the revised survey data corrected data input errors that minimized the pre-service and post service times and also incorporated survey data from the American College of General Surgeons. Also, utilizing reference codes with recently revised work relative values substantiated the STS recommendations for increases in relative values. By comparing the survey data to

recently approved codes, a change in work RVU for these three codes was approved. The STS also presented building block data for an additional nine codes but since a majority of the building block data was based on limited mini-survey data, the RUC concluded that the data was insufficient to develop a recommendation at this time. Therefore, the RUC agreed that STS be allowed to present these nine codes to the RUC in February, 2001 with a prefacilitation committee reviewing the submission prior to the February RUC meeting. These nine codes are: 32100 *Thoracotomy, major; with exploration and biopsy*, 32110 *Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear*, 32220 *Decortication, pulmonary (separate procedure)*; total, 32320 *Decortication and parietal pleurectomy*, 32482 *Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)*, 32500 *Removal of lung, other than total pneumonectomy; wedge resection, single or multiple*, 43107 *Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (transhiatal)*, 43112 *Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty*, 43122 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastronomy, with or without pyloroplasty*.

In February, 2001 the RUC reviewed the data for these nine codes. The presenters stated that a concerted effort was made to ensure that the survey respondents included general surgeons and thoracic surgeons outside of academic practice. The STS used a combination of random sample and nominations from respondents to identify additional respondents. The STS also enlisted the help of the American Society of General Surgeons and the American College of Surgeons. These specialties faxed the list of codes to be surveyed to a geographically distributed sample of their membership, asking the surgeons to indicate which procedures they were familiar with and whether they were able to participate in the survey effort. The STS identified 10 general thoracic surgeons that were geographically distributed and asked them to nominate five or more additional general thoracic surgeons in their region from both academic and nonacademic settings.

The RUC examined all nine codes as a group and in relation to the three codes that the RUC approved in October. This allowed the RUC to first obtain a sense of the relativity among the codes before examining each code individually. While 8 of the 9 codes reviewed included critical care visits, the three codes approved in October did not include these visits. The STS presenters stated that they used a level three hospital visit instead of a critical care visit in their October presentation because they were not aware that critical care could be included. To correct this anomaly, the RUC recommended changing one of the hospital visits for each of these codes to a critical care visit. The presenters stressed that for these three codes, 32440, 32480, and 43117 as well as 8 of the 9 codes reviewed in February, thoracic surgeons stated that they are typically providing the critical care services such as ventilator management for their patients.

The following is the building block calculations used for the reference service for the Adult cardiac surgery codes:

33410 Stentless valve			
	Time	Intensity (=time x intensity)	Work RVU
Pre-Service Total	30	0.0224	0.672
Post-service			
Immediate post	50	0.0224	1.12
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)
99211	0	0.17	0
99212	3	0.43	1.29
99213	0	0.65	0
99214	0	1.08	0
99215	0	1.73	0
99231	4	0.64	2.56
99232	0	1.06	0
99233	0	1.51	0
99238	1	1.28	1.28
99239	0	1.75	0
99291	1	4	4
Total non-intra rvws			10.92
current rvw			32.46
current – total non-intra			21.538
intra service time			210
IWPUT-intra			0.102

The following data contain the building block calculations for each anchor code. The total pre and post service work for each anchor code was assumed to be the same for each code in the family and this was subtracted from the total recommended RVU. The resulting IWPUT and building block calculations are also listed below for each family.

Family 9

33405

				Work RVU
Pre-Service Total	Time	Intensity (=time x intensity)		
	40	0.0224		0.896
Post-service				
Immediate post	60	0.0224		1.344
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)	
99211	1	0.17	0.17	
99212	1	0.43	0.43	
99213	1	0.65	0.65	
99214	1	1.08	1.08	
99215	0	1.73	0	
99231	6	0.64	3.84	
99232	1	1.06	1.06	
99233	0	1.51	0	
99238	0	1.28	0	
99239	1	1.75	1.75	
99291	0	4	0	
total post				8.98
Total non-intra			11.22	11.22
rvws				
current rvw				35
current – total non-intra			23.78	
intra service time			240	
IWPUT-intra			0.099	

FAMILY 9						
ANCHOR INTENSITY	0.099					
E/M WORK	11.22					
	Intra-Service Time (Survey Data)	Intra- work RVU (Anchor intensity x intra-time)	Total work RVU (Anchor pre & post work + intra work)	Specialty Rec.	IWPUT (specialty rec. – Anchor pre & post work / intra time)	Final RUC Rec.
33405	240	23.76	34.98	35	0.099	35
33400	180	17.82	29.04	30	0.104	28.5
33406	260	25.74	36.96	37.5	0.101	37.5
33411	260	25.74	36.96	36.25	0.096	36.25
33412	300	29.70	40.92	42	0.103	42
33413	300	29.70	40.92	43.5	0.108	43.5

Family 10

33427			
			Work RVU
	Time	Intensity (=time x intensity)	
Pre-Service Total	42.5	0.0224	0.952
Post-service			
Immediate post	60	0.0224	1.344
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)
99211	0	0.17	0
99212	1	0.43	0.43
99213	1	0.65	0.65
99214	1	1.08	1.08
99215	0	1.73	0
99231	4	0.64	2.56
99232	2	1.06	2.12
99233	0	1.51	0
99238	1	1.28	1.28
99239	0	1.75	0
99291	0	4	0
Total non-intra rvws			10.42
current rvw			40
current - total non-intra			29.58
intra service time			270
IWPUT-intra			0.110

FAMILY 10							
ANCHOR INTENSITY	0.110						
E/M WORK	10.42						
	Intra-Service Time (Survey Data)	Intra- work RVU (Anchor intensity x intra-time)	Total work RVU (Anchor pre & post work + intra work)	Specialty Rec.	IWPUT (specialty rec. – Anchor pre & post work / intra time)	Final RUC Rec.	
33427	270	29.57	39.99	40	0.110	40	
33425	180	19.71	30.13	32	0.120	27	no change
33426	220	24.09	34.51	33	0.103	33	
33430	220	24.09	34.51	33.5	0.105	33.5	
33468	220	24.09	34.51	35	0.112	30.12	no change
33475	200	21.90	32.32	33	0.113	33	

Family 11

33512

		Time	Intensity (=time x intensity)	Work RVU
Pre-Service Total		45	0.0224	1.008
Post-service				
Immediate post		52.5	0.0224	1.176
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)	
99211	1	0.17	0.17	
99212	1	0.43	0.43	
99213	0	0.65	0	
99214	2	1.08	2.16	
99215	0	1.73	0	
99231	10	0.64	6.4	
99232	3	1.06	3.18	
99233	0	1.51	0	
99238	1	1.28	1.28	
99239	0	1.75	0	
99291	0	4	0	
Total non-intra rvws				15.80
current rvw				31.8
current - total non-intra				16.00
intra service time				205
IWPUT-intra				0.078

FAMILY 11						
ANCHOR INTENSITY	0.078					
E/M WORK	15.8					
	Intra-Service Time (Survey Data)	Intra- work RVU (Anchor intensity x intra-time)	Total work RVU (Anchor pre & post work + intra work)	Specialty Rec.	IWPUT (specialty rec. – Anchor pre & post work / intra time)	Final RUC Rec.
33512	205	15.99	31.79	31.8	0.078	31.8
33510	150	11.70	27.50	29	0.088	29
33511	180	14.04	29.84	30	0.079	30
33513	210	16.38	32.18	32	0.077	32
33514	225	17.55	33.35	32.75	0.075	32.75
33516	253	19.73	35.53	35	0.076	35

Family 13

33533

	Time	Intensity	Work RVU (=time x intensity)
Pre-Service Total	40	0.0224	0.896
Post-service			
Immediate post	60	0.0224	1.34
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)
99211	2	0.17	0.34
99212	2	0.43	0.86
99213	0	0.65	0
99214	1	1.08	1.08
99215	0	1.73	0
99231	1	0.64	0.64
99232	1	1.06	1.06
99233	1	1.51	1.51
99238	1	1.28	1.28
99239	0	1.75	0
99291	0	4	0
Total non-intra rvws			9.01
current rvw			30
current – total non-intra			20.99
intra service time			155
IWPUT-intra			0.135

FAMILY 13							
ANCHOR INTENSITY	0.135						
E/M WORK	9.01						
	Intra-Service Time (Survey Data)	Intra- work RVU (Anchor intensity x intra-time)	Total work RVU (Anchor pre & post work + intra work)	Specialty Rec.	IWPUT (specialty rec. – Anchor pre & post work / intra time)	Final RUC Rec.	
33533	155	20.99	30.00	30	0.135	30	
33534	205	27.76	36.77	32.2	0.113	32.2	
33535	240	32.50	41.51	34.5	0.106	34.5	
33536	275	37.24	46.25	37.5	0.104	37.5	
33530	170	23.02	32.03	7.5	-0.009	5.86	no change

Family 14

33860			
			Work RVU
	Time	Intensity (=time x intensity)	
Pre-Service Total	60	0.0224	1.34
Post-service			
Immediate post	70	0.0224	1.57
Post-op services	Frequency (n)	E/M RVU	(=n x E/M RVU)
99211	0	0.17	0
99212	1	0.43	0.43
99213	2	0.65	1.3
99214	0	1.08	0
99215	0	1.73	0
99231	5	0.64	3.2
99232	1	1.06	1.06
99233	0	1.51	0
99238	1	1.28	1.28
99239	0	1.75	0
99291	0	4	0
Total non-intra rvws			10.18
current rvw			38
current - total non-intra			27.82
intra service time			300
IWPUT-intra			0.093

FAMILY 14							
ANCHOR INTENSITY	0.093						
E/M WORK	10.18						
	Intra-Service Time (Survey Data)	Intra- work RVU (Anchor intensity x intra-time)	Total work RVU (Anchor pre & post work + intra work)	Specialty Rec.	IWPUT (specialty rec. – Anchor pre & post work / intra time)	Final RUC Rec.	
33860	300	27.82	38.00	38	0.093	38	
33861	330	30.60	40.78	42	0.096	42	
33863	360	33.38	43.56	45	0.097	45	
33870	330	30.60	40.78	44	0.102	44	
33945	255	23.65	33.83	50	0.156	42.1	no change

AMA Specialty Society RVS Update Committee

RBRVS Five-Year Review

RUC Recommendations

Workgroup 3

Key	2000 CPT Code	Description	Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
	32520	Remove lung & revise chest	21.68	21.68	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The Specialty did not present any data for this code. Therefore, the RUC did not feel there was sufficient compelling evidence to support a change from the current RVUs.	2	
	33917	Repair pulmonary artery	24.50	24.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The Specialty did not present any data for this code. Therefore, the RUC did not feel there was sufficient compelling evidence to support a change from the current RVUs.	2	
	32000	Drainage of chest	1.54	1.54	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of over 143,000. Therefore the RUC concluded that the code should have received a full RUC survey. The data presented had a wide range of responses but the decrease in time was the only data presented and based on this, did not provide any compelling evidence for an increase in the RVU.	2	1
	32005	Treat lung lining chemically	2.19	2.19	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 8,793. The data presented include post operative time that was inappropriate for a 000 day global procedure. Additionally the time for the procedure was below original Harvard time and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2	1

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Key	2000	RUC					
CPT	Work	Rec					
Code	RVU	RVU	Comment	RUC Rationale	Key	Family	
32020	Insertion of chest tube	3.98	3.98	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The survey vignette for this code included a description of post operative work that the RUC felt was inappropriate for a code with a global period of 000. In conjunction with the recent inter-operative survey times of 20 minutes that were lower than original Harvard data of 24 minutes, the RUC determined that the data presented was skewed and that no sufficient rationale or evidence was provided to support a change from the current RVUs.	2	1
32035	Exploration of chest	8.67	8.67	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC had difficulty translating the mini-survey data for this 90 day global procedure into support for the recommended increases in RVUs since the intra-service time was lower than the original Harvard time and was difficult to compare to the reference code that had a 000 day global period. Without specific additional data on the post operative care and clear evidence that the surgeon provided all of the post operative care rather than an intensivist, the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs. The RUC felt that in comparison to other codes on the MPC the code may be undervalued but sufficient data was not presented to determine the magnitude of the undervaluation.	2	1

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Key CPT Code	Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
32220	Release of lung	19.27	24.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The intraoperative work for codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, 32320 is slightly more work than 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." Code 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on the survey results and the recommendation for using the median RVU, the Committee felt that the information presented supported the recommendation. Additionally, the recommended work relative values; CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50) would place these two procedures in proper rank order, which is greater than 32480 and less than 32440 (RUC recommended RVW = 25).	1	1
32225	Partial release of lung	13.96	13.96	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The survey data from the mini-survey provided lower time or not significantly different times than Harvard data and no compelling evidence was presented to justify a change in relative values. Additionally, these codes were compared to a 000 day reference procedure without additional rationale to assist in the comparison of codes with different global periods. Based on the lack of data, the RUC did not feel there was sufficient rationale to support a change from the current RVUs.	2	1

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
32320 Free/remove chest lining	20.54	24.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The intraoperative work for codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, 32320 is slightly more work than 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." Code 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on the survey results and the recommendation for using the median RVU, the Committee felt that the information presented supported the recommendation. Additionally, the recommended work relative values; CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50) would place these two procedures in proper rank order, which is greater than 32480 and less than 32440 (RUC recommended RVW = 25).	1	1
32602 Thoracoscopy, diagnostic	5.96	5.96	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 3,291. This code was reported with a 90 day global with length of stay and office visit data when actually the code is a 000 day global. Since it appears that the code was surveyed as a code with a 090 day global period, rather than a 000 day procedure, the RUC concluded that the data presented was inappropriate and the inclusion of the data that did apply for a 000 day procedure did not justify an increase in RVU compared to the previous RUC review of the procedure. In fact the data presented intra-service work at twice the value of critical care services.	2	1

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
32651 Thoracoscopy, surgical	12.91	12.91	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC did not believe that there was sufficiently compelling evidence to support an increase in the RVUs since this procedure was reviewed in 1993 and there was not sufficient evidence presented to demonstrate that the work had changed since the last RUC review. In addition to survey results similar to the previous survey, this code with a 90 day global period was compared to a 000 day global procedure that further complicated any comparison with the reference procedure. The RUC also questioned the inclusion of this code in the family using a 000 day anchor code and reference procedure.	2	1
32652 Thoracoscopy, surgical	18.66	18.66	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The data presented did not support a change from the previous RUC recommendation for this code. The RUC also questioned the inclusion of this code in the family using a 000 day anchor code and reference procedure. Using the reference service that is a non-invasive procedure when this code is an invasive procedure further complicates a comparison with the reference service.	2	1
32110 Explore/repair chest	13.62	23.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The STS explained that this procedure is typically performed on an emergent basis with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for 32110 is different, but still as complex as for 32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy). The patient requiring 32480 (RUC work RVU recommendation, 23.75), is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given the information provided, the committee felt that the survey results supported the recommendation and created proper rank order within the family by reflecting the difference in work for code 32110 compared code 32480.	1	2

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
32440 Removal of lung	21.02	25.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC first examined the reverse building block data presented by the specialty that validated the survey data for code 32440 Removal of lung, total pneumonectomy. With an IWPUT of .080 the RUC felt this was appropriate in comparison to codes such as 43860 Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or bowel resection; without vagotomy (work RVU 25) with a .088 IWPUT that was approved by the RUC as part of this five year review. Also, code 43415 Suture of esophageal wound or injury; transthoracic or transabdominal approach (work RVU 25) with a .085 IWPUT was used as a point of comparison. Code 43415 was also approved by the RUC during this five-year review. The RUC felt that these comparisons validated the median survey value of 25 since code 32440 was judged to have similar work as these comparison codes.	4	2
32480 Partial removal of lung	18.32	23.75	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC examined the reverse building block data that resulted in an IWPUT of .084 and also compared this code to 43415 (work RVU 25) with a .085 IWPUT. In comparison to code 32440 the specialty felt that the recommend RVU maintained proper rank order within the family. While this code is slightly more technically demanding than 32440, due to the type of dissection involved, this code is typically performed on a lower risk population with less post operative work. Also, since this code has fewer post operative visits than 43415, the RUC felt that the value should be below that of 43415 and accepted a value of 23.75 to maintain proper rank order within the family. This value was also the RUC member ballot median suggested value of 23.75.	4	3

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
32482 Bilobectomy	19.71	25.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code was compared to 32440 Removal of lung, total pneumonectomy; (RUC recommended RVW = 25.00) and 32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy) (RUC recommended RVW = 23.75). The STS data indicates that 32440 is less intraoperative work than 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. Code 32480 is also a large operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The committee agreed that the correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: 32482 (med RVW = 25.00); 32440 (RUC recommended RVW = 25.00); and 32480 (RUC recommended RVW = 23.75). This would create the proper rank order within the family.	1	3
32500 Partial removal of lung	14.30	22.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The STS data indicated that it is typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Given the survey data and the recommended median relative values, the Committee agreed that the survey median RVW of 22.00 reflects the slightly less total work for 32500 compared with the reference codes 32440 and 32480.	1	3

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
31600 Incision of windpipe	3.62	7.18	The American Society of General Surgeons believes that this code is undervalued relative to the physician work required to perform this service.	Both the STS and the ASGS proposed that the typical patient for this procedure is sicker and intubated longer than in 1995 when the RUC last reviewed this procedure. While the median value obtained by the ASGS was 8, the ASGS felt that the value was too high in relation to similar procedures and used a building block methodology to validate the recommended relative value. Based on the building block value of 7.18, with an intra-service intensity of .067 and pre and post service intensity of .040, the RUC felt that the value fit in between the 25th percentile relative value of 6 and the median value of 8 that was obtained by both the STS and ASGS. Also, in comparison to code 35474 repair arterial blockage, on the MPC with a value of 7.36, the RUC felt that these additional valuation methods supported the recommended value of 7.18.	1	4
32655 Thoracoscopy, surgical	13.10	13.10	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The mini-survey time data presented demonstrated a reduction in time compared with the previous RUC review in 1993 and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2	4
32657 Thoracoscopy, surgical	13.65	13.65	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The data presented suggest lowering the relative value as recommend by the specialty however, building block data supplied by the specialty suggest increasing the value. Due to the conflicting data presented, the RUC concluded that there was no compelling evidence for changing the relative value for this code.	2	4
38746 Remove thoracic lymph nodes	4.39	4.89	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 4,304. Although this code is an add on code that represents only the additional work for this procedure, the data presented post operative work data. Additionally, the vignette used for this code was a 90 day global procedure and therefore the RUC could not support the recommended increase in RVUs. However, the RUC felt that the work involved for this procedure was similar to 38747, Removal of abdominal lymph nodes (work RVU, 4.89). The RUC therefore recommends a relative value of 4.89.	4	5

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
39010 Exploration of chest	11.79	11.79	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 2,491. The limited mini-survey data did not differ from the original Harvard data and the specialty did not provide evidence to support a change in the current RVU. Additionally, the RUC compared the code to 32100, Thoracotomy, major; with exploration and biopsy, (work RVU, 11.84) and in comparison to 39010 (work RVU 11.79), the RUC felt that the code was appropriately valued since both procedures represented similar amounts of work. Therefore, the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVU.	2	5
39220 Removal chest lesion	17.42	17.42	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty felt that the data presented did not support a change in the RVU and the RUC agreed with this assessment.	2	5
39400 Visualization of chest	5.61	5.61	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 10,648. The STS argued that this procedure has historically been undervalued, however the workgroup found it difficult to compare this 10 day global period procedure to the reference service with a 90 day global. In an effort to validate the specialty's recommendation, the RUC calculated an IWP/UT of .24 that was not in line with the other procedures in the family. Therefore, the RUC concluded that no compelling evidence was presented to support change in the work RVU of this code.	2	5

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Key	2000	RUC					
CPT	Work	Rec					
Code	RVU	RVU	Comment	RUC Rationale	Key	Family	
43107	Removal of esophagus	28.79	43.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	<p>The STS presenters discussed that while 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. This procedure was described as having greater intensity in comparison with 43117, however, the survey results did not support this conclusion. After considerable discussion by the committee and obtaining a detailed description of the work involved, as well as a review of the accompanying literature contained in tab 16, the committee was convinced that the intensity of the approach described was greater than the reference code 43117.</p> <p>Of the four surveyed esophagectomy codes, 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including repositioning and redraping. The STS explained that the other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to 43112, they each include a gastric drainage procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both 43117 and 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. Code 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare.</p> <p>For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The committee discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.</p>	1	6

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
43112 Removal of esophagus	31.22	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The committee discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.	1	6
43117 Partial removal of esophagus	30.02	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The committee discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.	1	7
43122 Parital removal of esophagus	29.11	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The committee discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.	1	7

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Key	2000	RUC					
CPT	Work	Rec					
Code Description	RVU	RVU	Comment	RUC Rationale		Key	Family
31622 Dx bronchoscope/wash	2.78	2.78	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The presenters focused on the additional work required for performing a rigid bronchoscopy as opposed to a flexible bronchoscopy but did not present compelling evidence that the work for this procedure has changed to warrant the recommended change in RVUs. The RUC determined that the data presented may have been inflated since the vignette included a description of an initial flexible diagnostic bronchoscopy and a rigid bronchoscopy as well as follow up care that is not included in a 000 day global procedure. Although this code is for rigid or flexible bronchoscopy, the typical patient described in the vignette receives both. Additionally it was difficult to compare this proceeded to the reference code 32095 thorectomy, which has a 090 day global period. The survey results that showed that 86% of the respondents did not feel that the work has changed in the last five years and that half felt that the patients are more complex and the other half had no change in complexity. This also lent support that there is a wide variation in the procedure but overall the work had not changed and the data did not support an increase in RVU. The RUC discussed the possibility that the society may want to explore the possibility of created a new code if the work is significantly different for rigid bronchoscopy but the RUC recommends maintaining the current RVU.		2	8
31625 Bronchoscopy with biopsy	3.37	3.37	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 49,800. The presenters focused on the additional work required for performing a rigid bronchoscopy as opposed to a flexible bronchoscopy but did not present compelling evidence that the work for this procedure has changed to warrant the recommended change in RVUs. The RUC determined that the data presented may have been inflated since the vignette included a description of an initial flexible diagnostic bronchoscopy and a rigid bronchoscopy as well as follow up care that is not included in a 000 day global procedure. Although this code is for rigid or flexible bronchoscopy, the typical patients described in the vignette receives both. Additionally it was difficult to compare this proceeded to the reference code 32095 thorectomy, which has a 090 day global period. The survey results that showed that 86% of the respondents did not feel that the work of the anchor code 31622 had changed and the RUC did not find sufficient evidence to support a change from the current RVUs.		2	8

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Key	2000	RUC					
CPT	Work	Rec					
Code	Description	RVU	RVU	Comment	RUC Rationale	Key	Family
31645	Bronchoscopy, clear airways	3.16	3.16	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC was concerned that the data provided was from a mini-survey while the code has a Medicare frequency of 25,037. The presenters focused on the additional work required for performing a rigid bronchoscopy as opposed to a flexible bronchoscopy but did not present compelling evidence that the work for this procedure has changed to warrant the recommended change in RVUs. The RUC determined that the data presented may have been inflated since the vignette included a description of an initial flexible diagnostic bronchoscopy and a rigid bronchoscopy as well as follow up care that is not included in a 000 day global procedure. Although this code is for rigid or flexible bronchoscopy, the typical patients described in the vignette receives both. Additionally it was difficult to compare this proceeded to the reference code 32095 thorectomy, which has a 090 day global period. The survey results that showed that 86% of the respondents did not feel that the work of the anchor code 31622 had changed and the RUC did not find sufficient evidence to support a change from the current RVUs.	2	8

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Key	2000	RUC				
CPT	Work	Rec				
Code Description	RVU	RVU	Comment	RUC Rationale	Key	Family
33400 Repair of aortic valve	25.34	28.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33405, Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve (work RVU recommended 35). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The IWPUTs for the entire family were examined to identify any outliers. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. For code 33400 the building block value of 29.04 was less than the recommended value of 30 and therefore the RUC did not feel that the survey median value was validated. The RUC therefore used the lowest IWPUT for the family of .096 and calculated a value of 28.5 to maintain proper rank order within the family. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33405 be applied to this code since this assumption was made when reviewing the specialty recommendation.	4	9

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33405 Replacement of aortic valve	30.61	35.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code served as an anchor code for a family of codes submitted for review. However, a building block methodology was used to validate the survey results. The recommended RVU for this code was derived primarily from mini-survey data but due to the lack of data contained in the mini-survey summary, the RUC compared this code to a reference code that has been recently approved by the RUC. Code 33410, Replacement of aortic valve (work RVU 32.46) was selected as the reference. The family anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. Since this anchor code's IWPUT of .099 seemed appropriate in comparison to 33410, and the other codes in the family, the RUC supported the recommended value of 35. This validation process was necessary since the specialty included reference procedures that were also included in the five year review and may have resulted in skewed survey results.	1	9
33406 Replacement of aortic valve	32.30	37.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post-operative work was the same as the anchor code 33405. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The IWPUTs for the entire family were examined to identify any outliers. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33405 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	9

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Key	2000	RUC					
CPT	Work	Rec					
Code	RVU	RVU	Comment	RUC Rationale		Key	Family
33411	Replacement of aortic valve	32.47	36.25	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post-operative work was the same as the anchor code 33405. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The IWPUTs for the entire family were examined to identify any outliers. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33405 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	9

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Key	2000 CPT Code	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
	33412	34.79	42.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post-operative work was the same as the anchor code 33405. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The IWPUTs for the entire family were examined to identify any outliers. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33405 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	9

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33413 Replacement of aortic valve	35.24	43.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post-operative work was the same as the anchor code 33405. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The IWPUTs for the entire family were examined to identify any outliers. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33405 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	9
33425 Repair of mitral valve	27.00	27.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC used a building block methodology to validate the recommended RVU, however, the building block value of 30.13 did not support the recommended value of 32. Therefore, the RUC concluded that there was not sufficient evidence to support a change in the relative value.	2	10

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33426 Repair of mitral valve	31.03	33.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the code has a Medicare frequency of 3,085. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33427. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33427 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	10
33427 Repair of mitral valve	33.72	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code served as an anchor code for a family of codes submitted for review. The recommended RVU for this code was derived primarily from mini-survey data but due to the lack of data contained in the mini-survey summary, the RUC compared this code to a reference code that has been recently approved by the RUC. Code 33410, Replacement of aortic valve (work RVU 32.46) was selected as the reference. The family anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. The anchor code value and IWPUT seemed appropriate in comparison to 33410 as well as with the other codes in the family.	1	10

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Key	2000	RUC					
CPT	Work	Rec					
Code Description	RVU	RVU	Comment	RUC Rationale		Key	Family
33430 Replacement of mitral valve	31.43	33.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the code has a Medicare frequency of 12,007. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33427. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33427 be applied to this code since this assumption was made when reviewing the specialty recommendation.		1	10
33468 Revision of tricuspid valve	30.12	30.12	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC used a building block methodology to validate the recommended RVU, however, the building block IPUT of .112 was greater than the anchor code 33427 IWPUT of .110 for the same intra-service time and the RUC felt that the validation method did not support the recommended RVU. Therefore, the RUC concluded that there was not sufficient evidence to support a change in the relative value.		2	10

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Key	2000	RUC						
CPT	Work	Rec						
Code Description	RVU	RVU	Comment		RUC Rationale		Key	Family
33475 Replacement, pulmonary valve	28.41	33.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.		The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33427. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33427 be applied to this code since this assumption was made when reviewing the specialty recommendation.		1	10

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Key	2000	RUC				
CPT	Work	Rec				
Code Description	RVU	RVU	Comment	RUC Rationale	Key	Family
33510 CABG, vein, single	25.12	29.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the Medicare frequency for this code was 7,444 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33512 , Coronary artery bypass, vein only; three coronary venous grafts (recommended work RVU 31.8). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33512 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	11

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33511 CABG, vein, two	27.40	30.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the Medicare frequency for this code was 11,332 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33512 , Coronary artery bypass, vein only; three coronary venous grafts (recommended work RVU 31.8). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33512 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	11
33512 CABG, vein, three	29.67	31.80	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code served as an anchor code for a family of codes submitted for review. The recommended RVU for this code was derived primarily from a full RUC survey data but due to the comparison with a reference code included in the five year review the RUC compared this code to a reference code that has been recently approved by the RUC. Code 33410, Replacement of aortic valve (work RVU 32.46) was selected as the reference. The family anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. This anchor code building block value of 31.79 with an IWPUT of .078 seemed appropriate in comparison to 33410 and also within the values calculated for the entire family of codes. This validation process was necessary since the specialty included reference procedures that were also included in the five year review and may have resulted in skewed survey results.	1	11

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33513 CABG, vein, four	31.95	32.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data, although the Medicare frequency for this code was 10,632 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33512, Coronary artery bypass, vein only; three coronary venous grafts (recommended work RVU 31.8). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33512 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	11

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33514 CABG, vein, five	35.00	32.75	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the Medicare frequency for this code was 3,133 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33512 , Coronary artery bypass, vein only; three coronary venous grafts (recommended work RVU 31.8). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33512 be applied to this code since this assumption was made when reviewing the specialty recommendation.	3	11

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33516 Cabg, vein, six or more	37.40	35.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33512, Coronary artery bypass, vein only; three coronary venous grafts (recommended work RVU 31.8). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33512 be applied to this code since this assumption was made when reviewing the specialty recommendation.	3	11
33517 CABG, artery-vein, single	2.57	2.57	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12
33518 CABG, artery-vein, two	4.85	4.85	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12

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Key CPT Code	Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33519	CABG, artery-vein, three	7.12	7.12	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12
33521	CABG, artery-vein, four	9.40	9.40	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12
33522	CABG, artery-vein, five	11.67	11.67	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12
33523	Cabg, art-vein, six or more	13.95	13.95	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	12
33530	Coronary artery, bypass/reop	5.86	5.86	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty recommended no change in value for this add on procedure since it was surveyed as a 90 day global procedure and produced unreliable survey results.	2	13

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33533 CABG, arterial, single	25.83	30.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code served as an anchor code for a family of codes submitted for review. The recommended RVU for this code was derived primarily from a full RUC survey, but due to the comparison with a reference code included in the five year review the RUC compared this code to a reference code that has been recently approved by the RUC. Code 33410, Replacement of aortic valve (work RVU 32.46) was selected as the reference. Code 33533 underwent a building block calculation to arrive at an IWPUT calculation and total RVU calculation. The IWPUT for this code was also compared to the entire family and the building block RVUs were examined to identify any outliers and rank order anomalies. Although the IWPUT appeared somewhat high at .135, the RUC felt that this value was appropriate in comparison to intensities within the family. Also, when comparing this family to the CABG codes with vein alone, the increment in relative values seemed appropriate (30 vs 29 for single artery graft vs. single vein graft, respectively). Additionally, it is uncommon to perform a single arterial graft unless the patient is in an emergency situation such as a failed angioplasty, stent placement, or someone with a heart attack in progress and a critical; blockage of the left main artery. The specialty stated that the acute nature of the problem and the amount of heart muscle at risk justifies the increased intensity.	1	13

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33534 CABG, arterial, two	28.82	32.20	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the Medicare frequency for this code was 9,725 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33533 Coronary artery bypass, using arterial graft(s); single arterial graft (recommended work RVU 30). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33533 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	13

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33535 CABG, arterial, three	31.81	34.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data although the Medicare frequency for this code was 2,349 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33533 Coronary artery bypass, using arterial graft(s); single arterial graft (recommended work RVU 30). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The total RVU for each code in the family as calculated by the building block methodology was compared to the specialty recommended RVUs as a validation of the recommended RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33533 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	13

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Key	2000	RUC							
CPT	Work	Rec							
Code Description	RVU	RVU	Comment		RUC Rationale			Key	Family
33536 Cabg, arterial, four or more	34.79	37.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.		The recommended RVU for this code was derived primarily from mini-survey data and the Medicare frequency for this code was 1,113 in 1998. However, a building block methodology was used to validate the survey results. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33533 Coronary artery bypass, using arterial graft(s); single arterial graft (recommended work RVU 30). For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. The IWPUTs for the entire family were examined to identify any outliers. Additionally, a total RVU based on the anchor code's IWPUT was calculated for each code. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33533 be applied to this code since this assumption was made when reviewing the specialty recommendation.			1	13
33860 Ascending aortic graft	33.96	38.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.		This code served as an anchor code for a family of codes submitted for review. The recommended RVU for this code was derived primarily from a full RUC survey data but due to the comparison with a reference code included in the five year review the RUC compared this code to a reference code that has been recently approved by the RUC. Code 33410, Replacement of aortic valve (work RVU 32.46) was selected as the reference. The family anchor code underwent a building block calculation to arrive at an IWPUT calculation of .093 and this fit well within the family of codes as well as the reference code. The RUC concluded that the building block IWPUT and comparison within the family supported the recommended value of 38. This validation process was necessary since the specialty included reference procedures that were also included in the five year review and may have resulted in skewed survey results.			1	14

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33861 Ascending aortic graft	34.52	42.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33860, Ascending aorta graft (recommended work RVU 38). The anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the building block methodology was calculated for each code and compared to the specialty recommended RVUs as a validation of the recommended RVU. The IWPUTs for the entire family were examined to identify any outliers. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33860 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	14

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33863 Ascending aortic graft	36.47	45.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33860, Ascending aorta graft (recommended work RVU 38). The anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the building block methodology was calculated for each code and compared to the specialty recommended RVUs as a validation of the recommended RVU. The IWPUTs for the entire family were examined to identify any outliers. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33860 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	14

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Key	2000	RUC						
CPT	Work	Rec						
Code Description	RVU	RVU	Comment	RUC Rationale			Key	Family
33870 Transverse aortic arch graft	40.31	44.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The recommended RVU for this code was derived primarily from mini-survey data. Due to the lack of data contained in the mini-survey summary, the RUC made the assumption that the pre and post operative work was the same as the anchor code 33860, Ascending aorta graft (recommended work RVU 38). The anchor code underwent a building block calculation to arrive at an IWPUT calculation and the non intra-service relative values were calculated. For each code in the family, the pre and post-service work was subtracted from the total recommended relative value and an IWPUT was calculated based on the intra-service time contained in the mini-survey summary form. Additionally, a total RVU based on the building block methodology was calculated for each code and compared to the specialty recommended RVUs as a validation of the recommended RVU. The IWPUTs for the entire family were examined to identify any outliers. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33860 be applied to this code since this assumption was made when reviewing the specialty recommendation.			1	14
33945 Transplantation of heart	42.10	42.10	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC used a building block methodology to validate the recommended RVU, however, the building block IWPUT of .156 was greater than the anchor code 33860 IWPUT of .110 and of the other codes in the family. Additionally, the total building block calculated RVU was 33.83, significantly less than the recommended RVU of 42.1. Therefore, the RUC concluded that there was not sufficient evidence to support a change in the relative value.			2	14
33750 Major vessel shunt	21.41	21.41	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC determined that the mini-survey did not provide sufficient data to warrant a change in the relative value. Since the procedure was significantly different from the anchor code a full survey was warranted. Therefore, the RUC did not feel sufficient evidence was presented to support a change from the current RVU.			2	15

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33820 Revise major vessel	16.29	16.29	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The mini-survey data presented suggested a reduction in work rather than an increase as recommended by the specialty. The specialty contends that the difference was most likely a result of survey sampling "noise", however the RUC did not feel sufficient rationale was provided to support an increase in the RVU.	2	15
33840 Remove aorta constriction	20.63	20.63	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	While the society stated that the typical patient for this procedure has become younger, the vignette used was for a six month patient and resembled very closely the vignette used in 1993. Although the specialty stated that the previous value was understated due to high end compression of relative values the survey results reflected a decrease in time and give the same vignette and survey data indicating no change in work, the RUC did not feel the society presented sufficient evidence to support a change from the current RVU.	2	15
33641 Repair heart septum defect	21.39	21.39	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty contended that the intensity of this procedure has increased in recent years partially due to the frequent use of much smaller incisions leading to a more difficult procedure to repair an arterial septal defect. However, the survey intra-service time data was less than the original Harvard time data and 100% of the survey respondents indicated that the work in performing the service has not changed in the past 5 years. The RUC did not find any compelling evidence to warrant a change in the relative value for this procedure.	2	16

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Key	2000	RUC					
CPT	Work	Rec					
Code Description	RVU	RVU	Comment	RUC Rationale		Key	Family
33660 Repair of heart defects	25.54	30.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty presented a compelling rationale for an increase in the relative value for this procedure due to a change in the work involved. Since the RUC last reviewed this procedure in 1993, the typical surgery now involves the repair of the left valve while the procedure previously did not involve this additional work. However, recently research has shown that in is more efficient to perform the repair the left valve when performing this procedure since eventually the valve will need repair anyway. Rather than a two staged procedure as was done previously, the entire operation is currently being performed in one setting. This adds additional steps to the procedure and justifies the increase in work value. The mini-survey data demonstrated intra-service time comparable to the reference service 33401Valvuloplasty, aortic valve; open, with inflow occlusion (work RVU 30.61). Therefore, the RUC recommends acceptance of the recommended increase in RVU. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33641 be applied to this code since this assumption was made when reviewing the specialty recommendation.		1	16
33415 Revision, subvalvular tissue	27.15	27.15	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty stated that the typical patient for this procedure has not changed and the mini-survey did not provide sufficient data to justify a change in RVU. The RUC did not feel that sufficient rationale was provided to support a change from the current RVU.		2	17

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33681 Repair heart septum defect	27.67	30.61	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	While the same vignette was used in the current survey as was used in 1993 when the RUC last reviewed this code, the specialty stated that the vignette was not typical since rather than a one year old child, the typical child is now only 6 weeks old. Advances in technique led all survey respondents to agree that the work of performing the service is more complex than five years ago and the specialty stated that this is due to the younger typical patient leading to an increase in the intra-service intensity. This code was compared to the reference service as having lower intra-service time but slightly higher intensity and the RUC determined that the recommended RVU was justified as the specialty presented a compelling case for why the work intensity has changed since the last RUC review.	1	17
33615 Repair, simple fontan	32.06	34.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The intra service time of 250 minutes obtained through the mini-survey is greater than the reference service time of 210 minutes for CPT code 33412, Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU, 34.79) Additionally the code contains three days of critical care services that are not included in the reference code. The presenter stated that the overall intra-service intensity and post operative intensity due to the critical care codes is significant. The RUC questioned whether this code should be valued greater than the reference service since the recommended RVU is less than the reference service. However, the mini-survey data was insufficient to recommend an increase beyond the recommended RVU. Therefore, the RUC recommends acceptance of the increase in the work relative value. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33670 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	18

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Key	2000	RUC				
CPT	Work	Rec				
Code Description	RVU	RVU	Comment	RUC Rationale		Key Family
33670 Repair of heart chambers	32.73	35.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	Although the vignette describes the typical patient as a 4 month old child, the specialty stated that typical patient is more likely 6 weeks old. Given the younger age of the typical patient all survey respondents indicated that the patients requiring this service are more complex. Compared to the reference service 33412, Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79) this service has greater intra-service time and intensity and the RUC therefore concluded that the increase in relative value for this code was warranted.	1	18
33730 Repair heart-vein defect(s)	31.67	34.25	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This service in comparison to the reference service had a slightly higher intra-service time but the compelling evidence for a change in the relative value was due to the procedure now being performed within the first few months of life rather than waiting until the child is at least one year old. The change in the typical patient led to a more complex patient with greater pulmonary hypertension risk, especially when compared to the reference service of 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79). The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33670 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	18

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33611 Repair double ventricle	32.30	34.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The mini-survey time data indicate greater intra-service time than the reference procedure and the specialty stated that the intensity and provision of critical care services for this procedure in comparison to the reference service 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79) and code 33694, Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch, the anchor code for the family, (work RVU 34 recommended) warranted an increase in the relative value. Additionally, the intra-service time of 240 minutes was greater than the reference service with an intra-service time of 210 minutes. The RUC found this data to be compelling evidence for increasing the relative value to 34 to maintain rank order with similar procedures. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33694 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	19
33612 Repair double ventricle	33.26	35.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code was compared to code 33611, Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp (recommended work RVU, 34). The specialty explained that this procedure involved some additional work due to the partial enlargement of the right ventricle in comparison to 33611 and the specialty felt that one additional RVU represented the additional work. Therefore, the RUC agreed that the recommended value was appropriate to maintain appropriate rank order within this family of codes, in particular anchor code of 33694 Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch (recommended work RVU 34). The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33694 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	19

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33694 Repair of heart defects	31.73	34.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC reviewed the full survey data and concluded that all measures of physician work, both time and intensity were greater than the reference code 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79). Additionally, all survey respondents indicated that the typical patient is now more complex than five years ago. This is primarily due to a decrease in the age of the typical patient.	1	19
33697 Repair of heart defects	33.71	36.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This code involves additional work of placing a conduit as compared to code 33694 Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch (work RVU 31.73), and the patients have become younger with more performed as newborns. Additionally, the intra-service time of 260 minutes is greater than the reference service with intra-service time of 210 minutes and the RUC felt that this difference in time presented a compelling argument in favor of increasing the relative value. Also the increase is necessary to maintain rank order within the family of codes. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33694 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	19
33767 Major vessel shunt	24.50	24.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty stated that this code may not have been included in the correct family for this review and felt that the recommended RVU was too high. In light of this and also since the mini-survey time data is less than the previous RUC time, the RUC concluded that there was not compelling evidence for a change in the relative value.	2	19

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33617 Repair, modified fontan	34.03	37.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	This procedure in comparison to the reference procedure 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79) had higher intra-service time (300 minutes versus 210 minutes) as well as higher intensity rankings. The increase in work proposed by the specialty is due to a decrease in age of the patient, although the vignette did not capture this decrease. The procedure is now performed on a much younger patient population, under one year of age, were as previously this was not even an option. Additionally, 80% of respondents indicated that the work has changed and all respondents stated that the patients are more complex. The RUC agreed that the specialty was able to fully explain that the change in patient demographics translated into additional intra-service as well as post-service work. Therefore, the RUC recommends acceptance of the increase in the work relative value.	1	20
33619 Repair single ventricle	37.57	45.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty explained that this procedure has the highest mortality rate of 25% of all thoracic procedures. Due to the procedure on a child with a very small ascending aorta, the work involved is very time consuming and technically very difficult since a significant amount of work is performed during circulatory arrest. The intra-service time of 330 minutes was significantly higher than the intra-service time of the reference procedure 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79) of 210 minutes. The society stated that the work of this procedure has not changed and the patient population has not changed in the last five years, but rather the procedure was never correctly valued due to the previous low frequency of the procedure. The RUC also compared this code to 48150 Whipple procedure(work RVU, 43.48) and code 61530 Removal of Brain Lesion (work RVU 43.86)	1	21

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Key	2000	RUC				
CPT	Work	Rec				
Code Description	RVU	RVU	Comment	RUC Rationale	Key	Family
33506 Repair artery, translocation	26.71	35.50	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC compared the mini-survey time data to the previous RUC survey data and noted an increase in length of stay as well as a total of 5 days of critical care services. The specialty stated that this procedure is an outlier due to the patient population where the babies are in heart failure with severe left ventricular dysfunction where 40% of the patients leave the operating room on an left ventricular assist device (LVAD). To preserve proper rank order with this family of codes, the RUC accepts the recommended increase in relative value for this code. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33778 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	22
33770 Repair great vessels defect	33.29	37.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty stated that the age for the typical patient for this procedure has now decreased to the first couple of months as opposed to a one year old. Also in comparison to 33697 Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect (recommended work RVU 36) the placement of the sutures to anchor the VSD patch in this procedure is more difficult and warrants an increase above 33697. Based on comparison with 33697, the RUC agreed that the recommended value of 37 was appropriate. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33778 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	22

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33778 Repair great vessels defect	35.82	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The work involved in this procedure has changed due to an expansion in the types of newborns that now undergo the procedure. Previously surgeons were reluctant to perform this procedure on certain coronary artery patterns due to the high risk. This procedure involves manipulating a 1 millimeter vessel and repairing uncommon coronary patterns. Also this procedure was compared to MPC code 33870 Transverse Aortic Arch Graft, (work RVU 40.30) as requiring more work. Additionally the work involved, as measured by the time and intensity was significantly higher than the reference service 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU, 34.79.) The RUC therefore, concluded that there was compelling evidence for the recommended increase in relative values.	1	22
33780 Repair great vessels defect	36.94	41.75	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty stated that the typical patient for this procedure has decreased in age from 4 months to newborns leading to greater physician intra-service intensity. In comparison to the anchor code 33778 Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); (Recommended work RVU, 40) this procedure involves additional work of closing the ventricular septal defect and warrants the additional 1.75 RVUs due to the additional 35 minutes of intra-service time. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33778 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	22

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Key CPT Code Description	2000 Work RVU	RUC Rec RVU	Comment	RUC Rationale	Key	Family
33786 Repair arterial trunk	34.84	39.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	In comparison to the reference procedure, 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) (work RVU 34.79) all of the time and intensity measures indicated additional work. Also, all of the patients are newborns in an ICU. Although the vignette describes a 3 week old infant both in the current survey as well as the survey used in 1993 when the RUC originally reviewed this code. The presenter stated that previously patients were 3-4 months old but now it has been determined that the procedure should be performed earlier when the defect is diagnosed. In comparison to 33770 Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; (recommended work RVU 37) and 33697 Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect (recommended work RVU 36), the RUC felt that the recommendation of 39 RVUs fit well with the values of similar thoracic procedures.	1	23
33919 Repair pulmonary atresia	32.67	40.00	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty described the repair for the pulmonary atresia with ventricular septal defect as involving more work than similar procedures such as 33778 Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); (recommended RVU 40) since this procedure involves patients with multiple non-pulmonary sources of blood flow and the work involves the dissection outside the pericardium to unifocalize the vessels for the patch. However, given the limited mini-survey data, the RUC felt that the recommended increase to 40 RVUs was warranted, but the mini-survey data did not support a value higher than the recommended median value. The pre and post-service times for this code were originally collected via a mini-survey, which did not provide sufficient detail for the pre-service time or the number and level of post-operative visits. Therefore, since the RUC could not verify the mini survey data, the RUC recommends that the pre and post-service time data for the anchor code 33786 be applied to this code since this assumption was made when reviewing the specialty recommendation.	1	23

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Survey CPT Code: 31600

Global : 000

Current RVW: 3.62

Recommended RVW: 7.18(between 25th percentile and median)**CPT Code Descriptor:** Tracheostomy, planned (separate procedure);

Typical Patient/Service: A 65-year-old male with a history of COPD requires a tracheostomy. After a sigmoid resection and colostomy for a diverticular abscess was performed two weeks ago, he had gram negative sepsis and remained respirator dependent and hypoxia on room air. TPN had been started. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. Medical and anesthesiology consults are requested. The patient was transferred to the OR with a team required to maintain the ventilation and managed his other tubes. After general anesthesia was induced and the wound prepped, a transverse incision was made and the strap muscles were split. The isthmus of the thyroid was divided. An underlying tracheal ring was cleared and segment removed. The trach tube inserted and secured. Again a team is utilized to transfer the patient back to the intensive care unit. Postoperatively, the wound is monitored for infection and possible dislodgement. Discussions are conducted with the patient, family, and other health care providers with respect to further care of the patient. NOTE this CPT code has a 000 global period, therefore do NOT consider any work after the day of the procedure when evaluating this code.

CLINICAL DESCRIPTION OF SERVICE:**PREOPERATIVE WORK**

Preoperative work begins after the decision to operate and may include the procedural work-up, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, accompany the patient (who is respiratory dependent) during transfer to the OR, insure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

INTRAOPERATIVE WORK

After general anesthesia is induced, a transverse incision is made, dissecting through the layers of cervical fascia, and dividing or dissecting the strap musculature. The isthmus of the thyroid is divided. An underlying tracheal ring is cleared and segment removed. The trach tube is inserted and secured.

POSTOPERATIVE WORK

Apply dressing, write postoperative orders, supervise transfer of the patient, who is respirator dependent back to the ICU, and dictate postoperative note. Discuss the procedure outcome with the patient/family. Monitor wound for infection or dislodgement. Review chart x-ray. Discuss procedure outcome with referring physician.

SURVEY DATA**Presenter(s):** Charles M , Shoemaker, MD (ASGS)**Specialty(s):** American Society of General Surgeons**Sample Size:** 150 **Response Rate:** 39 (26%)**Type of Sample:** random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	3.88	6.00	8.00	9.00	14.77
Pre-Service			50		
Intra-Service	15	30	40	45	60
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	66				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	n/a				
Office Visits	n/a				

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
3.98	000	32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

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

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

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 31600 (n=39)	Ref CPT 32020 (n=11)
Pre-service time	50	30
Intra-service time	40	15
Immediate Post-service time	25	20
Total critical care time	0	0
Total other hospital visit time	41	15
Discharge management time	n/a	n/a
Total office visit time	n/a	n/a

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

Pre-service	3.00	2.33
Intra-service	3.46	2.33
Post-service	2.78	2.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.39	2.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.33
Urgency of medical decision making	2.89	2.44

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.30	2.33
Physical effort required	2.84	2.33

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.73	2.56
Outcome depends on the skill and judgment of physician	3.32	2.56
Estimated risk of malpractice suit with poor outcome	3.19	2.33

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

This code was reviewed during the previous five-year review. The recommended increase was rejected by the workgroup as noted in the RUC database: "The Otolaryngologists argument that the patient population has changed is not convincing. The intra-work per unit time already appears high. The Harvard data for intra-service time appears to be more accurate than the survey data."

We believe that these arguments against increasing 31600 are arbitrary and/or incorrect.

Patient population: An argument was presented by the otolaryngologists that the patient population presenting for elective tracheostomy is generally sicker. Ventilatory techniques (technology) have changed such that many patients are on ventilators 14 to 21 days, instead of five to seven days, prior to having a tracheostomy placed. These patients are sicker and require a more thorough evaluation prior to surgery, along with additional support in the postoperative period. We believe this statement was true five years ago and is even more true today (especially compared to the late 1980's).

IWPUT: The workgroup argued that the IWPUT already appeared high for this code. This is a 000-day global procedure. Previous survey data by the otolaryngologists and current survey data by general surgeons indicate that there is significant preservice work/time (30-50 minutes); 40 minutes of intraoperative time; immediate same day work of 25-20 minutes; and a critical care visit later in the day of 30 minutes. Assuming the preservice work is equal to 1 x 99222 (mid-level init hosp care) and the total same day post service work is equal to 1 x 99291 (for the immediate and later same day total time), then the residual RVW for intraoperative work is a negative value [3.62 – 2.14 (for 99222) – 4.00 (for 99291) = -2.52]. Even if you reduce the postoperative total work to 1x99233, then residual RVW for intraoperative work is only 0.81 rvu's. We don't understand how the previous workgroup arrived at the conclusion that the IWPUT for this code was already too high.

Intraoperative time: Although a survey time estimate by 30 surgeons who perform this service was greater than the Harvard data estimated by 14 surgeons (40 vs 25 minutes), the workgroup chose to believe that the intraoperative time from Harvard study was more correct. [As an aside, Phase 3 Harvard data indicates that this procedure was actually surveyed twice in two different cycles AND surveyed as a 90-day global procedure. The second intraoperative time estimate was 33 minutes. We do not know why the 25 minutes followed through in the Harvard data and not the 33 minutes and we do not know how the calculations were accomplished to adjust down from a 90-day global survey. We believe this may have been the root of the resulting incorrect low value for this code.] The current survey by general surgeons indicates a median intraoperative time of 40 minutes. This is the same as the previous survey time by otolaryngologists and should validate that this is the correct intraoperative time.

The previous review of this code was arbitrary and unjustified based on the discussion above. Patients requiring a tracheostomy are sick. This is a serious procedure that requires pre-planning and careful monitoring afterward. The structures in the neck do not allow for mistakes and intimated knowledge of regional anatomy is mandatory. We compare this service with the reference code 32020, which has an RVW of 3.98, and an intraoperative time of 15-20 minutes. Another comparable 000-day global procedure is 43260 ECRP (diagnostic), which has an RVW of 5.96 and 46 minutes of intraoperative time. **We recommend an RVW of 7.18 which is between the survey 25th percentile and median survey RVWs.** This accurately places this procedure relative to the reference services cited and more realistically reflects the total work required for this procedure.

The calculation below presents an intensity for the pre- and immediate post-work slightly more than for an office visit, but less than ICU care even though the patients are critically ill and on ventilators during the period and closely supervised by the surgeon during transport to and from the OR. The

intraoperative intensity is presented as equal to ICU care intensity. The sum of the incremental RVWs presented this way is 7.18 which is equal to our recommendation.

Valuing the increments

CPT Code 31600

	Time	Intensity	RVU (=time x intensity)
Pre-service	50	0.040	2.00
Intra-service	40	0.067	2.67
Post-service			
Immediate post	25	0.040	1.00
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99233	1	1.51	1.51
Total RVW by Building Block Method =			7.18

FREQUENCY INFORMATION

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

Commonly

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

Cannot estimate national frequency.

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

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

14,524	general surgery	16	endocrinology
13,571	otolaryngology	15	allergy/immunology
3,891	thoracic surgery	12	osteopathic man. therapy
1,289	cardiac surgery	11	diagnostic radiology
1,213	clinic or group practice	7	neurology
751	vascular surgery	6	cma, anesthesia assistant
581	pulmonary disease	6	hematology/oncology
268	neurosurgery	6	oral surgery (dentists only)
264	general practice	5	infectious disease
252	cardiology	2	dermatology
250	critical care (intensivists)	2	interventional radiology
181	plastic & reconst. surgery	2	obstetrics/gynecology
171	internal medicine	2	pathology
157	anesthesiology	2	physical medicine & rehab
113	emergency medicine	1	gastroenterology
106	surgical oncology	1	geriatric medicine
84	maxillofacial surgery	1	nephrology
71	colorectal surgery	1	neuropsychiatry
59	family practice	1	pediatric medicine
56	ophthalmology	1	physician assistant
53	peripheral vascular disease	1	public health/welfare
24	orthopaedic surgery	1	unknown supplier/provider
21	urology		

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 8 Yes
29 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
7 I do not agree

c. Patients requiring this service are now:

- 7 more complex (more work)
0 less complex (less work)
1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
0 from inpatient to outpatient
8 no change

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

(February 2001)

CPT Code: 32100

Global: 090

Current RVW: 11.84

Recommended RVW: ~~18.00 (25th pct)~~ 15.24

CPT Descriptor: Thoracotomy, major; with exploration and biopsy

Survey Vignette (Typical Patient)

A 68-year-old woman presents for diagnosis of a pleural mass that was not apparent on a chest x-ray two years earlier. She is a heavy smoker (50-pack-years) and presents with shortness of breath, hypertension being treated with a calcium channel blocker, and diet-controlled diabetes. Review of a previous chest CT demonstrated a diffuse pleural mass without pleural fluid. A prior fine needle aspiration biopsy was non-diagnostic. Preoperatively, the surgeon reviews laboratory, all x-ray and other imaging studies, evaluates the pulmonary and cardiac function, evaluates the risks and benefits of surgery compared to other treatment alternatives, communicates with the patient and the family, and obtains informed consent. At operation, through a posterolateral thoracotomy, the hemithorax is explored, the pleural mass is identified, and an incisional biopsy is performed. Chest tubes are placed as appropriate. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, and fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged to be followed up in the office on a regular basis during the 90-day global period to check the wound, assess pulmonary function, and remove sutures. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, including: History and physical examination; review chest x-ray; review laboratory results (CBC, electrolytes, renal function); review CT scans; review other staging studies as appropriate (eg, PET scan, bone scan, brain scan, primary site computed tomography); review pathology biopsy reports; cardiology assessment; review pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities)
- Place bladder catheter
- Position patient in lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- The pleural mass is carefully palpated and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that a biopsy is feasible
- Other abnormalities of the visceral and parietal pleura, the lung parenchyma, the mediastinum, and the diaphragm are noted
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the pleural mass
- The lung is mobilized as needed for assistance in exposing the pleural mass
- The pleural mass is determined to be a diffuse infiltrative non-localized process
- An incisional biopsy of approximately 1.0 - 2.0 grams of tissue is obtained
- Hemostasis is ensured with electrocautery
- Frozen section evaluation is requested to ensure that adequate biopsy material has been obtained. If not, additional biopsies are taken.
- The mediastinum is inspected for abnormal lymph nodes, which if present are biopsied
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the lung parenchyma is inspected for air leak.
- The saline is aspirated from the chest
- A single or more chest tube(s) are inserted through separate interspace incision(s) to provide optimal drainage of air from the apex of the chest and of fluid from the base / posterior mediastinum
- The chest tubes are secured to the skin with sutures
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table
- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions

- Examine chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work - beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Treat cardiac arrhythmias (in approximately 15% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
 Joseph Putnam, MD
 Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
 American Society of General Surgeons
 American College of Surgeons

Sample Size: 61 **Response Rate:** 48 (79%) [general surgery 9 / thoracic surgery 39]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.00	18.00	20.00	21.00	25.00

Pre-Service			90		
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Intra-Service	60	90	100	120	165
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Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>
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Day of Surgery:

Immediate	45	
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Other	41	99233
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After Day of Surgery:

Critical Care	0	
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Other Hospital	68	99232x1; 99231x2
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Discharge Day Mgmt	36	99238
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Office Visits	38	99213x1; 99212x1
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KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT Ref CPT	
	32100	32480
Count	48	38
Pre-service time	90	90
Intra-service time	100	180
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	30	35*
Post Total critical care time (not same day)	0	60
Post Total other hospital visit time (not same day)	68	87
Discharge management time	30	30
Total office visit time	38	76

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

Pre-service	3.94	4.27
Intra-service	3.49	4.35
Post-service	3.48	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.02	4.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	4.35
Urgency of medical decision making	3.54	3.97

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.63	4.54
Physical effort required	3.50	4.19

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.63	4.35
Outcome depends on the skill and judgment of physician	3.61	4.46
Estimated risk of malpractice suit with poor outcome	3.39	4.05

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

The intraoperative work for CPT codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, CPT 32320 is slightly more work than CPT 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." CPT 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on this discussion, the correct ranking for these decortication codes is reflected in the survey median RVW for each: CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50). These values also place these two procedures correctly greater than 32480 and less than 32482 or 32440.

CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
1 or 2	19.71	25.00	32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
1 or 2	21.02	25.00	32440	Removal of lung, total pneumonectomy;
3	20.54	24.50	32320	Decortication and parietal pleurectomy
4	19.27	24.00	32220	Decortication, pulmonary (separate procedure); total
5	18.32	23.75	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
6	13.62	23.00	32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
7	14.30	22.00	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly ~~Sometimes~~ ~~Rarely~~
 Specialty: general surgery ~~Commonly~~ Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 2,196
 Specialty: general surgery 1999 Medicare Frequency: 1,001

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of surveyees responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 22 Yes
 25 No
 1 no response

Surveyee Comments:

Easier biopsies are done percutaneously, leaving the more difficult cases for the open procedure. More cases diagnosed and treated by non-operative methods have increased the percentage of difficult cases going to the OR. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to more

patients of more advanced age and with more comorbidities presenting for surgery than previously.

2. Patients requiring this service are now:

- 29 more complex (more work)
- 0 less complex (less work)
- 18 no change
- 1 no response

Surveyee Comments:

Easier biopsies are done percutaneously, leaving the more difficult cases for the open procedure. Patients are increasingly of advanced age, require greater attention to postoperative care, and are less stable intraoperatively during manipulation of intrathoracic structures. Patients of advanced age – with more cardiac, renal, and other organ dysfunction – require more complex pre-, intra-, and postoperative care. More cases diagnosed and treated by non-operative methods have increased the percentage of difficult cases going to the OR. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously.

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

(February 2001)

CPT Code: 32110

Global: 090

Current RVW: 13.62

Recommended RVW: 23.00

CPT Descriptor: Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear

Survey Vignette (Typical Patient)

A 38-year-old man presents to the emergency department with hypotension and a stab wound of the high right anterolateral chest following an attempted robbery. Diagnostic tests are ordered and reviewed to rule out other injury and to plan the operative approach. The surgeon reviews and assesses the pre-existing medical problems, laboratory studies, all x-rays and other imaging studies, evaluates the pulmonary and cardiac function, stabilizes, prepares, and transports the patient for emergency surgery. Communication occurs with the patient and family, as well as coordination of care with other physicians and health care providers. At operation, through a posterolateral thoracotomy, the hemithorax is explored, blood clot is evacuated, and a bleeding source in the lacerated lung is identified and repaired. Exploration of the entire thorax and all thoracic and mediastinal structures is also performed to rule out other injury. Chest tubes are placed as appropriate. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, and fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged to be followed up in the office on a regular basis during the 90-day global period to check the wound, assess pulmonary function, and remove sutures.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Prior to emergent surgery:

- Review pre-operative work-up, with particular attention to films, scans, and lab reports
- Review arterial blood gas values
- Check with lab on availability of blood and/or cross match
- Examine patient to assess whether other systems may be injured
- Write pre-operative orders for peri-operative medications
- Review planned incisions and procedure
- Assure that the patient is adequately stabilized and hydrated prior to surgery, due to the emergent nature of intestinal evisceration and subsequent third space loss
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family (and possibly law enforcement officers)
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities)
- Place bladder catheter
- Position patient in lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Scrub and gown

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- Blood clot is evacuated.
- The hemithorax is carefully inspected, palpated, and otherwise examined for injury.
- The identified lung injury / stab wound is identified and its relationship to the pulmonary vasculature and bronchial tree is assessed to determine that a simple repair is feasible
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure and examination of the lobar vasculature and bronchus
- The lung is retracted posteriorly and inferiorly, allowing the hilar/mediastinal pleura is incised, carefully avoiding injury to the phrenic nerve
- The lung is retracted appropriately to permit exposure and examination of the pulmonary arterial supply to the lungs
- The lung is retracted appropriately to permit exposure and examination of the pulmonary venous drainage returning to the heart
- The mainstem and lobar bronchi are retracted appropriately to permit exposure and examination of the mainstem, lobar, and as necessary, the segmental bronchi to the lung
- The stab wound/tear of the lung parenchyma is identified, hemostasis obtained by suture-ligating lacerated parenchymal vessels, and the lung laceration repaired by application of the surgical stapler to eliminate any air leak.
- Other mediastinal structures, including the esophagus, great vessels, heart, etc. are inspected for injury.
- The pleural cavity is lavaged with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the repair is carefully inspected for an air leak and bleeding
- The saline is aspirated from the chest
- Chest tubes are inserted through separate interspace incisions to provide optimal drainage of air from the apex of the chest and of fluid from the base
- The chest tubes are secured to the skin with sutures
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table
- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Discuss procedure outcome with law enforcement officers, if necessary
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Examine chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work - beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Treat cardiac arrhythmias (in approximately 15% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Answer law enforcement questions, if necessary
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 61 **Response Rate:** 43 (70%) [general surgery 7 / thoracic surgery 36]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWW	15.00	21.00	23.00	26.25	41.30
Pre-Service			60		
Intra-Service	90	120	150	180	240
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	60	99291			
After Day of Surgery:					
Critical Care	41	99233*x1			
Other Hospital	68	99232x1; 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	61	99214x1; 99213x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	32110	32480
Count	43	33
Pre-service time	60	90
Intra-service time	150	180
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	45*	35*
Post Total critical care time (not same day)	41	60
Post Total other hospital visit time (not same day)	68	87
Discharge management time	30	30
Total office visit time	61	76

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

Pre-service	4.54	4.41
Intra-service	4.44	4.47
Post-service	3.95	4.22

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.22	4.34
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	4.56
Urgency of medical decision making	4.88	4.09

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	4.66
Physical effort required	4.32	4.47

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.64	4.47
Outcome depends on the skill and judgment of physician	4.40	4.53
Estimated risk of malpractice suit with poor outcome	4.31	4.09

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

The intraoperative work for CPT codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, CPT 32320 is slightly more work than CPT 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." CPT 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on this discussion, the correct ranking for these decortication codes is reflected in the survey median RVW for each: CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50). These values also place these two procedures correctly greater than 32480 and less than 32482 or 32440.

CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
1 or 2	19.71	25.00	32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
1 or 2	21.02	25.00	32440	Removal of lung, total pneumonectomy;
3	20.54	24.50	32320	Decortication and parietal pleurectomy
4	19.27	24.00	32220	Decortication, pulmonary (separate procedure); total
5	18.32	23.75	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
6	13.62	23.00	32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
7	14.30	22.00	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
 Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 373
 Specialty: general surgery 1999 Medicare Frequency: 172

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 10 Yes
 33 No
 0 no response

Surveyee Comments:

More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Percentage of multiple gunshot wounds (from bigger guns) has increased. More likely to have multiple penetrating injuries. Percentage of patients with this type of trauma are more likely today to have other medical problems (e.g., hepatitis, HIV+) and on other medications,

making the case more complex.

2. Patients requiring this service are now:

- 11 more complex (more work)
- 0 less complex (less work)
- 32 no change
- 0 no response

Surveyee Comments:

More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Percentage of patients with this type of trauma are more likely today to have other medical problems (e.g., hepatitis, HIV+) and on other medications, making the case more complex. There is an increased incidence of resistant bacterial organisms and increased infectious patients in the trauma population. More likely to have multiple penetrating injuries. More violent injuries that are complex and involve multiple organs.

CPT Code: 32220

Global: 090

Current RVW: 19.27
Recommended RVW: 24.00

CPT Descriptor: Decortication, pulmonary (separate procedure); total

Survey Vignette (Typical Patient)

A 64-year-old woman presents with a four-week history of low-grade fever, chills, malaise, anorexia, and left-sided pleuritic chest pain, all of which were preceded by a severe "chest cold." A review of chest x-rays and CT scans demonstrated a loculated pleural effusion in both the base and the apex of the left thoracic cavity, a large left pleural effusion of mixed density with lower lobe and upper lobe compression, and slightly thickened parietal pleura. Recent thoracentesis yielded purulent material, cultures of which grew *H.influenza*. Preoperatively, the surgeon reviews the laboratory and imaging studies and evaluates the cardiopulmonary risks with additional studies ordered and reviewed as needed, and communicates with and obtains informed consent from the patient and/or family. At operation, the patient undergoes a left posterolateral thoracotomy with removal of infected material, complete mobilization of the lung from the chest wall, decortication of the entire visceral pleural surface to achieve full expansion of the lung, and chest tube placement. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged with empyema tubes in place. Office visits are conducted as necessary through the 90-day global period to monitor the wound, remove sutures and progressively withdraw empyema tubes. In addition, the pathology report, microbiology results, and long-term plan of care are reviewed with the patient, family and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Pre-operative work-up, including: History and physical examination; review chest x-ray; review chest CT scan; review laboratory results (CBC, electrolytes, renal function); review pleural fluid chemistry values and cell count; review pleural fluid cytology report; review pleural fluid microbiology results; cardiology assessment; and review pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Monitor induction of anesthesia
- Confirm position of double lumen endotracheal tube
- Place bladder catheter
- Position patient in lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side being operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Scrub and gown

- Monitor and/or assist with draping

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1cm length of the 6th rib posteriorly to facilitate spreading of the ribs and parietal pleurectomy (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- The empyema cavity is entered and the infected contents evacuated (specimens are sent to pathology for culture)
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure
- The fibrous cortex overlying the visceral pleura is then identified, and when possible, an extrapleural subcortical plane is developed
- Dissection is carried out over the entire surface of the compressed lung and the remainder of the lung is freed from its adhesions to the chest wall to allow for complete re-expansion (care is necessary to avoid injury to the major pulmonary artery, veins and to other vital structures such as vagus and phrenic nerves, pericardium, esophagus, thoracic duct, aorta and great vessels)
- The pleural cavity is filled with warm saline and the lung reinflated to identify the multiple sites of air leak which inevitably occur
- Meticulous control of air leaks is undertaken using multiple fine sutures
- Hemostasis is achieved using suture and cautery on the surface of the lung
- Hemostasis is achieved on the chest wall and mediastinum with the cautery with care taken not to damage the aforementioned vessels, nerves and organs
- The thoracic cavity is irrigated with saline, which is subsequently aspirated to help clean out necrotic debris
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and lung expansion is assessed for adequate filling of the chest
- If the lung fails to expand adequately to fill the thoracic cavity then the surgeon may instill 1000ccs of air into the peritoneum through a catheter to elevate the diaphragm and help achieve apposition between the parietal and visceral pleura
- Two to three chest tubes are then placed to achieve adequate drainage and maintain lung re-expansion during the postoperative period
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated
- Chest tubes are connected to a drainage unit and the proper level of negative pressure applied
- The severity of air leak is assessed to be sure that adequate ventilation and lung expansion will be able to be maintained

Post-op same day work through discharge from recovery:

- Sterile dressing is applied to the incision
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Transfer patient to recovery room or appropriate care setting
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Discuss procedure outcome with referring physician
- Dictate post-op report
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Check chest X-ray to assess lung re-expansion and evaluate need for change in chest drainage settings
- Write and summarize orders for nurse on appropriate floor
- Write transfer order to appropriate floor unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Check vital signs, intake/output status, nutritional/dietary status, current pharmaceutical profile
- Examine wound, lungs, heart and extremities
- Assess adequacy of pain relief and manage appropriately
- Assess severity of air leak and rate of fluid leakage to guide chest tube management
- Encourage ambulation and vigorous pulmonary physiotherapy
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review chest x-ray and laboratory, microbiology and pathology results
- Review nursing/other staff patient chart notes
- Treat cardiac arrhythmias (in approximately 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Inform patient/family regarding hospital course and plans
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Chart patient progress notes

Discharge day work:

- Check vital signs, intake/output status, nutritional status, current pharmaceutical profile
- Examine wound, lungs, heart and extremities
- Assess adequacy of pain relief and manage appropriately
- Check final pathology/lab/film reports and discuss with patient
- Review nursing/other staff patient chart notes
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Communicate with referring physician regarding patient hospital course, dietary management, handling of wound or any drains and discharge medications

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Remove sutures, advance chest tubes and redress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review and revamp orders regarding pain medications, antibiotics and other medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 61 **Response Rate:** 43 (70%) [general surgery 8 / thoracic surgery 35]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	22.88	24.00	28.00	47.00
Pre-Service			90		
Intra-Service	100	150	180	205	320
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	41	99233*			
After Day of Surgery:					
Critical Care	60	99291			
Other Hospital	117	99232x2; 99231x3			
Discharge Day Mgmt	36	99238			
Office Visits	114	99214x1; 99213x2; 99212x2			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	32220	32480
Count	43	32
Pre-service time	90	90
Intra-service time	180	165
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	40*	35*
Post Total critical care time (not same day)	45	60
Post Total other hospital visit time (not same day)	117	87
Discharge management time	33	30
Total office visit time	114	76

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

Pre-service	4.15	4.32
Intra-service	4.36	4.46
Post-service	4.23	4.11

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.15	4.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	4.43
Urgency of medical decision making	4.38	4.14

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.21	4.57
Physical effort required	4.41	4.32

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.31	4.32
Outcome depends on the skill and judgment of physician	4.33	4.46
Estimated risk of malpractice suit with poor outcome	3.79	4.14

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

The intraoperative work for CPT codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, CPT 32320 is slightly more work than CPT 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." CPT 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on this discussion, the correct ranking for these decortication codes is reflected in the survey median RVW for each: CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50). These values also place these two procedures correctly greater than 32480 and less than 32482 or 32440.

CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
1 or 2	19.71	25.00	32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
1 or 2	21.02	25.00	32440	Removal of lung, total pneumonectomy;
3	20.54	24.50	32320	Decortication and parietal pleurectomy
4	19.27	24.00	32220	Decortication, pulmonary (separate procedure); total
5	18.32	23.75	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
6	13.62	23.00	32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
7	14.30	22.00	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
 Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 1,417
 Specialty: general surgery 1999 Medicare Frequency: 450

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 21 Yes
- 20 No
- 2 no response

Surveyee Comments:

More patients are drained with CT directed drains, leaving the more difficult and complex cases for the open procedure. Thoracoscopy is now used for most early pleural debridement, leaving open procedures to patients further along from their initial illness. More patients are of advanced age with prior surgery and chemoradiation treatments. Many more patients have underlying lung disease

(emphysema), which makes air leaks postoperatively last longer. preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. More resistant organisms being found that make treatment more difficult.

2. Patients requiring this service are now:

- 28 more complex (more work)
- 0 less complex (less work)
- 12 no change
- 3 no response

Surveyee Comments:

More patients are drained with CT directed drains, leaving the more difficult and complex cases for the open procedure. More complex patients are presenting after streptokinase treatment or VATS treatment. Resistant organisms and delayed presentation results in much more debris and infection in chest requiring more complex and aggressive decortication and drainage. Thoracoscopy is now used for most early pleural debridement, leaving open procedures to patients further along from their initial illness. Infectious complications are greater, need for aggressive postoperative pulmonary physiotherapy and ambulation is greater than ever. More patients are of advanced age with prior surgery and chemoradiation treatments. Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. More resistant organisms being found that make treatment more difficult.

CPT Code: 32320

Global: 090

Current RVW: 20.54
Recommended RVW: 24.50

CPT Descriptor: Decortication and parietal pleurectomy

Survey Vignette (Typical Patient)

A 70-year old man presents with a six-week history of cough, low-grade fever, and malaise following an upper respiratory infection that was treated with a short course of oral antibiotics. He also has left-sided pleuritic chest pain which began two weeks ago and has gradually increased in severity. A review of chest x-rays and CT scans demonstrated a left pleural effusion with small air fluid levels and a large left pleural effusion of mixed density with upper and lower lobe compression and a markedly thickened parietal pleura. Recent thoracentesis yielded purulent material, cultures of which grew *S.aureus*. Preoperatively, the surgeon reviews the laboratory and imaging studies and evaluates the cardiopulmonary risks with additional studies ordered and reviewed as needed, and communicates with and obtains informed consent from the patient and/or family. At operation, the patient undergoes a left posterolateral thoracotomy with parietal pleurectomy, decortication of the visceral pleural surface, removal of infected material, and chest tube placement. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged with empyema tubes in place. Office visits are conducted as necessary through the 90-day global period to monitor the wound, remove sutures and progressively withdraw empyema tubes. In addition, the pathology report, microbiology results, and long-term plan of care are reviewed with the patient, family and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Pre-operative work-up, including: History and physical examination; review chest x-ray; review chest CT scan; review laboratory results (CBC, electrolytes, renal function); review pleural fluid chemistry values and cell count; review pleural fluid cytology report; review pleural fluid microbiology results; cardiology assessment; and review pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Monitor induction of anesthesia
- Confirm position of double lumen endotracheal tube
- Place bladder catheter
- Position patient in lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Scrub and gown
- Monitor and assist with draping

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting the 6th rib to facilitate spreading of the ribs and parietal pleurectomy (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- An extrapleural plane is identified and carefully developed, taking care to achieve hemostasis in this inflamed field. Great care must be taken during this dissection to avoid damage to the chest wall, vagus and phrenic nerves, pericardium, esophagus, thoracic duct, aorta and great vessels.
- Once the thickened pleura has been dissected away from the chest wall and other structures, The empyema cavity is entered and the infected contents evacuated (specimens are sent to pathology for culture)
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure
- The fibrous cortex overlying the visceral pleura is then identified, and when possible, an extrapleural subcortical plane is developed
- Dissection is carried out over the entire surface of the compressed lung and the remainder of the lung is freed from its adhesions to the chest wall to allow for complete re-expansion (care is necessary to avoid injury to the major pulmonary artery, veins and to other vital structures such as vagus and phrenic nerves, pericardium, esophagus, thoracic duct, aorta and great vessels)
- The pleural cavity is filled with warm saline and the lung reinflated to identify the multiple sites of air leak which inevitably occur
- Meticulous control of air leaks is undertaken using multiple fine sutures
- Hemostasis is achieved using suture and cautery on the surface of the lung
- Hemostasis is achieved on the chest wall and mediastinum with the cautery with care taken not to damage the aforementioned vessels, nerves and organs
- The thoracic cavity is irrigated with saline which is subsequently aspirated to help clean out necrotic debris
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and lung expansion is assessed for adequate filling of the chest
- If the lung fails to expand adequately to fill the thoracic cavity then the surgeon may instill 1000ccs of air into the peritoneum through a catheter to elevate the diaphragm and help achieve apposition between the parietal and visceral pleura
- Two to three chest tube are then placed to achieve adequate drainage and maintain lung re-expansion in the postoperative period
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated
- Chest tubes are connected to a drainage unit and the proper level of negative pressure applied
- The severity of air leak is assessed to be sure that adequate ventilation and lung expansion will be able to be maintained

Post-op same day work through discharge from recovery:

- Sterile dressing is applied to the incision
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Transfer patient to recovery room or appropriate care setting
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Discuss procedure outcome with referring physician
- Dictate post-op report
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Check chest X-ray to assess lung re-expansion and evaluate need for change in chest drainage settings
- Write and summarize orders for nurse on appropriate floor
- Write transfer order to appropriate floor unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress

- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Check vital signs, intake/output status, nutritional/dietary status, current pharmaceutical profile
- Examine wound, lungs, heart and extremities
- Assess adequacy of pain relief and manage appropriately
- Assess severity of air leak and rate of fluid leakage to guide chest tube management
- Encourage ambulation and vigorous pulmonary physiotherapy
- Review chest x-ray, laboratory, microbiology and pathology results
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review nursing/other staff patient chart notes
- Treat cardiac arrhythmias (in approximately 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Inform patient/family regarding hospital course and plans
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Chart patient progress notes

Discharge day work:

- Check vital signs, intake/output status, nutritional status, current pharmaceutical profile
- Examine wound, lungs, heart and extremities
- Assess adequacy of pain relief and manage appropriately
- Check final pathology/lab/film reports and discuss with patient
- Review nursing/other staff patient chart notes
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Communicate with referring physician regarding patient hospital course, dietary management, handling of wound or any drains and discharge medications

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Remove sutures, advance chest tubes and redress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review and revamp orders regarding pain drugs, antibiotics and other medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 61 **Response Rate:** 44 (72%) [general surgery 8 / thoracic surgery 36]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	17.00	23.00	24.50	26.25	37.50
Pre-Service			90		
Intra-Service	100	150	180	200	330
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	41	99233*			
After Day of Surgery:					
Critical Care	60	99291			
Other Hospital	128	99233x1; 99232x1; 99231x3			
Discharge Day Mgmt	36	99238			
Office Visits	99	99214x1; 99213x2; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	32320	32480
Count	44	36
Pre-service time	90	90
Intra-service time	180	180
Same Day Immediate Post-service time	40	45
Same Day Other Post-service time (*critical care)	40*	35*
Post Total critical care time (not same day)	45	60
Post Total other hospital visit time (not same day)	133	87
Discharge management time	30	30
Total office visit time	99	76

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

Pre-service	4.19	4.34
Intra-service	4.36	4.43
Post-service	4.14	4.14

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.19	4.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	4.46
Urgency of medical decision making	4.17	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.26	4.60
Physical effort required	4.52	4.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.29	4.40
Outcome depends on the skill and judgment of physician	4.26	4.49
Estimated risk of malpractice suit with poor outcome	3.64	4.11

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

The intraoperative work for CPT codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, CPT 32320 is slightly more work than CPT 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." CPT 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on this discussion, the correct ranking for these decortication codes is reflected in the survey median RVW for each: CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50). These values also place these two procedures correctly greater than 32480 and less than 32482 or 32440.

CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
1 or 2	19.71	25.00	32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
1 or 2	21.02	25.00	32440	Removal of lung, total pneumonectomy;
3	20.54	24.50	32320	Decortication and parietal pleurectomy
4	19.27	24.00	32220	Decortication, pulmonary (separate procedure); total
5	18.32	23.75	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
6	13.62	23.00	32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
7	14.30	22.00	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
 Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 618
 Specialty: general surgery 1999 Medicare Frequency: 314

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 19 Yes
- 23 No
- 2 no response

Surveyee Comments:

More patients are drained with CT directed drains, leaving the more difficult and complex cases for the open procedure. Thoracoscopy is now used for most early pleural debridement, leaving open procedures to patients further along from their initial illness. More patients are of advanced age with prior surgery and chemoradiation treatments. Many more patients have underlying lung disease

(emphysema), which makes air leaks postoperatively last longer. preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. More resistant organisms being found that make treatment more difficult.

2. Patients requiring this service are now:

- 24 more complex (more work)
- 0 less complex (less work)
- 16 no change
- 4 no response

Surveyee Comments:

More patients are drained with CT directed drains, leaving the more difficult and complex cases for the open procedure. More complex patients are presenting after streptokinase treatment or VATS treatment. Resistant organisms and delayed presentation results in much more debris and infection in chest requiring more complex and aggressive decortication and drainage. Thoracoscopy is now used for most early pleural debridement, leaving open procedures to patients further along from their initial illness. Infectious complications are greater, need for aggressive postoperative pulmonary physiotherapy and ambulation is greater than ever. More patients are of advanced age with prior surgery and chemoradiation treatments. Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. More resistant organisms being found that make treatment more difficult.

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

CPT Code: 32440 Tracking Number: Global Period: 090 Recommended RVW: ~~25.05~~ 25.00 RUC

CPT Descriptor: Removal of lung, total pneumonectomy;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 58 year-old man presents with a 6-week history of intermittent hemoptysis. Chest x-ray demonstrates a 5 cm right hilar mass which was not present on chest x-ray one year previously. Computed tomography confirms the presence of the mass without evidence of paratracheal adenopathy. Bronchoscopy demonstrates a squamous cell carcinoma of the distal right mainstem bronchus. The patient is admitted to the hospital the morning of the scheduled operation. The surgeon reviews the patient's medical record, x-ray findings, pulmonary function tests, and both laboratory and bronchoscopic results. Informed consent is obtained. The planned procedure is discussed with the anesthesiologist. A right posterolateral thoracotomy is performed. The lateral chest wall, diaphragm, pericardium, and mediastinum are examined for evidence of metastatic disease; if detected, appropriate biopsies are obtained. The right upper, middle, and lower lobes are thoroughly examined to determine the extent of the right hilar mass. The mediastinum is opened anterior to the superior vena cava, and the paratracheal, subcranial, paraesophageal, inferior pulmonary ligament, and hilar lymph nodes are then sampled at the high, mid, and low tracheal levels for evidence of metastatic cancer. The mediastinal pleura is divided immediately anterior to the main pulmonary artery. The pulmonary artery is followed proximally into the mediastinum and isolated circumferentially just distal to its origin from the pulmonary trunk. The pulmonary artery is clamped, divided, and over sewn with two rows of 4-0 Prolene suture. The distal right pulmonary artery is ligated. Both the superior and inferior pulmonary veins are gently mobilized from the hilar mass and isolated circumferentially just lateral to their entrance into the left atrium, where they are divided and over sewn with two rows of 4-0 Prolene suture. Each distal vein is individually ligated. The right mainstem bronchus is isolated at the carina and divided with a linear stapling device. The closed bronchial stump is checked for competency by increasing tracheal airway pressures. A chest tube is inserted into the pleural cavity and the thoracotomy is closed. After respirations and hemodynamics have stabilized, pressure within the pleural cavity is adjusted to physiologic parameters and the chest tube is removed. The patient is taken to the intensive care unit where he is stabilized. Following hospital discharge in 7 days, the patient is followed in the office to monitor the incision site and chest, and pulmonary function. Skin sutures are removed at the first visit.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
 - History and physical examination
 - Chest x-ray
 - Laboratory results (CBC, electrolytes, renal function)
 - CT scans and other staging studies (EG, PET scan, bone and brain scans, etc.)
 - Pathology biopsy reports
 - Cardiology assessment
 - Pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab – check on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist

- Review planned procedure and positioning and draping of patient
- Position patient in lateral decubitus position
- Place axillary “roll” beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces side to be operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs
- Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- The lung tumor is carefully palpated and its relationship to the pulmonary artery, veins and bronchi assessed to determine that a pneumonectomy rather than a lesser pulmonary resection is required and is feasible
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the hilar structures
- The lung is retracted inferiorly and posteriorly, and the mediastinal pleura is opened to define the hilum
- Care is taken to avoid injury to the phrenic nerve
- The pulmonary artery is carefully dissected, mobilized, and encircled with tapes
- The pulmonary artery is occluded with the vascular surgical stapler, and its distal lobar branches ligated
- The stapler is removed to insure that firing of the staples has occurred, and the pulmonary artery divided, carefully assessing for bleeding from the proximal end
- The lung is retracted directly posteriorly
- The superior pulmonary vein is carefully dissected, mobilized, and encircled with tapes
- The vein is ligated proximally with heavy suture, its distal branches ligated, the proximal end is suture-ligated, and vein divided, carefully assessing for bleeding from the proximal end
- The inferior pulmonary vein is carefully dissected, mobilized, and encircled with tapes
- The vein is ligated proximally with heavy suture, its distal branches ligated, the proximal end is suture-ligated, and the vein divided, carefully assessing for bleeding from the proximal end
- The main bronchus is carefully dissected, mobilized and encircled with a tape as close to the carina as possible
- The main bronchus is crossed with the surgical stapler as close to the carina as possible
- After ascertaining that ventilation of the contralateral lung has not been compromised by clamping of the bronchus, the bronchus is divided sharply, and the stapler is removed
- The lung is removed from the field and submitted for frozen section confirmation of a “clear” bronchial margin of resection
- The divided bronchial stump is over sewn distal to the staple suture line with interrupted sutures
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the bronchial stump is carefully inspected for an air leak
- The saline is aspirated from the chest
- Mediastinal lymph node sampling is carried out, removing when possible lymph nodes from the high and low paratracheal, subcarinal, anterior mediastinal, paraesophageal, and inferior pulmonary ligament areas
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressing is applied to the incision
- The patient is positioned supine on the operating table
- The anterior chest is prepped and draped
- Air is aspirated from the now empty hemithorax through a needle inserted in the 2nd or 3rd interspace in the midclavicular line until mild negative pressure is felt on the syringe and the trachea can be felt to shift toward the operated side

- A postoperative chest x-ray is obtained and reviewed to document satisfactory expansion of the contralateral lung and position of the mediastinum
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Examine chest x-ray obtained within 6-12 hours of operation to assess rapidity with which empty pleural space is filling and expansion of remaining lung
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Treat cardiac arrhythmias (in approximately 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient Check wounds and patient progress

- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons, American Society of General Surgeons

Sample Size: 115 Response Rate: (%): 32% Median RVW: 25.00

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

25th Percentile RVW: 24.00 75th Percentile RVW: 30.00 Low: 20.00 High: 50.00

Median Pre-Service Time: 90.00 Median Intra-Service Time: 160.00

25th Percentile Intra-Svc Time: 131.00 75th Percentile Intra-Svc Time: 180.00 Low: 90.00 High: 210.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>40.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>139</u>	<u>99231x2, 99232x2, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>53</u>	<u>99212x2, 99213x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	18.32

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 32440	<u>Reference</u> <u>Service 1 CPT:</u> 32480
Median Pre-Time	45.00	45.00
Median Intra-Time	150.00	165.00
Median Immediate Post-service Time	40.00	30.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	139	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	53	

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

The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.78
Urgency of medical decision making	3.50	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.78	4.22
Physical effort required	3.94	3.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	3.83
Outcome depends on the skill and judgement of physician	4.56	3.94
Estimated risk of malpractice suit with poor outcome	3.78	3.61

INTENSITY/COMPLEXITY MEASURESCPT Code
32440Reference
Service 1:
32480**Time Segments (Mean)**

Pre-Service intensity/complexity	3.89	3.61
Intra-Service intensity/complexity	4.28	3.72
Post-Service intensity/complexity	4.00	3.28

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 1,615

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 STS Frequency 1,489

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 31.3% No 68.8%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 20.0% I do not agree 80.0%**
- b. **Patients requiring this service are now:
more complex (more work) 70.0% less complex (less work) 0.0% no change 30.0%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

CPT Code: 32480 Tracking Number: Global Period: 090 Recommended RVW: ~~23.00~~ 23.75 RUC

CPT Descriptor: Removal of lung, other than total pneumonectomy; single lobe (lobectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 64-year-old woman presents with a 3 cm mass in her left upper lobe, which was not present 18 months previously. Computed tomography confirms the presence of the mass without evidence of mediastinal adenopathy. Transthoracic fine needle aspiration reveals non-small cell lung cancer. The surgeon reviews the patient's medical record, x-ray findings, pulmonary function studies, laboratory results, and bronchoscopy report. A mediastinoscopy has been performed which shows no evidence of N2 or N3 nodal involvement. Informed consent is obtained. The planned procedure is discussed with the anesthesiologist. The patient is admitted to the hospital the morning of the scheduled operation and undergoes a left posterolateral thoracotomy. The lateral chest wall, diaphragm, pericardium, and mediastinum are examined for evidence of metastatic disease; if detected, appropriate biopsies are obtained. The pulmonary ligament is divided and representative pulmonary ligament, paraesophageal, aortopulmonary window, subcarinal, and hilar lymph nodes are sampled. The pulmonary artery is exposed in the fissure and the fissure is completed with a stapler. The segmental pulmonary arteries to the upper lobe are isolated, ligated, and divided. The superior pulmonary vein is isolated, divided and oversewn. The distal vein is ligated. All peribronchial tissue and lymph nodes are reflected into the specimen and the left upper lobe bronchus is isolated and divided at its origin. The closed bronchial stump is checked for competency. Two chest tubes are inserted into the pleural cavity and the thoracotomy is closed. The patient is extubated and sent to the post anesthesia recovery unit. Chest tubes are removed in the hospital on the third or fourth day. Following discharge on the seventh postoperative day, the patient is seen in the office for suture removal and checking of the incision site, chest x-ray, and management of routine postoperative problems with pain management, wound care, and return of preoperative pulmonary and physical function.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
 - History and physical examination
 - Chest x-ray
 - Laboratory results (CBC, electrolytes, renal function)
 - CT scans and other staging studies (EG, PET scan, bone and brain scans, etc.)
 - Pathology biopsy reports
 - Cardiology assessment
 - Pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Position patient in lateral decubitus position
- Place axillary “roll” beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck

- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs
- Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- The lung tumor is carefully palpated and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that a lobectomy is feasible
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the lobar vasculature and bronchus
- For upper lobectomies, the lung is retracted posteriorly and inferiorly, and the mediastinal pleura is incised, carefully avoiding injury to the phrenic nerve
- The lobar arterial blood supply is carefully dissected, mobilized, and encircled with ties
- The upper and lower lobes are carefully separated by dissecting within the major fissure until the appropriate lobar arteries are identified
- The isolated lobar arteries are ligated, suture-ligated, and then divided, carefully for bleeding from the proximal end
- The lung is retracted appropriately to permit exposure of the pulmonary venous drainage returning to the heart
- The pulmonary vein is carefully dissected, mobilized and encircled with ties
- The vein is ligated proximally with heavy suture, its distal branches ligated, the proximal end suture-ligated, and the vein divided, carefully assessing for bleeding from the proximal end
- The lobar bronchus is carefully dissected, mobilized, and encircled with a tape
- The lobar bronchus is crossed with a surgical stapler as close as possible to its origin
- After ascertaining that ventilation of the remaining lobe(s) has not been compromised by clamping of the bronchus, the lobar bronchus is divided sharply and the stapler is removed
- The lobe is removed from the field and submitted for frozen section confirmation of a “clear” bronchial margin of resection
- The divided bronchial stump is oversewn distal to the staples suture line with interrupted sutures
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the bronchial stump is carefully inspected for an air leak
- The saline is aspirated from the chest
- Mediastinal lymph node sampling is carried out, removing when possible lymph nodes from the high and low paratracheal, subcarinal, anterior mediastinal, paraesophageal, and inferior pulmonary ligament areas
- Chest tubes are inserted through separate interspace incisions to provide optimal drainage of air from the apex of the chest and of fluid from the base
- The chest tubes are secured to the skin with sutures
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressings are applied to the incisions
- The patient is positioned supine on the operating table
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Examine postoperative chest x-ray to assess chest tube placement and expansion of lungs
- Write orders for post-op labs, x-rays, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review recovery room care and medications with staff

- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and pulmonary physiotherapy
- Check wounds and patient progress
- Treat cardiac arrhythmias (in approximately 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons, American Society of General Surgeons

Sample Size: 115 Response Rate: (%): 34% Median RVW: 24.50

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

25th Percentile RVW: 22.00 75th Percentile RVW: 28.25 Low: 18.00 High: 40.00

Median Pre-Service Time: 90.00 Median Intra-Service Time: 155.00

25th Percentile Intra-Svc Time: 120.00 75th Percentile Intra-Svc Time: 180.00 Low: 90.00 High: 210.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>30.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>128</u>	<u>99231x3, 99232x1, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>53</u>	<u>99212x2, 99213x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
32440	Removal of lung, total pneumonectomy;	21.02

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 32480	<u>Reference</u> <u>Service 1 CPT:</u> 32440
Median Pre-Time	45.00	45.00
Median Intra-Time	150.00	150.00
Median Immediate Post-service Time	30.00	42.50
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	128	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	53	

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	3.79	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.36
Urgency of medical decision making	3.64	3.79

Technical Skill/Physical Effort (Mean)

Technical skill required	4.36	4.46
Physical effort required	3.85	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.57
Outcome depends on the skill and judgement of physician	4.14	4.57
Estimated risk of malpractice suit with poor outcome	3.50	3.71

INTENSITY/COMPLEXITY MEASURES

CPT Code
32480
Reference
Service 1
32440

Time Segments (Mean)

Pre-Service intensity/complexity	3.69	3.92
Intra-Service intensity/complexity	4.15	4.31
Post-Service intensity/complexity	3.46	4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 13,204
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 11,397

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 23.1% No 76.9%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 0.0% I do not agree 100.0%**

- b. **Patients requiring this service are now:
more complex (more work) 57.1% less complex (less work) 0.0% no change 42.9%**

- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

(February 2001)

CPT Code: 32482

Global: 090

Current RVW: 19.71
Recommended RVW: 25.00

CPT Descriptor: Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)

Survey Vignette (Typical Patient)

A 66-year-old woman, who is a heavy smoker (100-pack-years), presents for a lung resection of a 3.5 cm adenocarcinoma located in the anterior segment of the right upper lobe with extension across the minor fissure into the lateral segment of the right middle lobe. The adenocarcinoma was not present on a chest x-ray 18 months ago. Preoperatively, the surgeon reviews the laboratory and x-ray/imaging studies; evaluates operative risk, particularly from a cardiac and pulmonary standpoint; and communicates with and obtains informed consent from the patient and/or family. At operation, a thoracotomy is performed and the right upper and right middle lobes are resected to completely remove the malignancy. Chest tubes are placed, as necessary. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, and fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged to be followed up in the office on a regular basis during the 90-day global period to check the wound, assess pulmonary function, and remove sutures. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, including: History and physical examination; review chest x-ray; review laboratory results (CBC, electrolytes, renal function); review CT scans; review other staging studies as appropriate(eg, PET scan, bone scan, brain scan, primary site computed tomography); review pathology biopsy reports; cardiology assessment; review pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities).
- Place bladder catheter
- Position patient in lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- The lung tumor is carefully palpated, and its relationship to the pulmonary vasculature and bronchial tree as well as its position within the upper and middle lobes are assessed to determine that a bi-lobectomy is required and is feasible
- Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the lobar vasculature and bronchus
- The lung is retracted posteriorly and inferiorly, allowing the hilar/mediastinal pleura to be incised, carefully avoiding injury to the phrenic nerve
- The appropriate lobar arterial blood supply is carefully dissected, mobilized, and encircled with ties
- The upper and lower lobes are carefully separated by dissecting within the major fissure until the appropriate lobar arteries are identified
- The isolated lobar arteries are ligated, suture-ligated, and then divided, carefully assessing for bleeding from the proximal end
- Specifically the major fissure is dissected to facilitate exposure and precise identification of the lobar branch to the posterior segment of the right upper lobe (posterior ascending branch of the pulmonary artery), care being taken to identify and protect the superior segmental artery to the right lower lobe, and the middle lobe artery.
- The lung is retracted appropriately to permit exposure of the pulmonary venous drainage returning blood to the heart
- The superior pulmonary vein is carefully dissected, mobilized and encircled with ties
- Care is taken to identify and protect the venous drainage of the lower lobe
- The vein draining the upper and middle lobes is ligated proximally with heavy suture, its distal branches ligated, the proximal end suture-ligated, and the vein divided, carefully assessing for bleeding from the proximal end
- The appropriate lobar bronchi are carefully dissected, mobilized, and encircled with a tape
- Specifically, the bronchus to the right middle lobe is identified, care being taken to identify and protect the superior segmental bronchus of the lower lobe and the basilar bronchi of the lower lobe
- The right upper lobe and right middle lobe bronchi are individually crossed with a surgical stapler as close as possible to its origin
- After ascertaining that ventilation of the remaining lower lobe has not been compromised by clamping of the bronchus, the upper and middle lobar bronchi are divided sharply and the stapler removed
- The lobes are removed from the field and submitted for frozen section confirmation of a "clear" bronchial margin of resection
- The divided bronchial stumps are oversewn distal to the staple suture lines with interrupted sutures
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the bronchial stump is carefully inspected for an air leak
- The saline is aspirated from the chest
- Mediastinal lymph node sampling is carried out, removing when possible lymph nodes from the high and low paratracheal, subcarinal, anterior mediastinal, paraesophageal, and inferior pulmonary ligament areas
- Chest tubes are inserted through separate interspace incisions to provide optimal drainage of air from the apex of the chest and of fluid from the base
- The chest tubes are secured to the skin with sutures
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table

- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Examine chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work [beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Treat cardiac arrhythmias (in approximately 15% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions

- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 60 **Response Rate:** 44 (73%) [general surgery 4 / thoracic surgery 40]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	23.75	24.33	25.00	26.25	38.70
Pre-Service			95		
Intra-Service	120	160	198	225	360
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	41	99233*			
After Day of Surgery:					
Critical Care	60	99291			
Other Hospital	87	9932x1; 99231x3			
Discharge Day Mgmt	36	99238			
Office Visits	76	99214x1; 99213x1; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	32482	32480
Count	44	43
Pre-service time	95	90
Intra-service time	198	180
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	40*	30*
Post Total critical care time (not same day)	60	60
Post Total other hospital visit time (not same day)	87	87
Discharge management time	30	30
Total office visit time	76	76

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

Pre-service	4.33	4.31
Intra-service	4.72	4.44
Post-service	4.19	4.18

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.35	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.42	4.42
Urgency of medical decision making	4.02	4.02

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.63	4.58
Physical effort required	4.42	4.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.58	4.42
Outcome depends on the skill and judgment of physician	4.60	4.51
Estimated risk of malpractice suit with poor outcome	4.02	4.02

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

The intraoperative work for CPT codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and aggressive decortication and drainage. Relative to each other, CPT 32320 is slightly more work than CPT 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." CPT 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on this discussion, the correct ranking for these decortication codes is reflected in the survey median RVW for each: CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50). These values also place these two procedures correctly greater than 32480 and less than 32482 or 32440.

CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
1 or 2	19.71	25.00	32482	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
1 or 2	21.02	25.00	32440	Removal of lung, total pneumonectomy;
3	20.54	24.50	32320	Decortication and parietal pleurectomy
4	19.27	24.00	32220	Decortication, pulmonary (separate procedure); total
5	18.32	23.75	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
6	13.62	23.00	32110	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
7	14.30	22.00	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
 Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 913
 Specialty: general surgery 1999 Medicare Frequency: 518

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

34 Yes
 9 No
 1 no response

Surveyee Comments:

Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Surgical staging and clinical trials/studies have advanced the understanding and complexity of decision making and treatment options. More perioperative counseling

is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Metastatic workup has changed (e.g., MRI, PET, other nuclear scans) making preoperative review more complex. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more mediastinal fibrosis.

2. Patients requiring this service are now:

- 35 more complex (more work)
- 0 less complex (less work)
- 8 no change
- 1 no response

Surveyee Comments:

More complex patients are presenting after streptokinase treatment or VATS treatment. Resistant organisms and delayed presentation results in much more debris and infection in chest requiring more complex and aggressive decortication and drainage. Infectious complications are greater, need for aggressive postoperative pulmonary physiotherapy and ambulation is greater than ever. More patients are of advanced age with prior surgery and chemoradiation treatments. Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. More resistant organisms being found that make treatment more difficult.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(February 2001)

CPT Code: 32500

Global: 090

Current RVW: 14.30
Recommended RVW: 22.00

CPT Descriptor: Removal of lung, other than total pneumonectomy; wedge resection, single or multiple

Survey Vignette (Typical Patient)

A 66-year-old woman presents for a lung resection of an 8 mm nodule located in the periphery of the left lower lobe as well as a 1.5 cm nodule in the periphery of the right upper lobe. Nine months prior, she underwent surgery, radiation, and chemotherapy for soft tissue sarcoma of the anterior thigh. Her primary site remains disease free. Preoperatively, the surgeon reviews the laboratory and x-ray/imaging studies; evaluates operative risk, particularly from a cardiac and pulmonary standpoint; and communicates with and obtains informed consent from the patient and/or family. At operation, a median sternotomy is performed and the two initially identified nodules are resected, along with any additional nodules that are identified intraoperatively. Postoperative care includes monitoring of ventilator settings, respiratory status, hemodynamics, and fluid balance, and chest tube drainage. After a routine postoperative hospital stay, the patient is discharged to be followed up in the office on a regular basis during the 90-day global period to monitor the wound and remove sutures and drains. In addition, the final pathology report is reviewed, discussed with the patient, family, and other health care providers, especially with respect to further care of the patient.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, including: History and physical examination; review chest x-ray; review laboratory results (CBC, electrolytes, renal function); review CT scans; review other staging studies as appropriate (eg, PET scan, bone scan, brain scan, primary site computed tomography); review pathology biopsy reports; cardiology assessment; review pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already performed
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities).
- Place bladder catheter
- Position patient in median sternotomy position with a "roll" under the shoulders
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that position of table results in optimal positioning of the mediastinum
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A median sternotomy is performed. The lung are sequentially deflated and palpated (as will be described). Care is taken to protect the heart and bilateral lungs from injury
- The anterior mediastinum is inspected and assessed for the presence of adhesions between the heart, pericardium, lungs, and the sternum which are carefully divided before inserting the sternal spreader to prevent a tear of the lung, or injury to the mediastinal structures or the heart
- Ventilation of the right lung is discontinued, and the lung allowed to deflate
- Single lung ventilation of the left lung is maintained
- The pleura is entered.
- The right hemithorax is explored and assessed for the presence of adhesions between the lung and the chest wall which are carefully divided to facilitate exposure of the entire lung. The pleura, lung parenchyma, mediastinum, and other thoracic structures are inspected
- The pulmonary ligament is identified and divided to facilitate exposure and palpation of the entire right lung
- The deflated lung is carefully palpated
- The right upper lobe nodule is carefully palpated and its relationship to the pulmonary artery, veins and bronchi assessed to determine that a wedge resection rather than a lobectomy or pneumonectomy, is feasible and appropriate from this approach
- Care is taken to avoid injury to the phrenic nerve
- The pulmonary artery is identified and protected
- The pulmonary veins are identified and protected
- Additional nodules (if any) are identified within the right lung
- The surgical stapler is placed to ensure complete resection of the pulmonary nodule(s) with an adequate margin
- The stapler is "fired"
- The stapler is removed to insure that firing of the staples has occurred and the lung parenchyma is intact. The staple line is carefully assessed for bleeding. The stapler is applied again thereby completing the "wedge" resection
- The wedge resection is removed from the field. As needed, the wedge resection is submitted for frozen section confirmation of the pathological diagnosis and that a "clear" parenchymal margin of resection exists
- Additional pulmonary nodules, if identified, are resected in a similar fashion
- The mediastinum is examined for the presence of abnormal lymph nodes, which if present are biopsied
- Ventilation of the right lung is resumed
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the parenchymal staple suture lines are carefully inspected for an air leak
- If such air leak exists, it is controlled with individual suture ligation
- The saline is aspirated from the chest
- After ascertaining that there is adequate ventilation of both lungs, the left lung is approached
- Ventilation to the right lung continues
- Left lung ventilation is discontinued and the lung deflated and manually palpated
- The pulmonary ligament is identified and divided to facilitate exposure and palpation of the entire ipsilateral lung
- All the known nodule(s) are identified with the left lung completely deflated.
- The left lung nodule is carefully palpated and its relationship to the pulmonary artery, veins and bronchi assessed to determine that a wedge resection rather than a lobectomy or pneumonectomy, is feasible and appropriate from this approach
- Care is taken to avoid injury to the phrenic nerve
- The pulmonary artery is identified and protected
- The pulmonary veins are identified and protected
- Additional nodules (if any) are identified within the ipsilateral lung
- The surgical stapler is placed to ensure complete resection of the pulmonary nodule with an adequate margin
- The stapler is "fired"
- The stapler is removed to insure that firing of the staples has occurred and the lung parenchyma is intact. The staple line is carefully assessed for bleeding. The stapler is applied again thereby completing the "wedge" resection

- The wedge resection is removed from the field. As needed, the wedge resection is submitted for frozen section confirmation of the pathological diagnosis and that a "clear" parenchymal margin of resection exists
- Additional pulmonary nodules, if identified, are resected in a similar fashion
- Ventilation of the left lung is reinstated
- The pleural cavity is filled with warm saline
- The anesthetist is asked to inflate the airway with 20 cm water pressure, and the parenchymal staple suture lines are carefully inspected for an air leak
- If such air leak exists, then it is controlled with individual suture ligation
- The saline is aspirated from the chest
- Mediastinal lymph node sampling or dissection is carried out if abnormal lymph nodes are identified
- Chest tubes are placed in both hemithoraces
- The median sternotomy incision is reapproximated with heavy wire sutures around or through the sternum, carefully avoiding injury to the intercostal neurovascular bundles and to the internal mammary arteries. The surgeon ensures that the closure provides stability of the sternum
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

- Post-op same day work through discharge from recovery:
- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table
- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Review chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work - beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress

- Review chest radiograph
- Treat cardiac arrhythmias (in approximately 15% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work - After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 56 **Response Rate:** 36 (64%) [general surgery 4 / thoracic surgery 32]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	20.88	22.00	23.64	30.00
Pre-Service			90		
Intra-Service	75	- 120	150	180	220
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	41	99233*			
After Day of Surgery:					
Critical Care	0				
Other Hospital	139	99233x1; 99232x2; 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	76	99214x1; 99213x1; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Recommended RVW (10/00)
32440	Removal of lung, total pneumonectomy;	090	21.02	25.00
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	18.32	23.75

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	32500	32480
Count	36	33
Pre-service time	90	90
Intra-service time	150	180
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	30*	35*
Post Total critical care time (not same day)	0	60
Post Total other hospital visit time (not same day)	139	87
Discharge management time	30	30
Total office visit time	76	76

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

Pre-service	3.94	4.33
Intra-service	4.09	4.60
Post-service	3.85	4.23

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.18	4.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.30	4.53
Urgency of medical decision making	3.73	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.94	4.67
Physical effort required	3.85	4.47

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.94	4.37
Outcome depends on the skill and judgment of physician	4.24	4.50
Estimated risk of malpractice suit with poor outcome	3.79	3.97

ADDITIONAL RATIONALE

Please note that CPT 32440 (total pneumonectomy) and CPT 32480 (single lobectomy) were previously reviewed by the RUC and are the primary references for six additional surveyed lung procedures.

CPT 32440 is less intraoperative work than CPT 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. CPT 32480 is also a big operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: CPT 32482 (med RVW = 25.00); CPT 32440 (med RVW = 25.00); and CPT 32480 (med RVW = 23.75).

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CPT 32500 (wedge resection single or multiple) may be a simple or complicated operation. Although resection of a solitary pulmonary nodule may be performed under this code, it is more typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill, and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Based on this discussion, we believe the survey median RVW of 22.00 reasonably reflects the slightly less total work for CPT 32500 compared with the reference codes CPT 32440 and CPT 32480.

CPT 32110 (major thoracotomy with control of traumatic hemorrhage and/or lung tear) is an emergency operation with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for CPT 32110 is different, but still as complex as for 32480. The patient requiring 32480 is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. Additionally, this patient will likely be drug-user and have hepatitis or be HIV positive, all issues that complicate postoperative care. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given this course of thought and the discussion above, it is our opinion that the median RVW of 23.00 for CPT 32110 reasonably reflects the difference in work for code 32110 compared code 32480.

CPT 32100 (thoracotomy major with exploration and biopsy) requires less *total* work than a wedge resection (32500) or control of traumatic lung hemorrhage (32110). Postoperatively, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. We note that because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. Based on this discussion and a review of the survey time and visit data in comparison to the other lung codes being reviewed, we believe the survey median RVW is too high. Instead, we recommend the survey 25th percentile RVW of 18.00.

The table below summarizes the recommended RVWs for these eight lung procedures (ranked from most to least total work):

Relative Ranking	2001 RVW	Recommended RVW	CPT	Descriptor
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8	11.84	18.00	32100	Thoracotomy, major; with exploration and biopsy

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
 Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 5,290
 Specialty: general surgery 1999 Medicare Frequency: 1,834

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 23 Yes
- 12 No
- 1 no response

Surveyee Comments:

Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. More surgery on smaller multiple lesions. Increased number of patients with multiple metastases requiring multiple wedge resections (e.g., 4, 5, 10, etc.). More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex.

Chemoradiation increases risk to lung. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. Surgical staging and clinical trials/studies have advanced the understanding and complexity of decision making and treatment options. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Metastatic workup has changed (e.g., MRI, PET, other nuclear scans) making preoperative review more complex. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more mediastinal fibrosis.

2. Patients requiring this service are now:

28 more complex (more work)

0 less complex (less work)

8 no change

0 no response

Surveyee Comments:

Many more patients have underlying lung disease (emphysema), which makes air leaks postoperatively last longer. More surgery on smaller multiple lesions. Increased number of patients with multiple metastases requiring multiple wedge resections (e.g., 4, 5, 10, etc.). More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. Chemoradiation increases risk to lung. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. Surgical staging and clinical trials/studies have advanced the understanding and complexity of decision making and treatment options. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Metastatic workup has changed (e.g., MRI, PET, other nuclear scans) making preoperative review more complex. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more mediastinal fibrosis.

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

CPT Code: 33400 Tracking Number: Global Period: 90 Recommended RVW:
30.00 — 28.50 RUC

CPT Descriptor: Valvuloplasty, aortic valve; open, with cardiopulmonary bypass

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated

Post-op same day work (patient transported directly to cardiac ICU):

- Patient is only in the ICU for 24hrs.

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 139 Response Rate: (%): 29% Median RVW: 30.00

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

25th Percentile RVW: 26.25 75th Percentile RVW: 34.50 Low: 25.00 High: 50.00

Median Pre-Service Time: 40 Median Intra-Service Time: 180.00

25th Percentile Intra-Svc Time: 177.50 75th Percentile Intra-Svc Time: 217.50 Low: 70.00
High: 270.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	_____
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1,</u> <u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 570

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 STS _____ Frequency 298

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: 33405 Tracking Number: Global Period: 090 Recommended RVW: 35.00

CPT Descriptor: Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 75-year-old female is admitted to the hospital with severe congestive failure and was stabilized medically prior to catheterization. She has a past medical history of cigarette smoking, chronic obstructive pulmonary disease requiring nasal oxygen, osteoporosis and hip replacement 6 months previously. A cardiac catheterization reveals a normal coronary vascular system, a transaortic gradient = 85mm Hg., aortic valve area = 0.4cm square, post stenotic dilatation of the ascending aorta (3.9cm) and 3+ aortic regurgitation. The patient undergoes a transesophageal echocardiogram after the induction of general anesthesia at which time the surgeon notes mitral annular calcification and 2+ mitral regurgitation. After performing a median sternotomy, cannulas are placed in aorta, right atrium, left ventricle through the right superior pulmonary vein and retrograde into the coronary sinus. After the application of myocardial protection and ascending aortic cross clamping, the aortic root is visualized and reveals a heavily calcified bicuspid aortic valve, and calcified proximal ascending aortic plaques which project into the supra coronary area. The aortic valve is excised, the annulus is debrided and sized to accommodate a 21mm biologic prosthetic valve, which is placed using a series of interrupted sutures. In addition, a partial ascending aortic endarterectomy is performed to allow the valve to reach the aortic root. The aortotomy is closed, air is removed from the left side of the heart and the patient weaned from cardiopulmonary bypass. Because of the thin walled ascending aorta, a period of time is spent securing homeostasis at the aortotomy site. Postoperatively, the patient is hemodynamically stable, but requires the administration of blood component products to control postoperative bleeding. The patient is gradually weaned from the respirator 48 hours postoperatively and is transferred to the step-down unit on the 3rd postoperative day. On the fifth postoperative day, as plans are being made for transfer to a rehabilitation facility, the patient develops atrial fibrillation, which requires an additional 48 hours in the hospital for pharmacological conversion to a normal sinus rhythm. The patient is discharged to a rehabilitation facility the 8th postoperative day. She is seen in the office 3 weeks later for a wound evaluation (4 weeks postoperatively).

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac Cannulas placed
- Cardiopulmonary bypass initiated

Post-op same day work (patient transported directly to cardiac ICU):

- Apply dressings
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day

Post-op same-day work (Cardiac patient generally remains in ICU 1-2 days)

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress

- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 28% Median RVW: 35.00

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

25th Percentile RVW: 32.22 75th Percentile RVW: 45.00 Low: 19.00 High: 31.00

Median Pre-Service Time: 40.00 Median Intra-Service Time: 240.00

25th Percentile Intra-Svc Time: 227.50 75th Percentile Intra-Svc Time: 255.00 Low: 170.00 High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33405	<u>Reference Service 1 CPT:</u> 33430
Median Pre-Time	40.00	38.00
Median Intra-Time	240.00	240.00
Median Immediate Post-service Time	60.00	60.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	116.5	
Median Discharge Day Management Time	38.0	
Median of Aggregate Office Visit Times	69.5	

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

The number of possible diagnosis and/or the number of management options that must be considered	3.89	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.22
Urgency of medical decision making	4.11	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.78	4.78
Physical effort required	4.44	4.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.78	4.78
Outcome depends on the skill and judgement of physician	4.89	4.78

Estimated risk of malpractice suit with poor outcome	4.00	4.00
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CPT Code: 33405

INTENSITY/COMPLEXITY MEASURES

CPT Code
33405
Reference
Service 1
33430

Time Segments (Mean)

Pre-Service intensity/complexity	3.78	4.11
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Intra-Service intensity/complexity	4.56	4.44
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Post-Service intensity/complexity	4.11	3.89
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ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 58,752

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 STS Frequency 31,979

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 77.8% No 22.2%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 14.3% I do not agree 85.7%**
- b. **Patients requiring this service are now:
more complex (more work) 75.0% less complex (less work) 0.0% no change 25.0%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

CPT Code: 33406 Tracking Number: Global Period: 90 Recommended RVW: 37.50

CPT Descriptor: Replacement, aortic valve, with cardiopulmonary bypass; with homograft valve (freehand)

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Sculpture homograft valve
- Double suture line

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 28% Median RVW: 37.50

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

25th Percentile RVW: 34.00 75th Percentile RVW: 43.50 Low: 30.00 High: 60.00

Median Pre-Service Time: 40 Median Intra-Service Time: 260.00

25th Percentile Intra-Svc Time: 220.00 75th Percentile Intra-Svc Time: 300.00 Low: 180.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 1,168

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 STS _____ Frequency 683

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: 33411 Tracking Number: Global Period: 90 Recommended RVW:
36.25

CPT Descriptor: Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Placement of patch to enlarge aortic root

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 28% Median RVW: 36.25

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

25th Percentile RVW: 34.00 75th Percentile RVW: 42.75 Low: 30.00 High: 65.00

Median Pre-Service Time: 40 Median Intra-Service Time: 260.00

25th Percentile Intra-Svc Time: 220.00 75th Percentile Intra-Svc Time: 300.00 Low: 180.00
High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	_____
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1,</u> <u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 823

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 STS _____ Frequency 447

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: 33412 Tracking Number: Global Period: 90 Recommended RVW: 42.00

CPT Descriptor: Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Enlarge aortic root and ventricular septum; placement of right ventricular outflow patch

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 139 Response Rate: (%): 28% Median RVW: 42.00

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

25th Percentile RVW: 35.56 75th Percentile RVW: 50.00 Low: 34.00 High: 80.00

Median Pre-Service Time: 40 Median Intra-Service Time: 300.00

25th Percentile Intra-Svc Time: 260.00 75th Percentile Intra-Svc Time: 330.00 Low: 195.00 High: 420.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 23

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 STS _____ Frequency 15

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: 33413 Tracking Number: Global Period: 90 Recommended RVW: 43.50

CPT Descriptor: Replacement, aortic valve; by translocation of autologous pulmonary valve with homograft replacement of pulmonary valve (Ross procedure)

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Excise patients pulmonary valve and replace with prosthetic valve
- Use patients pulmonary valve to replace excised aortic valve (double suture line)

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 139 Response Rate: (%): 28% Median RVW: 43.50

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

25th Percentile RVW: 36.94 75th Percentile RVW: 55.00 Low: 34.00 High: 80.00

Median Pre-Service Time: 40 Median Intra-Service Time: 300.00

25th Percentile Intra-Svc Time: 300.00 75th Percentile Intra-Svc Time: 360.00 Low: 225.00 High: 480.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>144</u>	<u>99231x6, 99232x1</u>
Discharge Day Mgmt.:	<u>38.0</u>	<u>99239x1</u>
Office Visits:	<u>83</u>	<u>99211x1, 99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33430	Replacement, mitral valve, with cardiopulmonary bypass	31.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 47

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 STS Frequency 33

Specialty _____ Frequency _____

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

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

CPT Code: 33426 Tracking Number: Global Period: 90 Recommended RVW:
33.00

CPT Descriptor: Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Incise commissures and/or evaluate mitral regurgitation
- Size annuloplasty ring
- Insert annuloplasty ring

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 33.00

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

25th Percentile RVW: 30.00 75th Percentile RVW: 39.25 Low: 25.00 High: 50.00

Median Pre-Service Time: 42.5 Median Intra-Service Time: 220.00

25th Percentile Intra-Svc Time: 195.00 75th Percentile Intra-Svc Time: 240.00 Low: 75.00
High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>136</u>	<u>99231x4, 99232x2</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>76</u>	<u>99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 5,172

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 STS _____ Frequency 3,579

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: 33427 Tracking Number: Global Period: 090 Recommended RVW: 40.00

CPT Descriptor: Valvotomy, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old woman had fatigue and dyspnea on exertion. Physical examination revealed a Grade 3/6 holosystolic murmur at the lower left sternal border, radiating to the axilla. Her heart was in normal sinus rhythm. Transesophageal echocardiogram revealed severe posterior leaflet prolapse with moderate anterior leaflet prolapse, chordal rupture, and preserved left ventricular function. Mitral regurgitation was graded as severe (4+). The patient undergoes median sternotomy. She is heparinized and cannulated for retrograde cardioplegia. She is placed on cardiopulmonary bypass and cooled to 28°C. The patient is found to have a Carpentier Type II prolapse of the valve leaflets involving A1, P1, and the anterior commissure. A large area of A1, including the anterior commissure, and a smaller portion of P1 are excised. An aneurysmal segment of A2 was resected and closed with interrupted 5-0 polypropylene sutures, using an oblique technique. Another area of anterior leaflet containing several chordal attachments was maintained intact for later use. Several chordae were shortened by tunneling them into papillary muscle and securing them with figure-of-eight GORE-TEX sutures. Stay sutures are then placed around chordae adjacent to the resected areas. Two 2-0 compression sutures of braided Dacron are used to compress ventricular tissue and narrow the annulus. Ring sutures of nonpledgeted 2-0 braided Dacron are placed around the annulus. A sliding leaflet technique is utilized for both A2 and P2, using running 4-0 suture. The chordae from the island of tissue previously resected were divided and attached to both anterior and posterior leaflets. The valve is then sized and a 32 mm Carpentier annuloplasty ring is secured in place, using the previously placed annulus sutures. The patient is warmed, the left ventricle vented, and the atriotomy closed. The patient was weaned from bypass, a transesophageal echocardiographic assessment is done of valve function and her sternotomy is closed. She is sent to the intensive care unit, stabilized, and extubated five hours later. Chest tubes are removed on the first postoperative day. She is heparinized until therapeutic prothrombin time prolongation is accomplished with Coumadin. The patient is discharged on the seventh postoperative day. Follow-Up visits are made in the office for routine post surgical care, for Coumadin dosage adjustments and to assess cardiac function and rhythm.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Excise flail or redundant segment of mitral valve
- Shorten or lengthen chordae tendineae
- Replace chordae with prosthetic chords
- Insert valvuloplasty ring

Post-op same day work (patient transported directly to cardiac ICU):

- Apply dressings
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day

Post-op same-day work (Cardiac patient generally remains in ICU 1-2 days)

- Examine patient, check wounds and patient progress
- Review post op echocardiogram
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions

- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 40.00

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

25th Percentile RVW: 35.70 75th Percentile RVW: 42.00 Low: 35.00 High: 50.00

Median Pre-Service Time: 42.50 Median Intra-Service Time: 270.00

25th Percentile Intra-Svc Time: 240.00 75th Percentile Intra-Svc Time: 300.00 Low: 180.00 High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>136</u>	<u>99231x4, 99232x2</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>76</u>	<u>99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33427	<u>Reference Service 1 CPT:</u> 33412
Median Pre-Time	42.50	45.00
Median Intra-Time	270.00	300.00
Median Immediate Post-service Time	60.00	60.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	136	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	76	

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

The number of possible diagnosis and/or the number of management options that must be considered	4.14	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.43
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.43	5.00
Physical effort required	4.29	4.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.43	4.86
Outcome depends on the skill and judgement of physician	4.43	4.86

Estimated risk of malpractice suit with poor outcome 3.86 4.43

CPT Code: 33427

INTENSITY/COMPLEXITY MEASURES

CPT Code
33427
Reference
Service 1
33412

Time Segments (Mean)

Pre-Service intensity/complexity 4.00 4.00

Intra-Service intensity/complexity 4.57 5.00

Post-Service intensity/complexity 4.29 4.14

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

Specialty STS 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 STS Frequency 2,049

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 STS Frequency 1,563

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions: (

Has the work of performing this service changed in the past 5 years? Yes 100.0% No 0.0%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 42.9% I do not agree 57.1%**
- b. **Patients requiring this service are now:
more complex (more work) 85.7% less complex (less work) 0.0% no change 14.3%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

CPT Code: 33430 Tracking Number: Global Period: 90 Recommended RVW:
33.50

CPT Descriptor: Replacement, mitral valve, with cardiopulmonary bypass

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Excise mitral valve or preserve chordae and roo? valve leaflets to annulus
- Size mitral annulus
- Replace mitral valve

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 33.50

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

25th Percentile RVW: 30.93 75th Percentile RVW: 40.00 Low: 24.00 High: 55.00

Median Pre-Service Time: 42.5 Median Intra-Service Time: 220.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 240.00 Low: 75.00
High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>136</u>	<u>99231x4, 99232x2</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>

Office Visits:

76

99212x1, 99213x1, 99214x1

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 20,095

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 STS _____ Frequency 14,762

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: 33475 Tracking Number: Global Period: 90 Recommended RVW: 33.00

CPT Descriptor: Replacement, pulmonary valve

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 33.00

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

25th Percentile RVW: 30.00 75th Percentile RVW: 36.00 Low: 24.75 High: 50.00

Median Pre-Service Time: 42.5 Median Intra-Service Time: 200.00

25th Percentile Intra-Svc Time: 175.00 75th Percentile Intra-Svc Time: 235.00 Low: 75.00 High: 270.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>136</u>	<u>99231x4, 99232x2</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>76</u>	<u>99212x1, 99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 41

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 STS Frequency 23

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33506 Tracking Number: Global Period: 90 Recommended RVW: 35.50

CPT Descriptor: Repair of anomalous coronary artery; by translocation from pulmonary artery to aorta

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intra-cardiac heparinization
- Dissection and occlusion of pulmonary arteries to prevent run-off from coronary circulation
- Placement of left ventricular vent to prevent distension of left heart
- Induction of deep hypothermia with bypass
- Clamping of aorta and administration of cardioplegia into both the aorta and the main pulmonary artery
- Incision of main pulmonary artery and identification of anomalous origin of coronary artery. Decision about technique of establishing connection between aorta and coronary circulation
- Excision of anomalous coronary artery ostium and reimplantation into aorta after creating aortotomy
- Patch or direct closure of site of anomalous coronary artery in pulmonary artery
- De-airing of heart and release of aortic clamp
- Placement of left atrial, right atrial, and pulmonary artery pressure monitoring lines
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, and oxygen saturations
- Assess need for additional inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy for bleeding, additional suture as necessary
- Closure of sternum with wires if hemodynamically tolerated
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30% Median RVW: 35.50

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

25th Percentile RVW: 33.50 75th Percentile RVW: 42.75 Low: 30.00 High: 46.00

Median Pre-Service Time: 37.5 Median Intra-Service Time: 230.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 240.00 Low: 100.00 High: 240.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>261</u>	<u>99231x9, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33510 Tracking Number: Global Period: 90 Recommended RVW:
29.00

CPT Descriptor: Coronary artery bypass, vein only; single coronary venous grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform one proximal and one distal bypass anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 29.00

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

25th Percentile RVW: 25.88 75th Percentile RVW: 31.25 Low: 20.00 High: 50.00

Median Pre-Service Time: 45 Median Intra-Service Time: 150.00

25th Percentile Intra-Svc Time: 120.00 75th Percentile Intra-Svc Time: 155.00 Low: 75.00
High: 240.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 13,092

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 STS _____ Frequency 9,209

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: 33511 Tracking Number: Global Period: 90 Recommended RVW: 30.00

CPT Descriptor: Coronary artery bypass, vein only; two coronary venous grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform two proximal and two distal bypass anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 30.00

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

25th Percentile RVW: 28.00 75th Percentile RVW: 35.00 Low: 20.00 High: 50.00

Median Pre-Service Time: 45 Median Intra-Service Time: 180.00

25th Percentile Intra-Svc Time: 140.00 75th Percentile Intra-Svc Time: 180.00 Low: 75.00
High: 220.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 20,116

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 STS _____ Frequency 13,969

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: 33512 Tracking Number: Global Period: 090 Recommended RVW: 31.80

CPT Descriptor: Coronary artery bypass, vein only; three coronary venous grafts

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is an 84-year-old female admitted to the hospital with new onset angina. She has a past medical history of a right cerebrovascular accident with hemiparesis, hypertension, weight loss, cigarette smoking, chronic bronchitis and increasing evidence of congestive heart failure. A cardiac catheterization reveals left main coronary obstruction, and obstruction of the right, and circumflex coronary arteries as well as severe ventricular dysfunction. The next day the patient is brought urgently to the operating room and a triple coronary bypass is performed using only venous conduits. The patient is weaned from bypass without any hemodynamic problems. Her postoperative course is lengthened by difficulty in weaning from the respirator requiring a 7-day stay in the ICU; she is discharged from the hospital on the 13th postoperative day to a rehabilitation facility. She is seen in the office 3 weeks later.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform three distal and three proximal bypass anastomosis

Post-op same day work (patient transported directly to cardiac ICU):

- Apply dressings
- Dictate operative note for patients chart

- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day

Post-op same-day work (Cardiac patient generally remains in ICU 1-2 days)

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 31.80

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

25th Percentile RVW: 30.00 75th Percentile RVW: 39.50 Low: 25.00 High: 40.00

Median Pre-Service Time: 45.00 Median Intra-Service Time: 205.00

25th Percentile Intra-Svc Time: 155.00 75th Percentile Intra-Svc Time: 232.50 Low: 150.00 High: 320.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary 30.61 bypass; with prosthetic valve other than homograft or stentless valve	

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

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

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 33512	<u>Reference</u> <u>Service 1 CPT:</u> 33405
Median Pre-Time	45.00	42.50
Median Intra-Time	205.00	210.00
Median Immediate Post-service Time	52.50	45.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	250	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	98	

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	3.83	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	4.18
Urgency of medical decision making	4.25	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	4.73
Physical effort required	4.08	4.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.58	4.45
Outcome depends on the skill and judgement of physician	4.67	4.82

Estimated risk of malpractice suit with poor outcome 4.08 4.36

CPT Code: 33512

INTENSITY/COMPLEXITY MEASURES

CPT Code
33512
Reference
Service 1
33405

Time Segments (Mean)

Pre-Service intensity/complexity 4.33 4.08

Intra-Service intensity/complexity 4.17 4.50

Post-Service intensity/complexity 4.42 4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

Specialty STS 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 STS Frequency 30,630

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 STS Frequency 20,718

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 100.0% No 0.0%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 27.3% I do not agree 72.7%**
- b. **Patients requiring this service are now:
more complex (more work) 100.0% less complex (less work) 0.0% no change 0.0%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 9.1% from inpatient to outpatient 0.0% no change 90.9%**

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

CPT Code: 33513 Tracking Number: Global Period: 90 Recommended RVW: 32.00

CPT Descriptor: Coronary artery bypass, vein only; four coronary venous grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform four proximal and four distal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 32.00

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

25th Percentile RVW: 30.00 75th Percentile RVW: 38.50 Low: 24.00 High: 65.00

Median Pre-Service Time: 45 Median Intra-Service Time: 210.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 240.00 Low: 75.00 High: 290.00

Median Post-Service Time:	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

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

CPT Code: 33514 Tracking Number: Global Period: 90 Recommended RVW: 32.75

CPT Descriptor: Coronary artery bypass, vein only; five- coronary venous grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform five proximal and five distal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 32.75

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

25th Percentile RVW: 31.00 75th Percentile RVW: 40.00 Low: 24.00 High: 65.00

Median Pre-Service Time: 45 Median Intra-Service Time: 225.00

25th Percentile Intra-Svc Time: 200.00 75th Percentile Intra-Svc Time: 260.00 Low: 75.00 High: 320.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS X Commonly Sometimes
 Rarely

Specialty Commonly Sometimes
 Rarely

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

Specialty STS Frequency 6,012

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 STS Frequency 4,074

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: 33516 Tracking Number: Global Period: 90 Recommended RVW: 35.00

CPT Descriptor: Coronary artery bypass, vein only; six or more coronary venous grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest greater saphenous vein
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Perform six+ proximal and six+ distal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 35.00

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

25th Percentile RVW: 32.50 75th Percentile RVW: 40.00 Low: 27.00 High: 68.00

Median Pre-Service Time: 45 Median Intra-Service Time: 252.50

25th Percentile Intra-Svc Time: 217.50 75th Percentile Intra-Svc Time: 300.00 Low: 160.00 High: 350.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>52.50</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>98</u>	<u>99211x1, 99212x1, 99214x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 1,424

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 STS Frequency 945

Specialty _____ Frequency _____

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

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

CPT Code: 33533 Tracking Number: Global Period: 090 Recommended RVW: 30.00

CPT Descriptor: Coronary artery bypass, using arterial graft(s); single arterial graft

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is a 58-year-old male, who is admitted to the hospital with unstable angina. He has a past medical history of diabetes complicated by moderate renal insufficiency, hypertension and a previous myocardial infarction. A cardiac catheterization reveals a 95% stenosis of the left anterior descending coronary artery (LAD) and moderately depressed ventricular function. During performance of a PTCA & stent placement, the coronary artery is dissected and becomes thrombosed; the patient becomes hypotensive. The cardiac surgeon is called emergently to the catheterization laboratory; inotropic support and placement of an intra-aortic balloon assist device (IABAD) is initiated. The surgeon calls the operating room and preparation is made for emergent surgical coronary revascularization. With the onset of anesthesia, a median sternotomy is performed, the left internal mammary artery (IMA) harvested on a muscle pedicle, the patient placed on cardiopulmonary bypass, the aorta is cross clamped, cardioplegia administered and a single IMA to LAD bypass graft is performed. The patient comes off bypass easily and is sent to the ICU and the IABAD removed the next day. The postoperative course is complicated by sustained atrial fibrillation on the 3rd postoperative day necessitating drug therapy. By the 5th postoperative day, the patient is stabilized and discharged from the hospital. When seen in the office 3 weeks after discharge, there is discharge from the lower sternal wound, which requires an incision and drainage of a minor wound infection, the initiation of antibiotic therapy and giving oral instructions to the home health care agency for local wound care. The patient is seen at 10-day intervals (3x) until the wound is healed.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest one arterial conduit (IMA)

- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Single distal bypass graft

Post-op same day work (patient transported directly to cardiac ICU):

- Apply dressings
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day

Post-op same-day work (Cardiac patient generally remains in ICU 1-2 days)

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions

- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 31.00

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

25th Percentile RVW: 30.00 75th Percentile RVW: 35.00 Low: 28.00 High: 45.00

Median Pre-Service Time: 40.00 Median Intra-Service Time: 155.00

25th Percentile Intra-Svc Time: 120.00 75th Percentile Intra-Svc Time: 180.00 Low: 120.00 High: 225.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>90</u>	<u>99231x1, 99232x1, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>82</u>	<u>99211x2, 99212x2, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33512	Coronary artery bypass, vein only; three coronary venous grafts	29.67

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33533	<u>Reference</u> <u>Service 1 CPT:</u> 33512
Median Pre-Time	40.00	40.00
Median Intra-Time	155.00	180.00
Median Immediate Post-service Time	60.00	45.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	90	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	82	

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

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.91
Urgency of medical decision making	4.73	4.09

Technical Skill/Physical Effort (Mean)

Technical skill required	4.55	4.18
Physical effort required	4.00	3.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	4.27
Outcome depends on the skill and judgement of physician	4.36	4.18

Estimated risk of malpractice suit with poor outcome

4.27

4.00

CPT Code: 33533

INTENSITY/COMPLEXITY MEASURES

CPT Code
33533

Reference
Service 1
33512

Time Segments (Mean)

Pre-Service intensity/complexity

4.30

3.30

Intra-Service intensity/complexity

4.30

3.70

Post-Service intensity/complexity

4.10

3.70

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The STS Facilitation committee determined that while the median RVW for the single arterial graft was 31.0, the committee felt that a slightly lower RVW of 30.0 was a more accurate work value and more in line with the family of codes.

FREQUENCY INFORMATION

Specialty STS 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 STS Frequency 202,340

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 STS Frequency 138,765

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 90.0% No 10.0%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 33.3% I do not agree 66.7%**
- b. **Patients requiring this service are now:
more complex (more work) 100.0% less complex (less work) 0.0% no change 0.0%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

CPT Code: 33534 Tracking Number: Global Period: 90 Recommended RVW: 32.20

CPT Descriptor: Coronary artery bypass, using arterial graft(s); two coronary arterial grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest two lengths of arterial conduit
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Two distal anastomosis
- One proximal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 32.20

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

25th Percentile RVW: 30.00 75th Percentile RVW: 40.00 Low: 24.00 High: 50.36

Median Pre-Service Time: 40 Median Intra-Service Time: 205.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 240.00 Low: 140.00 High: 280.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>90</u>	<u>99231x1, 99232x1, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>82</u>	<u>99211x2, 99212x2, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33512	Coronary artery bypass, vein only; three coronary venous grafts	29.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 16,678

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 STS Frequency 11,585

Specialty _____ Frequency _____

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

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

CPT Code: 33535 Tracking Number: Global Period: 90 Recommended RVW:
34.50

CPT Descriptor: Coronary artery bypass, using arterial graft(s); three coronary arterial grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest three lengths of arterial conduit
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Three distal anastomosis
- Two proximal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 34.50

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

25th Percentile RVW: 32.00 75th Percentile RVW: 42.75 Low: 26.00 High: 60.00

Median Pre-Service Time: 40 Median Intra-Service Time: 240.00

25th Percentile Intra-Svc Time: 207.50 75th Percentile Intra-Svc Time: 262.50 Low: 180.00
High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>90</u>	<u>99231x1, 99232x1, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>

Office Visits: 82 99211x2, 99212x2, 99214x1

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33512	Coronary artery bypass, vein only; three coronary venous grafts	29.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS X Commonly Sometimes
 Rarely

Specialty Commonly Sometimes
 Rarely

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

Specialty STS Frequency 3,860

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 STS Frequency 2,602

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: 33536 Tracking Number: Global Period: 90 Recommended RVW:
37.50

CPT Descriptor: Coronary artery bypass, using arterial graft(s); four coronary arterial grafts

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Harvest four lengths of arterial conduit
- Cardiac cannulas placed
- Cardiopulmonary bypass initiated
- Four distal bypass anastomosis
- Three proximal anastomosis

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 27% Median RVW: 37.50

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

25th Percentile RVW: 34.00 75th Percentile RVW: 44.25 Low: 27.00 High: 55.00

Median Pre-Service Time: 40 Median Intra-Service Time: 275.00

25th Percentile Intra-Svc Time: 237.50 75th Percentile Intra-Svc Time: 300.00 Low: 200.00
High: 350.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>90</u>	<u>99231x1, 99232x1, 99233x1</u>

Discharge Day Mgmt.: 36 _____ 99238x1
Office Visits: 82 _____ 99211x2, 99212x2, 99214x1

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33512	Coronary artery bypass, vein only; three coronary venous grafts	29.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS _____ X _____ Commonly _____ Sometimes
_____ Rarely

Specialty _____ _____ Commonly _____ Sometimes
_____ Rarely

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

Specialty STS _____ Frequency 1,873

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 STS _____ Frequency 1,154

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: 33611 Tracking Number: Global Period: 90 Recommended RVW: 34.00

CPT Descriptor: Repair of double outlet right ventricle with intraventricular tunnel repair;

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparin administration
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
 - Assessment of right ventricular outflow tract, and closure of atriotomy and/or ventriculotomy incisions
 - Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33% Median RVW: 34.00

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

25th Percentile RVW: 31.75 75th Percentile RVW: 36.25 Low: 30.00 High: 55.00

Median Pre-Service Time: 45 Median Intra-Service Time: 240.00

25th Percentile Intra-Svc Time: 207.50 75th Percentile Intra-Svc Time: 300.00 Low: 140.00 High: 300.00

Median Post-Service Time:

Level of Service by CPT Code

	<u>Total Time</u>	<u>(List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>110.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>38</u>	<u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33612 Tracking Number: Global Period: 90 Recommended RVW:
35.00

CPT Descriptor: Repair of double outlet right ventricle with intraventricular tunnel repair, with repair of right ventricular outflow tract obstruction

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated
- Cardiopulmonary bypass initiated after intracardiac heparin administration
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
 - Assessment of right ventricular outflow tract and decision made for transannular incision and patch enlargement of RVOT with suturing of patch to pulmonary artery and ventriculotomy incision
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33%

Median RVW: 35.00

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

25th Percentile RVW: 34.00 75th Percentile RVW: 37.50 Low: 32.00 High: 60.00

Median Pre-Service Time: 45 Median Intra-Service Time: 240.00

25th Percentile Intra-Svc Time: 202.50 75th Percentile Intra-Svc Time: 322.50 Low: 140.00
High: 330.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>110.00</u>	
Critical Care:	<u>NA</u>	<u>_____</u>
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>38</u>	<u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33615 Tracking Number: ___ Global Period: 90 Recommended RVW: 34.00

CPT Descriptor: Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atriotomy, inspection of intra-atrial anatomy
- Closure of ASD with patch
- Division of superior vena cava, and anastomosis of divided ends to superior and inferior arteriotomies in right pulmonary artery
- De-airing of left & right heart
- Removal of aortic clamp & rewarming
- Placement of left atrial, and right atrial pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Assess chest x-rays for evidence of pleural fluid or pericardial fluid accumulation
- Order echocardiogram to assess for pericardial effusion

SURVEY DATA:



Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33%

Median RVW: 34.00

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

25th Percentile RVW: 33.50 75th Percentile RVW: 36.25 Low: 30.00 High: 50.00

Median Pre-Service Time: 45 Median Intra-Service Time: 250.00

25th Percentile Intra-Svc Time: 210.00 75th Percentile Intra-Svc Time: 300.00 Low: 120.00
High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33617 Tracking Number: Global Period: 090 Recommended RVW: 37.00

CPT Descriptor: Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 2-year-old child with double inlet single ventricle with left atrioventricular valve stenosis and a persistent left superior vena cava draining to the coronary sinus has increasing cyanosis. The arterial saturation is 78% and the Hct is 52%.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- X-ray plain films
- Labs
- Echocardiogram
- Catheterization data and angiograms
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Answer patient and family questions .
- Obtain informed consent

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparinization
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atriotomy, inspection of intra-atrial anatomy
- Division of superior vena cava, and anastomosis of divided ends to superior and inferior arteriotomies in right pulmonary artery
- Creation of intra-atrial baffle to convey inferior vena cava blood to superior vena caval orifice
- Division and oversewing of anatomic main pulmonary artery
- Closure of right atriotomy
- De-airing of left & right heart
- Removal of aortic clamp & rewarming
- Placement of left atrial, and right atrial pressure catheters and connect to pressure transducers.

- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Assessment of right and left atrial pressures to assess pulmonary vascular resistance
- Examine patient with auscultation for residual murmur
- Assess chest tube losses
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Determine need for and doses of inotropic and vasoactive medications
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Examine patient with auscultation for residual murmur
- Assess chest tube losses
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Determine need for and doses of inotropic and vasoactive medications
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient, auscultation for evidence of residual left to right shunt
- Assessment of right and left atrial pressures and right atrial saturation to estimate pulmonary vascular resistance and assess cardiac output
- Check wounds and patient progress
- Assess cardiorespiratory status and complete weaning from ventilator (POD#1)
- Remove chest tubes
- Remove intracardiac monitoring lines on POD#1 or #2
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of chest tube output and chest x-ray for development of pleural and/or pericardial effusion

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart
- Arrange for post-operative echocardiogram if indicated

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30% Median RVW: 37.00

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

25th Percentile RVW: 35.00 75th Percentile RVW: 44.00 Low: 35.00 High: 45.00

Median Pre-Service Time: 60.00 Median Intra-Service Time: 330.00

25th Percentile Intra-Svc Time: 225.00 75th Percentile Intra-Svc Time: 330.00 Low: 210.00 High: 330.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>201</u>	<u>99231x9, 99232x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33617	<u>Reference</u> <u>Service 1 CPT:</u> 33412
Median Pre-Time	60.00	45.00
Median Intra-Time	330.00	210.00
Median Immediate Post-service Time	100.00	100.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	201	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	61	

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

The number of possible diagnosis and/or the number of management options that must be considered	5.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.00
Urgency of medical decision making	4.60	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.80
Physical effort required	5.00	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.00
Outcome depends on the skill and judgement of physician	5.00	4.00

Estimated risk of malpractice suit with poor outcome 4.80 4.00

CPT Code: 33617

INTENSITY/COMPLEXITY MEASURES

CPT Code
33617
Reference
Service 1
33412

Time Segments (Mean)

Pre-Service intensity/complexity 4.80 3.80

Intra-Service intensity/complexity 4.80 4.00

Post-Service intensity/complexity 4.80 4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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.

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 80.0% No 20.0%

a. This service represents new technology that has become more familiar (i.e., less work).

I agree I do not agree 100.0%

b. Patients requiring this service are now:

more complex (more work) 100.0% less complex (less work) no change

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient no change 100.0%

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

CPT Code: 33619 Tracking Number: Global Period: 090 **Recommended RVW:** 45.00

CPT Descriptor: Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplasia left heart syndrome) (eg, Norwood procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A child presents in the newborn period with cyanosis and tachypnea. Echocardiogram shows an enlarged right ventricle with hypoplasia of the left ventricle, left atrioventricular valve atresia, and severe sub aortic and aortic valvular stenosis. The ascending aortic diameter is 2.5mm. The ductus arteriosus is patent and there is coarctation of the aorta with hypoplasia of the aortic arch. The child is supported with prostaglandin E1, mechanical ventilation, and intravenous dopamine.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- X-ray plain films
- Labs
- Echocardiogram
- Catheterization data and angiograms
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Answer patient and family questions
- Obtain informed consent

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Dissection of pulmonary arteries and aortic arch brachiocephalic artery branches
- Cardiopulmonary bypass initiated with occlusion of pulmonary arteries to prevent run-off into pulmonary circulation
- Ligation of ductus arteriosus
- Induction of deep hypothermia on bypass (<20oC) and induction of circulatory arrest and cardioplegic arrest of heart
- Division of main pulmonary artery and oversewing of distal orifice
- Incision of ascending aorta extending into transverse arch and descending aorta with excision of ductus arteriosus
- Creation of proximal main pulmonary artery to aortic anastomosis with patch augmentation of entire aortic arch and ascending aorta
- Right atriotomy and atrial septectomy
- De-airing of heart and reinstitution of cardiopulmonary bypass and rewarming
- Construction of right modified Blalock-Taussig shunt (see 33750)
- Insertion of atrial pressure monitoring catheters and institution of inotropic support

- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, and oxygen saturations
- Assess need for additional inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires if hemodynamically tolerated
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status, oxygen saturation
- Adjust ventilation and inspired oxygen levels to control pulmonary vascular resistance/systemic vascular resistance balance
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status, urine output, oxygen saturation
- Adjust ventilation and inspired oxygen levels to control pulmonary vascular resistance/systemic vascular resistance balance and cardiac output
- Adjust inotropic and vasoactive drugs to maintain cardiac output

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status, urine output, oxygen saturation
- Adjust ventilation and inspired oxygen levels to control pulmonary vascular resistance/systemic vascular resistance balance and cardiac output
- Adjust inotropic and vasoactive drugs and diuretics to maintain cardiac output and fluid status
- Wean patient from ventilator and inotropic medications
- Assess neurologic status post circulatory arrest

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine patient and assess for adequacy of arch repair and pulmonary/systemic blood flow balance
- Check wounds and patient progress including weight gain and feeding
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart
- Arrange for follow-up echocardiogram and catheterization (within 3-4 months)

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30% Median RVW: 45.00

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

25th Percentile RVW: 38.00 75th Percentile RVW: 53.75 Low: 38.00 High: 55.00

Median Pre-Service Time: 45.00 Median Intra-Service Time: 330.00

25th Percentile Intra-Svc Time: 285.00 75th Percentile Intra-Svc Time: 360.00 Low: 280.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>356</u>	<u>99231x7, 99232x6, 99233x1</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>88</u>	<u>99211x5, 99212x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 33619	<u>Reference</u> <u>Service 1 CPT:</u> 33412
Median Pre-Time	45.00	30.00
Median Intra-Time	330.00	210.00
Median Immediate Post-service Time	100.00	100.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	356	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	88	

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	5.00	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.50
Urgency of medical decision making	5.00	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.75
Physical effort required	5.00	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	3.50
Outcome depends on the skill and judgement of physician	5.00	3.50

Estimated risk of malpractice suit with poor outcome	4.50	3.50
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CPT Code: 33619

<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference</u>
	33619	<u>Service 1</u> 33412

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	3.00
Intra-Service intensity/complexity	5.00	3.50
Post-Service intensity/complexity	5.00	3.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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.

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No 100.0%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree __ I do not agree ___**

- b. **Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___**

- c. **The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___**

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

CPT Code: 33660 Tracking Number: Global Period: 90 Recommended RVW: 30.00

CPT Descriptor: Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect) with
without atrioventricular valve repair

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, deficit identified, location of all 4 pulmonary veins
 - Assess mitral valve anatomy and function
 - Repair mitral valve cleft and place annuloplasty sutures if necessary
- Closure of atrial defect with patch
- Closure of atriotomy
- De-airing of left and right heart
- Removal of aortic clamp and begin rewarming on bypass
 - Place left atrial and right atrial pressure monitoring catheters and connect to pressure transducers.
 - Place atrial and ventricular pacing wires.
- Wean from bypass assessing cardiac contractions and rhythm, blood pressure, atrial filling pressure and character of atrial pressure tracings.
- Removal of bypass cannulas and repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s)
- Inspection of cannulation sites and atriotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Assess mitral valve repair by auscultation and analysis of left atrial pressure tracing

Post-op same day work after discharge from recovery

- Assess mitral valve repair by auscultation and analysis of left atrial pressure tracing

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Removal of intracardiac monitoring lines & assess for bleeding from insertion sites

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress

- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Removal of temporary pacing wires

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33% Median RVW: 30.00

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

25th Percentile RVW: 27.00 75th Percentile RVW: 31.00 Low: 25.00 High: 35.00

Median Pre-Service Time: 90 Median Intra-Service Time: 200.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 220.00 Low: 120.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>95</u>	<u>99231x5</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>53</u>	<u>99212x2, 99213x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	33405 Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

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

CPT Code: 33670 Tracking Number: Global Period: 090 Recommended RVW: 35.00

CPT Descriptor: Repair of complete atrioventricular canal, with or without prosthetic valve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 4-month-old child with Down syndrome presents with tachypnea and failure to thrive. An echocardiogram shows a complete atrioventricular canal defect with large atrial and ventricular septal defect components and moderate left atrioventricular valve regurgitation. The catheterization demonstrates systemic level pulmonary artery pressures and a pulmonary to systemic flow ration of 3.8:1.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
 - Films
 - Labs
 - Echocardiogram
 - Catheterization data and angiograms
- Answer patient and family questions
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened & patch harvested
- Cardiopulmonary bypass initiated
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atriotomy made, intracardiac anatomy inspected
- Atrioventricular valve function assessed
- Decision made on alignment of atrioventricular valve tissue and points of valve leaflet division
- Suture of VSD patch to ventricular septum, avoiding area of conduction system
- Reattachment of AV valve tissue to patch
- Assessment of atrioventricular valve function and valve plasty to create competent AV valves
- Closure of atrial septal defect component with avoidance of AV conduction system
- De-airing of left & right heart
- Removal of aortic clamp & rewarming

- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess atrial pressure tracings to assess AV valve repair
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair
- Examine patient with auscultation for residual murmur
- Assess chest tube losses
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Determine need for and doses of inotropic and vasoactive medications
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair
- Examine patient with auscultation for residual murmur
- Assess chest tube losses
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, neurologic and respiratory status
- Determine need for and doses of inotropic and vasoactive medications
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient, auscultation for evidence of residual VSD or AV valve regurgitation
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair
- Check wounds and patient progress
- Assess cardiorespiratory status and complete weaning from ventilator (POD#1)
- Remove chest tubes

- Remove intracardiac monitoring lines on POD#1 or #2
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess left atrial pressure tracings to assess AV valve repair

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart
- Arrange for post-operative echocardiogram if indicated

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33% Median RVW: 35.00

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

25th Percentile RVW: 34.00 75th Percentile RVW: 41.25 Low: 30.00 High: 45.00

Median Pre-Service Time: 45.00 Median Intra-Service Time: 270.00

25th Percentile Intra-Svc Time: 210.00 75th Percentile Intra-Svc Time: 300.00 Low: 200.00 High: 300.00

Median Post-Service Time:

Total Time

Level of Service by CPT Code
(List CPT Code & # of Visits)

Immediate Post Service Time:

100.00

Critical Care:

NA

Other Hospital Visits:

190

99231x10

Discharge Day Mgmt.:

36

99238x1

Office Visits:

61

99213x1, 99214x1

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33670	<u>Reference</u> <u>Service 1 CPT:</u> 33412
Median Pre-Time	45.00	30.00
Median Intra-Time	270.00	210.00
Median Immediate Post-service Time	100.00	100.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	190	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	61	

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

The number of possible diagnosis and/or the number of management options that must be considered	4.50	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	3.50
Urgency of medical decision making	4.75	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.75	3.75
Physical effort required	4.75	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.75	3.50
Outcome depends on the skill and judgement of physician	4.75	3.50

Estimated risk of malpractice suit with poor outcome

CPT Code: 33670

INTENSITY/COMPLEXITY MEASURES

CPT Code
33670
Reference
Service 1
33412

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**



FREQUENCY INFORMATION

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

Specialty STS 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 STS

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 25.0% No 75.0%

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 0.0% I do not agree 100.0%

b. Patients requiring this service are now:

more complex (more work) 100.0% less complex (less work) ___ no change ___

c. The usual site-of-service has changed:

from outpatient to inpatient ___ from inpatient to outpatient ___ no change 100.0%

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

CPT Code: 33681 Tracking Number: Global Period: 090 Recommended RVW: 30.61

CPT Descriptor: Closure of ventricular septal defect, with or without patch;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A child presents at 12 months of age with a systolic murmur and cardiomegaly. Echocardiogram and catheterization showed a ventricular septal defect with a single ventricular septal defect and a pulmonary to systemic flow ration of 2.4:1 with a pulmonary artery pressure which is 50% of systemic.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Films
- Labs
- Echocardiogram, catheterization data, and angiograms
 - Review planned incisions and procedure
 - Confirm OR start time – notify patient and family
 - Arrange for surgical assistant
 - Obtain informed consent
 - Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened & patch harvested
- Cardiopulmonary bypass initiated
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
- Closure of atriotomy and/or ventriculotomy
- De-airing of left & right heart
- Removal of aortic clamp & rewarming
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites

- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Assess chest tube losses
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings, amount of chest tube drainage
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Assess for adequacy of cardiac output pulse, blood pressure, skin temperature, urine output
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Neurologic assessment
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess blood gases and adjust ventilator support and initiate weaning
- Adjust inotropic and vasoactive medications
- Assess rhythm for evidence of surgically induced damage to conduction system
- Order sampling from right atrial and pulmonary artery catheter to assess for residual VSD

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Assess cardiorespiratory status and complete weaning from ventilator (POD#1)
- Remove chest tubes
- Remove intracardiac monitoring lines on POD#1 or #2
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess for residual VSD (auscultation and pulmonary artery/right atrial saturations)
- Assess rhythm for evidence of surgically induced damage to conduction system

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film/EKG reports and discuss with patient

- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Remove temporary pacing wires

Post-op office work – After discharge from hospital:

- Examine and talk with patient Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart
- Assess for residual or recurrent VSD by auscultation and chest x-ray

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33% Median RVW: 30.61

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

25th Percentile RVW: 30.15 75th Percentile RVW: 31.65 Low: 30.00 High: 32.00

Median Pre-Service Time: 52.50 Median Intra-Service Time: 150.00

25th Percentile Intra-Svc Time: 127.50 75th Percentile Intra-Svc Time: 172.50 Low: 120.00 High: 180.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>114</u>	<u>99231x6</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>84</u>	<u>99213x2, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary 30.61 bypass; with prosthetic valve other than homograft or stentless valve	

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

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

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 33681	<u>Reference Service</u> <u>1 CPT:</u> 33405
Median Pre-Time	52.50	52.50
Median Intra-Time	150.00	180.00
Median Immediate Post-service Time	60.00	60.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	114	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	84	

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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	3.25
Outcome depends on the skill and judgement of physician	4.00	3.25

Estimated risk of malpractice suit with poor outcome

CPT Code: 33681

INTENSITY/COMPLEXITY MEASURES

CPT Code
33681
Reference
Service 1
33405

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 100.0% No

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0.0% I do not agree 100.0%**
- b. Patients requiring this service are now:
more complex (more work) 100.0% less complex (less work) 0.0% no change 0.0%**
- c. The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

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

CPT Code: 33694 Tracking Number: Global Period: 090 Recommended RVW: 34.00

CPT Descriptor: Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 7-month old child presents with cyanosis and a history of a recent hypercyanotic spell with loss of consciousness. Echocardiogram and catheterization demonstrate tetralogy of Fallot with a single ventricular septal defect and significant hypoplasia of the infundibulum and pulmonary valve annulus (z score= -3.5). There is a somewhat hypoplastic main pulmonary artery (z score= -2.8). There is no branch pulmonary artery stenosis. The aortic saturation is 75%.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- X-ray plain films
- Labs
- Echocardiogram
- Catheterization data and angiograms
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Answer patient and family questions
- Obtain informed consent

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparin administration
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
- Assessment of right ventricular outflow tract and decision made for transannular incision and patch enlargement of RVOT with suturing of patch to pulmonary artery and ventriculotomy incision
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present and assess atrial pressure tracings to assess AV valve repair

- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status, oxygen saturation
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Assess chest tube losses
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, neurologic, and respiratory status
- Assess chest tube losses and remove chest tubes and monitoring lines on POD #1 or 2
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assessment of residual RV outflow tract obstruction by examination of right ventricle to pulmonary artery pull-back tracing

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, medications, handling of wound or any drains, return appointment to office, etc.

- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Remove temporary pacing wires

Post-op office work – After discharge from hospital:

- Examine and talk with patient Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%) 33% Median RVW: 34.00

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

25th Percentile RVW: 33.38 75th Percentile RVW: 41.25 Low: 30.00 High: 46.00

Median Pre-Service Time: 45.00 Median Intra-Service Time: 285.00

25th Percentile Intra-Svc Time: 225.00 75th Percentile Intra-Svc Time: 300.00 Low: 210.00 High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>110.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>38</u>	<u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33694	<u>Reference</u> <u>Service 1 CPT:</u> 33412
Median Pre-Time	45.00	30.00
Median Intra-Time	285.00	210.00
Median Immediate Post-service Time	110.00	110.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	190	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	38	

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	5.00	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.75
Urgency of medical decision making	5.00	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.75	3.50
Physical effort required	4.75	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	3.75
Outcome depends on the skill and judgement of physician	5.00	3.75

Estimated risk of malpractice suit with poor outcome

CPT Code: 33694

INTENSITY/COMPLEXITY MEASURES

CPT Code
33694
Reference
Service 1
33412

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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.

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 50.0% No 50.0%

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 100.0% I do not agree

b. Patients requiring this service are now:

more complex (more work) 100.0% less complex (less work) no change

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient no change 100.0%

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

CPT Code: 33697 Tracking Number: Global Period: 90 Recommended RVW:
36.00

CPT Descriptor: Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparin administration
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
 - Assessment of right ventricular outflow tract and decision made for placement of right ventricle to distal pulmonary artery conduit. Incision made in distal pulmonary artery and in right ventricle. Anastomosis of distal and proximal ends of conduit to incisions in PA and RV.
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons
Sample Size: 39 Response Rate: (%): 33% Median RVW: 36.00

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

25th Percentile RVW: 34.75 75th Percentile RVW: 38.50 Low: 32.00 High: 65.00

Median Pre-Service Time: 45 Median Intra-Service Time: 260.00

25th Percentile Intra-Svc Time: 232.50 75th Percentile Intra-Svc Time: 352.50 Low: 140.00
High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>110.00</u>	
Critical Care:	<u>NA</u>	<u>_____</u>
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>38</u>	<u>99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33730 Tracking Number: Global Period: 90 Recommended RVW: 34.25

CPT Descriptor: Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atriotomy, inspection of intra-atrial anatomy
- Dissection of pulmonary veins behind the pericardium
- Determination of site for pulmonary vein to left atrial anastomosis
- Creation of parallel incisions in pulmonary vein confluence and left atrium, and creation of side-to-side anastomosis
- Closure of atrial septal defect
- Closure of right atriotomy
- De-airing of left & right heart
- Removal of aortic clamp & rewarming
- Placement of left atrial, pulmonary artery, and right atrial pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, pulmonary artery and atrial filling pressures
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 33% Median RVW: 34.25

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

25th Percentile RVW: 32.75 75th Percentile RVW: 37.00 Low: 30.00 High: 50.00

Median Pre-Service Time: 45 Median Intra-Service Time: 225.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 240.00 Low: 120.00 High: 240.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>190</u>	<u>99231x10</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33770 Tracking Number: Global Period: 90 Recommended RVW: 37.00

CPT Descriptor: Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intra-cardiac heparinization
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Right atrium opened, ventricular septal defect located. Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch
 - Assessment of right ventricular outflow tract and decision made for placement of right ventricle to distal pulmonary artery conduit. Incision made in distal pulmonary artery and in right ventricle. Anastomosis of distal and proximal ends of conduit to incisions in PA and RV.
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%) 30% Median RVW: 37.00

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

25th Percentile RVW: 34.75 75th Percentile RVW: 46.00 Low: 32.00 High: 60.00

Median Pre-Service Time: 37.5 Median Intra-Service Time: 300.00

25th Percentile Intra-Svc Time: 250.00 75th Percentile Intra-Svc Time: 352.50 Low: 160.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>261</u>	<u>99231x9, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33778 Tracking Number: Global Period: 090 Recommended RVW: 40.00

CPT Descriptor: Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatc. type);

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A newborn child presents on the first day of life with cyanosis. An echocardiogram and catheterization demonstrate transposition of the great arteries with intact ventricular septum. A balloon atrial septostomy is performed and the child is maintained on mechanical ventilation with Prostaglandin infusion to provide adequate oxygenation.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- X-ray plain films
- Labs
- Echocardiogram
- Catheterization data and angiograms
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Answer patient and family questions
- Obtain informed consent

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Assessment of suitability of great vessel and coronary anatomy for arterial switch operation
- Cardiopulmonary bypass initiated after intracardiac heparinization, Cooling to deep hypothermic levels
- Ligation and division of ductus arteriosus, and thorough mobilization of both pulmonary arteries into hila of lungs
- Clamp aorta and administer cardioplegia
- Divide aorta, excise coronary buttons from aortic sinuses and mobilize proximal coronary arteries, reimplant coronaries separately into original pulmonary artery (neo-aorta)
- Anastomosis of distal aorta to proximal neo-aorta after translocating distal pulmonary arteries anteriorly
- Suturing of pericardial patches to fill coronary donor sites in original aorta (neo-pulmonary artery)
- Induction of circulatory arrest, right atriotomy, closure of atrial septal defect
- Closure of right atrium, de-airing of heart, re-institution of cardiopulmonary bypass
- Removal of aortic clamp and assessment of adequacy of myocardial perfusion through translocated coronary arteries
- Anastomosis of proximal neo-pulmonary artery to distal pulmonary arteries
- Placement of left atrial, right atrial, and pulmonary artery pressure monitoring lines
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, and oxygen saturations

- Assess need for additional inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy for bleeding, additional suture as necessary
- Closure of sternum with wires if hemodynamically tolerated
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, appearance of EKG for signs of ischemia, respiratory status, oxygen saturation
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist
- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, EKG for evidence of ischemia, respiratory status, urine output, oxygen saturation
- Adjust inotropic and vasoactive drugs to maintain cardiac output.
- Examine patient, check wounds and patient progress
- Assess neurologic status after hypothermic circulatory arrest
- Assess pulmonary artery and right atrial saturations for evidence of residual VSD

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, EKG for evidence of ischemia, respiratory status, urine output
- Assess chest tube losses and remove chest tubes and monitoring lines on POD #1 or 2
- Assess patient for weaning from ventilatory support
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, EKG for evidence of ischemia, respiratory status, urine output, oxygen saturation
- Adjust inotropic and vasoactive drugs to maintain cardiac output.
- Examine patient, check wounds and patient progress
- Assess neurologic status after hypothermic circulatory arrest
- Assess pulmonary artery and right atrial saturations for evidence of residual VSD

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30% Median RVW: 40.00

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

25th Percentile RVW: 38.00 75th Percentile RVW: 49.00 Low: 35.00 High: 50.00

Median Pre-Service Time: 37.50 Median Intra-Service Time: 300.00

25th Percentile Intra-Svc Time: 180.00 75th Percentile Intra-Svc Time: 360.00 Low: 120.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>261</u>	<u>99231x9, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33778	<u>Reference</u> <u>Service 1 CPT:</u> 33412
Median Pre-Time	37.50	30.00
Median Intra-Time	300.00	210.00
Median Immediate Post-service Time	100.00	100.00
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	261	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	61	

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

The number of possible diagnosis and/or the number of management options that must be considered	4.60	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	3.80
Urgency of medical decision making	4.80	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	4.80	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	3.80
Outcome depends on the skill and judgement of physician	5.00	3.60

Estimated risk of malpractice suit with poor outcome	4.60	3.40
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CPT Code: 33778

<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference</u>
	33778	<u>Service 1</u> 33412

Time Segments (Mean)

Pre-Service intensity/complexity	4.60	3.20
Intra-Service intensity/complexity	5.00	3.80
Post-Service intensity/complexity	4.80	3.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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.

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 40.0% No 60.0%

a. This service represents new technology that has become more familiar (i.e., less work).

I agree I do not agree 100.0%

b. Patients requiring this service are now:

more complex (more work) 100.0% less complex (less work) no change

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient no change 100.0%

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

CPT Code: 33780 Tracking Number: Global Period: 90 Recommended RVW:
41.75

CPT Descriptor: Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparinization, Cooling to deep hypothermic levels
- Ligation and division of ductus arteriosus, and thorough mobilization of both pulmonary arteries into hila of lungs
- Clamp aorta and administer cardioplegia
- Divide aorta, excise coronary buttons from aortic sinuses and mobilize proximal coronary arteries, reimplant coronaries separately into original pulmonary artery (neo-aorta)
- Anastomosis of distal aorta to proximal neo-aorta after translocating distal pulmonary arteries anteriorly
- Suturing of pericardial patches to fill coronary donor sites in original aorta (neo-pulmonary artery)
- Induction of circulatory arrest, right atriotomy, closure of atrial septal defect
- Decision on atrial vs. ventricular approach to VSD made.
- Placement of sutures to anchor VSD patch and placement of sutures through patch, patch tied down into place.
- Closure of right atrium, de-airing of heart, re-institution of cardiopulmonary bypass
- Removal of aortic clamp and assessment of adequacy of myocardial perfusion through translocated coronary arteries
- Anastomosis of proximal neo-pulmonary artery to distal pulmonary arteries
- Placement of left atrial, right atrial, and pulmonary artery pressure monitoring lines
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, and oxygen saturations
- Assess need for additional inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy for bleeding, additional suture as necessary
- Closure of sternum with wires if hemodynamically tolerated
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30%

Median RVW: 41.75

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

25th Percentile RVW: 39.00 75th Percentile RVW: 48.50 Low: 34.00 High: 55.00

Median Pre-Service Time: 37.5 Median Intra-Service Time: 335.00

25th Percentile Intra-Svc Time: 245.00 75th Percentile Intra-Svc Time: 390.00 Low: 180.00
High: 400.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>100.00</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>261</u>	<u>99231x9, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

CPT Code: 33786 Tracking Number: Global Period: 090 Recommended RVW: 39.00

CPT Descriptor: Total repair, truncus arteriosus (Rastelli type operation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 3-week-old child is referred after presenting with tachypnea and failure to thrive. Evaluation by echocardiogram and catheterization demonstrates truncus arteriosus with a single ventricular septal defect and origin of the right and left pulmonary arteries from the truncal root. There is mild truncal valve stenosis (20 mm gradient) without regurgitation, and the pulmonary to systemic flow ratio 4:1 with an arterial saturation of 89%.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- X-ray plain films
- Labs
- Echocardiogram
- Catheterization data and angiograms
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Answer patient and family questions
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cardiopulmonary bypass initiated after intracardiac heparinization
- Dissection and temporary occlusion of right and left pulmonary arteries to prevent run-off from systemic circulation
- Insertion of left heart vent
- Both vena cavae encircled
- Aorta clamped, cardioplegia administered
- Pulmonary arteries excised from truncal root preserving truncal (aortic) valve and avoiding injury to right and left coronary ostia.
- Defect in truncal root repaired primarily or with patch

- Right atrium opened, atrial septal defect located and repaired
- Right ventriculotomy made avoiding injury to coronary arteries and truncal and tricuspid valves.
- Placement of sutures to anchor VSD patch avoiding conduction system
- Placement of RV to PA conduit by anastomosis of distal and proximal ends of conduit to incisions in PA and RV.
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

Post-op same day work through discharge from recovery:

- Apply dressings
- Dictate operative note for patients chart
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, appearance of EKG for signs of ischemia, respiratory status, oxygen saturation
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist
- Examine patient, check wounds and patient progress
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, respiratory status
- Assess chest tube losses
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Examine patient with auscultation for residual murmur, check wounds and patient progress
- Assess patient for hemodynamic status, chest tube drainage, cardiac rhythm, neurologic status, respiratory status
- Assess chest tube losses and remove chest tubes and monitoring lines on POD #1 or 2
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

- Assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assessment of residual RV outflow tract obstruction by examination of right ventricle to pulmonary artery pull-back tracing

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, medications, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Remove temporary pacing wires

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%): 30% Median RVW: 39.00

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

25th Percentile RVW: 36.00 75th Percentile RVW: 47.25 Low: 33.00 High: 48.00

Median Pre-Service Time: 45.00 Median Intra-Service Time: 285.00

25th Percentile Intra-Svc Time: 215.00 75th Percentile Intra-Svc Time: 360.00 Low: 140.00 High: 360.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>87.50</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>250</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>84</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33786	<u>Reference Service 1 CPT:</u> 33412
Median Pre-Time	45.00	30.00
Median Intra-Time	285.00	210.00
Median Immediate Post-service Time	87.50	87.50
Median of Aggregate Critical Care Times	NA	
Median of Aggregate Other Hospital Visit Times	250	
Median Discharge Day Management Time	36	
Median of Aggregate Office Visit Times	84	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.50	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	3.83
Urgency of medical decision making	4.83	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	4.83	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.67	3.83
Outcome depends on the skill and judgement of physician	5.00	3.83

Estimated risk of malpractice suit with poor outcome

CPT Code: 33786

INTENSITY/COMPLEXITY MEASURES

CPT Code
33786
Reference
Service 1
33412

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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.

There are approximately 20,000 babies born each year with all forms of congenital heart disease which require surgery. Codes 33641 atrial septal defect, and 33681 ventricular septal defect are the most common defects and account for less than 20% of all congenital heart disease.

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 STS Frequency Rarely, Cannot estimate Medicare Frequency

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 33.3% No 66.7%

a. This service represents new technology that has become more familiar (i.e., less work).

I agree I do not agree 100.0%

b. Patients requiring this service are now:

more complex (more work) 100.0% less complex (less work) no change

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient no change 100.0%

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

CPT Code: 33860 Tracking Number: Global Period: 090 Recommended RVW: 38.00

CPT Descriptor: Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is a 59-year-old hypertensive male seen in the emergency room with severe chest pain. A dissection of the ascending aorta with moderate aortic insufficiency is diagnosed by transesophageal echocardiogram and a coronary arteriogram reveals normal coronary vasculature. The patient is brought emergently to the operating room, a median sternotomy is performed and patient is placed on cardiopulmonary bypass using femoral cannulation. Using hypothermic circulatory arrest methodology, the ascending aorta is replaced with a prosthetic graft and the aortic valve is resuspended. An extensive period of rewarming is required before the patient can be weaned from bypass. The patient is extubated 36 hours postoperatively, while in the ICU and is discharged from the hospital on the 6th postoperative day. He is seen in the office 3 weeks later.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab – check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cannulas placed
- Cardiopulmonary bypass initiated
- Hypothermic systemic arrest
- Prepare graft to limit ?

Post-op same day work (patient transported directly to cardiac ICU):

- Apply dressings
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity

- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day

Post-op same-day work (Cardiac patient generally remains in ICU 1-2 days)

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
 - Check wounds and patient progress
 - Answer patient/family questions
 - Answer insurance staff questions
 - Discuss patient progress with referring physician (verbal and written)
 - Coordinate care with other physicians
 - Write orders for medications
 - Review post-discharge labs/films
 - Discuss progress with patient/family
 - Remove sutures/drains
 - Dictate patient progress notes for medical chart
-

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 26% Median RVW: 38.00

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

25th Percentile RVW: 36.00 75th Percentile RVW: 42.00 Low: 35.00 High: 61.00

Median Pre-Service Time: 60.00 Median Intra-Service Time: 300.00

25th Percentile Intra-Svc Time: 240.00 75th Percentile Intra-Svc Time: 300.00 Low: 180.00 High: 300.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>70.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>125</u>	<u>99231x5, 99232x1</u>
Discharge Day Mgmt.:	<u>36.0</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99212x1, 99213x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

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

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

TIME ESTIMATES (Median)

	<u>CPT Code</u> 33860	<u>Reference Service 1 CPT:</u> 33405
Median Pre-Time	60.00	45.00
Median Intra-Time	300.00	207.50
Median Immediate Post-service Time	70.00	45.00
Median of Aggregate Critical Care Times	33.5	
Median of Aggregate Other Hospital Visit Times	125	
Median Discharge Day Management Time	36.0	
Median of Aggregate Office Visit Times	61	

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

The number of possible diagnosis and/or the number of management options that must be considered	4.71	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.71	3.86
Urgency of medical decision making	5.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.43
Physical effort required	5.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.29
Outcome depends on the skill and judgement of physician	4.71	4.43

Estimated risk of malpractice suit with poor outcome

CPT Code: 33860

INTENSITY/COMPLEXITY MEASURES

CPT Code
33860
Reference
Service 1
33405

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

Specialty STS 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 STS Frequency 2,927

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 STS Frequency 2,119

Specialty _____ Frequency _____

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 71.4% No 28.6%

- a. **This service represents new technology that has become more familiar (i.e., less work).**
I agree 100.0% I do not agree 0.0%
- b. **Patients requiring this service are now:**
more complex (more work) 83.3% less complex (less work) 0.0% no change 16.7%
- c. **The usual site-of-service has changed:**
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%

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

CPT Code: 33861 Tracking Number: Global Period: 90 Recommended RVW:
42.00

CPT Descriptor: Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cannulas placed
- Cardiopulmonary bypass initiated
- Hypothermic systemic arrest
- Prepare coronary artery buttons or construct graft from left coronary to right coronary and anastomose to ascending aorta

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 26% Median RVW: 42.00

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

25th Percentile RVW: 37.75 75th Percentile RVW: 50.00 Low: 35.00 High: 75.00

Median Pre-Service Time: 60 Median Intra-Service Time: 330.00

25th Percentile Intra-Svc Time: 267.50 75th Percentile Intra-Svc Time: 360.00 Low: 210.00
High: 540.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>70.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>125</u>	<u>99231x5, 99232x1</u>
Discharge Day Mgmt.:	<u>36.0</u>	<u>99238x1</u>

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

CPT Code: 33863 Tracking Number: Global Period: 90 Recommended RVW: 45.00

CPT Descriptor: Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cannulas placed
- Cardiopulmonary bypass initiated
- Hypothermic systemic arrest
- Prepare coronary artery buttons or construct graft from left coronary to right coronary and anastomose to ascending aorta

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 26% Median RVW: 45.00

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

25th Percentile RVW: 41.25 75th Percentile RVW: 52.50 Low: 35.00 High: 75.00

Median Pre-Service Time: 60 Median Intra-Service Time: 360.00

25th Percentile Intra-Svc Time: 285.00 75th Percentile Intra-Svc Time: 380.00 Low: 240.00
High: 540.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>70.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>125</u>	<u>99231x5, 99232x1</u>

Discharge Day Mgmt.: 36.0 99238x1
Office Visits: 61 99212x1, 99213x2

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RWV</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS X Commonly Sometimes
 Rarely

Specialty Commonly Sometimes
 Rarely

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

Specialty STS Frequency 1,824
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 STS Frequency 1,289
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: 33870 Tracking Number: Global Period: 90 Recommended RVW: 44.00

CPT Descriptor: Transverse arch graft, with cardiopulmonary bypass

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened
- Cannulas placed
- Cardiopulmonary bypass initiated
- Hypothermic systemic arrest

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 Response Rate: (%): 26% Median RVW: 44.00

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

25th Percentile RVW: 39.00 75th Percentile RVW: 60.00 Low: 30.00 High: 75.00

Median Pre-Service Time: 60 Median Intra-Service Time: 330.00

25th Percentile Intra-Svc Time: 300.00 75th Percentile Intra-Svc Time: 360.00 Low: 190.00 High: 480.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>70.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>125</u>	<u>99231x5, 99232x1</u>
Discharge Day Mgmt.:	<u>36.0</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99212x1, 99213x2</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	30.61

ADDITIONAL RATIONALE



Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 665

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 STS Frequency 493

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33919 Tracking Number: Global Period: 90 Recommended RVW: 40.00

CPT Descriptor: Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; with cardiopulmonary bypass

Intra-service work – Skin to skin:

- Skin incision made via standard median sternotomy
- Sternum is divided in the midline
- Pericardium opened and patch harvested
- Dissection, identification, and control of aortopulmonary collateral arteries supplying pulmonary blood flow in retropericardial space and along brachiocephalic vessels
- Cardiopulmonary bypass initiated and collateral vessels occluded
- Collateral vessels divided from aorta or other systemic artery origins and connected to end of RV to PA conduit individually
- Right ventriculotomy made avoiding injury to coronary arteries and aortic and tricuspid valves.
- Placement of sutures to anchor VSD patch avoiding conduction system and tying of patch into place
 - Placement of RV to PA conduit by anastomosis of proximal end of conduit to incisions in RV.
- Placement of left atrial, right atrial, and pulmonary artery pressure catheters and connect to pressure transducers.
- Placement of atrial and ventricular pacing wires
- Wean from bypass assessing cardiac contraction & rhythm, blood pressure, atrial filling pressures, pulmonary artery pressure.
- Palpation of pulmonary artery and assessment of pulmonary artery and right atrial saturations to determine if residual VSD is present
- Assess need for inotropic and/or vasoactive medications
- Removal of bypass cannulas & repair of cannulation sites
- Reversal of heparin with protamine observing closely for protamine reaction
- Placement of chest tube(s).
- Inspection of cannulation sites and atriotomy or ventriculotomy for bleeding, additional suture as necessary
- Closure of sternum with wires
- Closure of remaining layers

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 39 Response Rate: (%) 30% Median RVW: 40.00

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

25th Percentile RVW: 38.25 75th Percentile RVW: 52.50 Low: 36.00 High: 65.00

Median Pre-Service Time: 45 Median Intra-Service Time: 360.00

25th Percentile Intra-Svc Time: 300.00 75th Percentile Intra-Svc Time: 400.00 Low: 270.00 High: 420.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>87.50</u>	
Critical Care:	<u>NA</u>	
Other Hospital Visits:	<u>280</u>	<u>99231x10, 99232x3</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238x1</u>
Office Visits:	<u>61</u>	<u>99213x1, 99214x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	34.79

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38746 Tracking Number: Global Period: ZZZ Recommended
RVW: ~~11.50~~ 4.89 RUC

CPT Descriptor: Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)

Intra-service work – Skin to skin:

- Perform thoracotomy
- Spread ribs
- Dissect and remove mediastinal lymph nodes
- Place chest tube
- Close ribs and skin

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons

Sample Size: 115 Response Rate: (%): 24% Median RVW: 11.50

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

25th Percentile RVW: 6.75 75th Percentile RVW: 15.00 Low: 2.00 High: 25.00

Median Pre-Service Time: NA Median Intra-Service Time: 40.00

25th Percentile Intra-Svc Time: 30.00 75th Percentile Intra-Svc Time: 65.00 Low: 15.00 High: 180.00

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	18.32

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

FREQUENCY INFORMATION

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

Specialty STS 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 STS Frequency 4,110

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 STS Frequency 3,708

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(February 2001)

CPT Code: 43107

Global: 090

Current RVW: 28.79
Recommended RVW: 40.00

CPT Descriptor: Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (transhiatal)

Survey Vignette (Typical Patient)

A 73-year-old man is referred for esophageal resection and reconstruction. His history includes gastroesophageal reflux with progressive dysphagia and distal esophageal adenocarcinoma arising within Barrett's mucosa that had been treated with radiation and chemotherapy. A percutaneous gastrostomy had previously been placed for nutritional support. Preoperatively, the surgeon reviews the laboratory and x-ray/imaging studies; evaluates operative risk, particularly from a cardiac and pulmonary standpoint; and communicates with and obtains informed consent from the patient and/or family. At operation, gastric mobilization is carried out through an abdominal incision. The previously performed gastrostomy is closed, and a pyloroplasty is performed. A feeding jejunostomy tube (separately billable/reportable) is inserted. Distal esophageal mobilization is carried out through the diaphragmatic hiatus. The upper thoracic esophagus is mobilized through a left cervical incision. Mobilization of the remainder of the thoracic esophagus is completed through the diaphragmatic hiatus. The thoracic esophagus and proximal stomach are resected. Alimentary continuity is reestablished by mobilizing the stomach through the posterior mediastinum in the original esophageal bed and then constructing a cervical esophagogastric anastomosis. Drains are placed as necessary. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, fluid balance, and chest thoracostomy drainage. The chest tube and neck drain are removed when appropriate. Oral feeding is resumed after return of bowel function the patient's diet is advanced, intravenous fluid is discontinued, and discharge plans are completed. The patient is discharged after he is afebrile, wound healing is satisfactory, and he is maintaining adequate nutrition with oral and/or jejunostomy tube feedings. Office visits are conducted as necessary through the 90-day global period to insure that no delayed gastrointestinal problem, wound complications, or infections occur, and to remove staples and sutures. *[Please note that physician work related to insertion/removal of the jejunostomy feeding tube is separately reportable/billable. Do not consider this work when completing the survey questions.]*

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Pre-operative work-up, including: History and physical examination; review of chest x-rays; review of CT scan and other staging studies (esophageal endoscopic ultrasonography-EUS; brain, bone, PET scans, barium esophagram, endoscopy report, etc.); review of laboratory results (CBC, electrolytes, renal and liver function); review of pathology biopsy results; and cardiology/pulmonary assessment as indicated
- Review planned incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Place bladder catheter
- Remove previously placed percutaneous gastrostomy-jejunostomy feeding tube and suture skin opening closed
- Place a small folded towel beneath the scapulae to extend the neck, and rotate the head toward the right side and support on pads to avoid pressure injury
- Carefully pad the extremities to prevent pressure injury

- Prep and drape the skin of the neck, anterior chest and abdomen from the mandibles to the pubis and anterior to each axillary line

Intra-service work – Skin to skin:

- Through an upper midline incision, the abdomen is explored for metastatic disease, with particular attention directed toward the liver, upper abdominal lymph nodes and the esophagogastric junction
- Fixation of either the stomach or jejunum to the anterior abdominal wall at the site of the previously placed feeding tube is addressed by separating these organs from the abdominal wall with electrocautery and repairing the defect in either the stomach or the bowel
- Peritoneum overlying the esophagogastric junction is incised
- Mobilization of the stomach is performed by dividing the left gastric, left gastroepiploic, and short gastric vessels between the spleen and the stomach
- The right gastroepiploic and right gastric vascular arcades are carefully preserved
- Accessible upper abdominal lymph nodes (left gastric, celiac axis, esophagogastric junction) are resected for purpose of staging
- The second portion of the duodenum is carefully mobilized from its retroperitoneal location to facilitate the subsequent upward reach of the stomach
- A gastric drainage procedure (pyloromyotomy or pyloroplasty) is performed to avoid problems with gastric outlet obstruction after division of the vagus nerves which occurs during the esophagectomy
- A feeding jejunostomy tube is placed for postoperative nutritional support and is well secured to the bowel and anterior abdominal wall with sutures
- The esophagogastric junction is encircled with a rubber drain
- The inferior mediastinum is entered through the diaphragmatic hiatus, and the size and mobility of the distal esophageal tumor assessed by careful palpation
- Once it has been determined that the tumor is resectable, narrow deep retractors are placed into the diaphragmatic hiatus to facilitate visualization of the distal esophagus
- Intraarterial blood pressure is carefully monitored during the esophageal mobilization and retraction on the diaphragmatic hiatus which may displace the heart
- The esophagus is mobilized from the lower half of the mediastinum under direct vision, carefully clamping and ligating lateral esophageal attachments with the use of long clamps and ties
- With mobilization of the distal esophagus and stomach completed, the abdominal wound is temporarily covered with a sterile towel
- Attention is turned to the neck, where an incision is made along the anterior border of the left sternocleidomastoid muscle
- The sternocleidomastoid muscle and underlying carotid sheath and its contents are retracted to the left, carefully avoiding undue compression on the carotid artery; the trachea and thyroid gland are retracted to the right, carefully avoiding pressure on the tracheoesophageal groove and the potential for injury to the recurrent laryngeal nerve
- The inferior thyroid artery is identified, ligated and divided, and the underlying cervical esophagus identified
- Carefully avoiding injury to the left recurrent laryngeal nerve in the tracheoesophageal groove, the cervical esophagus is encircled with a rubber drain, and the remaining high thoracic esophagus mobilized out of the chest and into the neck wound by careful blunt dissection
- Turning attention back to the abdomen, the hand is inserted upward through the diaphragmatic hiatus into the posterior mediastinum and the few remaining lateral esophageal attachments mobilized and divided
- A suction catheter inserted through the neck wound into the posterior mediastinum is used to evacuate blood and to assess any untoward bleeding
- The cervical esophagus is divided with a surgical stapler
- By traction on the mobilized stomach, the intrathoracic esophagus is delivered out of the posterior mediastinum and placed on the anterior chest wall with the mobilized stomach
- The mediastinum is inspected for bleeding and for entry into either or both pleural cavities, and chest tubes inserted into either chest as indicated, the chest tubes are connected to drainage systems
- The posterior mediastinum is carefully packed with gauze packs to facilitate hemostasis
- The lesser curvature of the stomach is cleaned of adjacent fat and vessels between clamps and ties
- The surgical stapling device is applied to the stomach beginning at approximately the level of the divided second vascular arcade, 4-6 cm distal to the esophagogastric junction, and with each progressive application of the stapler toward the gastric fundus, gentle traction is placed upon the tip of the greater curvature of the stomach to insure construction of as long and straight gastric conduit as is possible
- The resected esophagus and proximal stomach are removed from the field

- The gastric staple suture line is oversewn with an inverting running synthetic suture
- The previously placed packs within the posterior mediastinum are carefully removed and the mediastinum inspected for bleeding
- Once hemostasis has been assured, the tip of the mobilized stomach is gently grasped with one hand, which is then inserted through the posterior mediastinum and advanced superiorly behind the trachea and adjacent to the aortic arch, until the tip of the stomach can be grasped by the second hand inserted downward into the superior mediastinum through the neck incision
- Throughout this positioning of the stomach through the posterior mediastinum in the original esophageal bed, careful attention to the intraarterial blood pressure is mandatory so that prolonged hypotension is avoided.
- Once the tip of the stomach is grasped in the neck incision, gentle traction is delivered on the stomach from above as the now intrathoracic stomach is gently pushed upward by the hand within the posterior mediastinum (Care is taken to insure that the stomach is not twisted as it is brought through the posterior mediastinum and delivered into the neck)
- Through the abdominal incision, several sutures between the diaphragmatic hiatus and adjacent stomach are placed to minimize the risk of subsequent herniation of intestine into the chest through the diaphragmatic hiatus
- After careful inspection for hemostasis, the abdominal wound is closed in layers in the usual fashion
- Returning to the neck incision, a cervical esophagogastric anastomosis is constructed in two layers of 4-0 suture
- A nasogastric tube inserted by the anesthetist is carefully guided through the anastomosis and into the intrathoracic stomach for postoperative gastric decompression
- After a careful inspection for hemostasis, the neck wound is irrigated, a cervical wound drain placed, and the incision closed loosely in layers in the standard fashion

Post-op same day work through discharge from recovery:

- Sterile dressing are applied to the incisions
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Obtain and examine postoperative chest x-ray to assess expansion of the lungs and placement of the chest and nasogastric tubes
- Write orders for post-op labs, films, medications, diet, and patient activity
- Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Treat cardiac arrhythmias (in up to 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral and oral feedings
- Obtain and evaluate postoperative barium esophagogram to document anastomotic healing and satisfactory emptying of intrathoracic stomach
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Remove sutures/drains
- Answer patient/family questions
- Discuss progress with patient/family
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Answer insurance staff questions
- Write orders for medications
- Review post-discharge labs/films
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 54 **Response Rate:** 41 (76%) [general surgery 7 / thoracic surgery 34]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	32.00	38.00	40.00	42.00	50.00
Pre-Service			90		
Intra-Service	180	260	300	360	480
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	45				
Other	60	99291			
After Day of Surgery:					
Critical Care	60	99291			
Other Hospital	207	99233x1; 99232x3; 99231x4			
Discharge Day Mgmt	40	99239			
Office Visits	76	99214x1; 99213x2; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Rec RVW
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	90	30.02	40.00

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT Ref CPT	
	43107	43117
Count	41	37
Pre-service time	90	95
Intra-service time	300	360
Same Day Immediate Post-service time	45	45
Same Day Other Post-service time (*critical care)	45*	45*
Post Total critical care time (not same day)	45	45
Post Total other hospital visit time (not same day)	208	248
Discharge management time	40	40
Total office visit time	99	99

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

Pre-service	4.70	4.74
Intra-service	4.95	4.91
Post-service	4.73	4.76

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.59	4.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.70	4.71
Urgency of medical decision making	4.46	4.44

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.92	4.85
Physical effort required	4.86	4.91

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.92	5.00
Outcome depends on the skill and judgment of physician	4.89	4.88
Estimated risk of malpractice suit with poor outcome	4.24	4.29

ADDITIONAL RATIONALE

Additional discussion for the family of four esophagectomy codes. Note that CPT 43117 was previously reviewed by the RUC and is the primary reference for the other three surveyed codes.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (transhiatal)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty

43117 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastronomy, with or without pyloroplasty (Ivor Lewis)

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastronomy, with or without pyloroplasty

Of the four surveyed esophagectomy codes, CPT 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including repositioning and redraping. The other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to CPT 43112, they each include a gastric drainage procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both CPT 43117 and CPT 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. CPT 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare. While CPT 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. A more detail discussion of the differences and similarities between these codes is presented in the attached article "Comparison of Three Techniques of Esophagectomy Within a Residency Training Program" (*Ann Thor Surg* 1994;57:319-325).

For this family of four "all inclusive" codes, there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. Given this course of thought and the discussion above, it is our opinion that the median RVWs for this family of codes ranks them correctly. We recommend the survey median RVW for each code: CPT 43107 (med RVW = 40.00); CPT 43112 (med RVW = 43.50); CPT 43117 (med RVW = 40.00); and CPT 43122 (med RVW = 40.00).

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely
Specialty: general surgery Commonly Sometimes Rarely

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 365
Specialty: general surgery 1999 Medicare Frequency: 462

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 31 Yes
- 6 No
- 4 no response

Surveyee Comments:

More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/Barretts adenocarcinoma) making the intraoperative work more complex.

2. Patients requiring this service are now:

- 33 more complex (more work)
- 0 less complex (less work)
- 5 no change
- 3 no response

Surveyee Comments:

Seeing patients of advanced age returning for "re-do" operations. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have lead to patients with of advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/Barretts adenocarcinoma) making the intraoperative work more complex.

CPT Code: 43112

Global: 090

Current RVW: 31.22
Recommended RVW: 43.50

CPT Descriptor: Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty

Survey Vignette (Typical Patient)

A 70-year-old man is referred for esophageal resection and reconstruction. His history includes progressive dysphagia and esophageal squamous cell carcinoma at the level of the carina that had been treated with radiation and chemotherapy. A percutaneous gastrostomy had previously been placed for nutritional support. Preoperatively, the surgeon reviews the laboratory and x-ray/imaging studies; evaluates operative risk, particularly from a cardiac and pulmonary standpoint; and communicates with and obtains informed consent from the patient and/or family. At operation, through a transthoracic approach, the intrathoracic esophagus is mobilized away from the distal trachea and carina and is resected. Through an abdominal incision, the stomach is mobilized, the previously performed gastrostomy closed, and a pyloroplasty is performed. A feeding jejunostomy tube (separately billable/reportable) is inserted. Through a neck incision, the cervical esophagus is mobilized. Alimentary continuity is reestablished by mobilizing the stomach through the posterior mediastinum in the original esophageal bed and constructing a cervical esophagogastric anastomosis. Drains are placed as necessary. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, fluid balance, and chest thoracostomy drainage. The patient is discharged after he is afebrile, wound healing is satisfactory, and he is maintaining adequate nutrition with oral and/or jejunostomy tube feedings. Office visits are conducted as necessary through the 90-day global period to insure that no delayed gastrointestinal problem, wound complications, or infections occur, and to remove staples and sutures. *[Please note that physician work related to insertion/removal of the jejunostomy feeding tube is separately reportable/billable. Do not consider this work when completing the survey questions.]*

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Pre-operative work-up, including: History and physical examination; review of chest x-rays; review of CT scan and other staging studies (esophageal endoscopic ultrasonography-EUS; brain, bone, PET scans, barium esophagram, endoscopy report, etc.); review of laboratory results (CBC, electrolytes, renal and liver function); review of pathology biopsy results; and cardiology/pulmonary assessment as indicated
- Review planned incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Place bladder catheter
- Remove previously placed gastrostomy–jejunostomy feeding tube and suture skin opening closed
- Position patient in left lateral decubitus position
- Place axillary “roll” beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon

- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A right posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs)
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- Single lung ventilation of the contralateral lung is instituted to facilitate the mediastinal dissection
- The right lung and mediastinum are carefully palpated to assess the esophageal pathology and associated adenopathy and any unsuspected pulmonary nodules
- The right lung is carefully retracted anteriorly while blood pressure is monitored
- The inferior pulmonary ligament is divided, and lymph nodes contained within it are resected and submitted to pathology
- The mediastinal pleura is incised posterior to the pericardium from the level of the inferior pulmonary vein to the azygous vein, thereby revealing the intrathoracic esophagus
- The azygous vein is carefully mobilized, encircled with ties, doubly ligated with heavy suture, suture-ligated, and divided to facilitate exposure and resection of the esophagus
- The diseased esophagus and associated mediastinal soft tissues are mobilized away from the pericardium, aorta, tracheobronchial tree, and spine, carefully avoiding injury to these structures and monitoring blood pressure throughout to avoid prolonged hypotension or cardiac arrhythmias
- The esophageal mobilization extends from the thoracic inlet at the apex of the chest down to the level of the diaphragm
- With mobilization of the intrathoracic esophagus completed, the upper and lower ends of the esophagus are divided with a surgical stapler insuring optimal margins of resection beyond palpable tumor, and the esophagus and its contained tumor are removed from the field
- After a careful inspection for hemostasis, the chest is irrigated with saline
- A chest tube is inserted through a separate low interspace incision and is sutured to the skin; the tube is connected to a drainage system
- The ipsilateral lung is expanded
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated
- The chest incision is covered with sterile dressings and a plastic surgical drape
- The surgical drapes are then removed from the field, and the patient is positioned supine on the operating table
- A small folded towel is positioned beneath the scapulae to extend the neck, and the head is rotated toward the right side and supported on pads to avoid pressure injury
- The extremities are carefully padded to prevent pressure injury
- The skin of the neck, anterior chest, and abdomen is prepped and draped from the mandibles to the pubis and anterior to each axillary line
- Through an upper midline incision, the abdomen is explored for metastatic disease, with particular attention directed toward the liver, upper abdominal lymph nodes and the esophagogastric junction
- Fixation of either the stomach or jejunum to the anterior abdominal wall at the site of the previously placed feeding tube is addressed by separating these organs from the abdominal wall with electrocautery and repairing the defect in either the stomach or bowel
- Peritoneum overlying the esophagogastric junction is incised
- Mobilization of the stomach is performed by dividing the left gastric, left gastroepiploic, and short gastric vessels between the spleen and the stomach
- The right gastroepiploic and right gastric vascular arcades are carefully preserved
- Accessible upper abdominal lymph nodes (left gastric, celiac axis, esophagogastric junction) are resected for purpose of staging.
- The second portion of the duodenum is carefully mobilized from its retroperitoneal location to facilitate the subsequent upward reach of the stomach

- A gastric drainage procedure (pyloromyotomy or pyloroplasty) is performed to avoid problems with gastric outlet obstruction after division of the vagus nerve which has occurred during the esophagectomy
- A feeding jejunostomy feeding tube is placed for postoperative nutritional support and is well secured to the bowel and anterior abdominal wall with sutures
- Any remaining attachments between the esophagogastric junction and diaphragmatic hiatus are divided, thereby allowing the stomach to be delivered out of the abdominal cavity and placed on the anterior chest wall
- The lesser curvature of the stomach is cleaned of adjacent fat and vessels between clamps and ties
- The surgical stapling device is applied to the stomach beginning at approximately the level of the divided second vascular arcade, and with each progressive application of the stapler toward the gastric fundus, gentle traction is placed upon the tip of the greater curvature of the stomach to insure construction of as long and straight a gastric conduit as is possible
- The resected esophagogastric junction is removed from the field and submitted to pathology for histologic assessment of the distal margin of resection
- The gastric staple suture line is oversewn with an inverting running synthetic suture
- The now completely mobilized stomach is returned to the abdominal cavity, and the abdominal wound is temporarily covered with a sterile towel
- Attention is turned to the neck, where an incision is made along the anterior border of the left sternocleidomastoid muscle
- The sternocleidomastoid muscle and underlying carotid sheath and its contents are retracted to the left, carefully avoiding undue compression on the carotid artery; the trachea and thyroid gland are retracted to the right, carefully avoiding pressure on the tracheoesophageal groove and the potential for injury to the recurrent laryngeal nerve
- The inferior thyroid artery is identified, ligated and divided, and the underlying cervical esophagus identified
- Carefully avoiding injury to the left recurrent laryngeal nerve in the tracheoesophageal groove, the cervical esophagus is encircled with a rubber drain, and the remaining high thoracic esophagus mobilized out of the chest and into the neck wound
- Turning attention back to the abdomen once again, the mobilized stomach is carefully straightened, its tip gently grasped with one hand, which is then inserted through the posterior mediastinum and advanced superiorly behind the trachea and adjacent to the aortic arch, until the tip of the stomach can be grasped by the second hand inserted downward into the superior mediastinum through the neck incision
- Throughout this positioning of the stomach through the posterior mediastinum in the original esophageal bed, careful attention to the intraarterial blood pressure is mandatory so that prolonged hypotension is avoided
- Once the tip of the stomach is grasped in the neck incision, gentle traction is delivered on the stomach from above as the now intrathoracic stomach is gently pushed upward by the hand within the posterior mediastinum
- Care is taken to insure that the stomach is not twisted as it is brought through the posterior mediastinum and delivered into the neck
- Through the abdominal incision, several sutures between the diaphragmatic hiatus and adjacent stomach are placed to minimize the risk of subsequent herniation of intestine into the chest through the diaphragmatic hiatus
- After a careful inspection for hemostasis, the abdominal wound is closed in layers in the usual fashion
- Returning to the neck incision, a cervical esophagogastric anastomosis is constructed in two layers of interrupted 4-0 suture
- A nasogastric tube inserted by the anesthetist is carefully guided through the anastomosis and into the intrathoracic stomach for postoperative gastric decompression
- After a careful inspection for hemostasis, the neck wound is irrigated, a cervical wound drain placed, and the incision closed loosely in layers in the standard fashion

Post-op same day work through discharge from recovery:

- Sterile dressing are applied to the incisions
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Obtain and examine postoperative chest x-ray to assess expansion of the lungs and placement of the chest and nasogastric tubes
- Write orders for post-op labs, films, medications, diet, and patient activity

- Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiography
- Treat cardiac arrhythmias (in up to 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral and oral feedings
- Obtain and evaluate postoperative barium esophagogram to document anastomotic healing and satisfactory emptying of intrathoracic stomach
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient, check wounds and patient progress

- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
Joseph Putnam, MD
Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
American Society of General Surgeons
American College of Surgeons

Sample Size: 54 **Response Rate:** 38 (70%) [general surgery 6 / thoracic surgery 32]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	40.00	42.00	43.50	46.75	55.00
Pre-Service			103		
Intra-Service	220	343	415	450	540
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	48				
Other	60	99291			
After Day of Surgery:					
Critical Care	101	99291x1; 99233*x1			
Other Hospital	207	99233x1; 99232x3; 99231x4			
Discharge Day Mgmt	40	99239			
Office Visits	99	99214x1; 99213x2; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Rec RVW
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastronomy, with or without pyloroplasty (Ivor Lewis)	90	30.02	40.00

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

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

TIME ESTIMATES (MEDIAN)	Svy CPT Ref CPT	
	43112	43117
Count	38	35
Pre-service time	103	95
Intra-service time	415	360
Same Day Immediate Post-service time	48	45
Same Day Other Post-service time (*critical care)	45*	45*
Post Total critical care time (not same day)	94	45
Post Total other hospital visit time (not same day)	207	248
Discharge management time	40	40
Total office visit time	99	99

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

Pre-service	4.86	4.73
Intra-service	5.00	4.92
Post-service	4.83	4.78

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.75	4.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.75	4.70
Urgency of medical decision making	4.47	4.38

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	5.00	4.86
Physical effort required	4.97	4.89

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	4.94	4.89
Estimated risk of malpractice suit with poor outcome	4.33	4.19

ADDITIONAL RATIONALE

Additional discussion for the family of four esophagectomy codes. Note that CPT 43117 was previously reviewed by the RUC and is the primary reference for the other three surveyed codes.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty

43117 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty

Of the four surveyed esophagectomy codes, CPT 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including repositioning and redraping. The other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to CPT 43112, they each include a gastric drainage procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both CPT 43117 and CPT 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. CPT 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare. While CPT 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. A more detail discussion of the differences and similarities between these codes is presented in the attached article "Comparison of Three Techniques of Esophagectomy Within a Residency Training Program" (*Ann Thor Surg* 1994;57:319-325).

For this family of four "all inclusive" codes, there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. Given this course of thought and the discussion above, it is our opinion that the median RVWs for this family of codes ranks them correctly. We recommend the survey median RVW for each code: CPT 43107 (med RVW = 40.00); CPT 43112 (med RVW = 43.50); CPT 43117 (med RVW = 40.00); and CPT 43122 (med RVW = 40.00).

FREQUENCY INFORMATION

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

Specialty: cardiothoracic surgery ~~Commonly~~ ~~Sometimes~~ **Rarely**
 Specialty: general surgery ~~Commonly~~ ~~Sometimes~~ **Rarely**

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

Data not available.

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: cardiothoracic surgery 1999 Medicare Frequency: 104
 Specialty: general surgery 1999 Medicare Frequency: 122

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. **Has the work of performing this service changed in the past 5 to 10 years?**

- 31 Yes
- 6 No
- 1 no response

Surveyee Comments:

More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/Barretts adenocarcinoma) making the intraoperative work more complex.

2. **Patients requiring this service are now:**

- 35 more complex (more work)
- 0 less complex (less work)
- 3 no change
- 0 no response

Surveyee Comments:

Seeing patients of advanced age returning for "re-do" operations. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have lead to patients with of advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/Barretts adenocarcinoma) making the intraoperative work more complex.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43117 Tracking Number: Global Period: 090 Recommended RVW: 40.00

CPT Descriptor: Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old woman presents with one-month history of progressive dysphagia. An esophagogram demonstrates a long segment of irregular narrowing in the middle third of the esophagus and CT scan shows a bulky middle esophageal tumor without evidence of airway involvement or metastatic disease. Esophagoscopy confirms adenocarcinoma extending from 27 to 35 cm from the incisors. Bronchoscopy reveals no evidence of airway invasion. Pulmonary function tests are normal. The patient is evaluated for multi-disciplinary management of her esophageal cancer and undergoes concurrent induction chemoradiotherapy with two cycles of cisplatin/5-FU and 45 Gy of intrathoracic radiation. She has a good clinical and radiologic response and presents for surgical resection 4 weeks after completion of her radiation. Preoperatively the surgeon conducts a reevaluation of patient along with re-review of laboratory and x-ray/imaging studies, including a repeat chest CT scan, discusses the surgical procedure with the patient and obtains informed consent. The surgical approach is discussed with the anesthesiologist. A laparotomy is performed and the abdomen explored for signs of metastatic disease. The stomach is mobilized after dividing the left gastric, left gastroepiploic, and short gastric arteries. A Kocher maneuver is performed, the esophageal hiatus enlarged, and dissection carried into the distal mediastinum. A pyloroplasty is completed for gastric drainage. The abdomen is closed and the patient is repositioned to the lateral decubitus position and re-prepped and draped. Through a right posterolateral thoracotomy the esophagus is mobilized and carefully dissected away from the trachea and left mainstem bronchus where it is adherent. The azygos vein is divided and gastrointestinal continuity is established by transposition of the stomach into the thorax with a esophagogastrostomy performed in the upper chest. Chest tubes are placed. Postoperatively the surgeon manages the patient in the intensive care unit and postoperative ward, including monitoring of ventilation, hemodynamics, fluid balance, evidence of pulmonary or anastomotic complications, and tube thoracostomy drainage. The chest tube is removed on day three. Oral feeding is resumed on postoperative day seven after a normal postoperative esophagogram. The patient is advanced on dietary intake on postoperative days 8 and 9, and is discharged on day ten. Multiple office visits are conducted during the initial three months of follow up to evaluate chest-x-ray, normalization of eating, wound and pain management, and surveillance for postoperative morbidity.

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
 - History and physical examination
 - Chest x-rays
 - CT scan and other staging studies (esophageal endoscopic ultrasonography-EUS; brain, bone, PET scans, etc.)
 - Laboratory results (CBC, electrolytes, renal and liver function)
 - Pathology biopsy results
 - Cardiology/pulmonary assessment as indicated
- Review planned incisions and procedure
- History and physical examination
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab – check on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family

- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Position patient in left lateral decubitus position with hips rotated to the right to allow access to the anterior surface of the abdomen
- Remove previously placed gastrostomy–jejunostomy feeding tube and suture skin opening closed
- Place axillary “roll” beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A right posterolateral thoracotomy is performed in the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 6th rib posteriorly to facilitate spreading of the ribs
- Care is taken to avoid injury to the intercostal neurovascular bundles of the 5th and 6th ribs
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- Single lung ventilation of the contralateral lung is instituted to facilitate the mediastinal dissection
- The right lung and mediastinum are carefully palpated to assess the esophageal pathology and associated adenopathy and any unsuspected pulmonary nodules
- The right lung is carefully retracted anteriorly while blood pressure is monitored
- The inferior pulmonary ligament is divided, and lymph nodes contained within it are resected and submitted to pathology
- The mediastinal pleura is incised posterior to the pericardium from the level of the inferior pulmonary vein to the azygous vein, thereby revealing the intrathoracic esophagus
- The azygous vein is carefully mobilized, encircled with ties, doubly ligated with heavy suture, suture-ligated, and divided to facilitate exposure and resection of the esophagus
- The diseased esophagus and associated mediastinal soft tissues are mobilized away from the pericardium, aorta, tracheobronchial tree, and spine, carefully avoiding injury to these structures and monitoring blood pressure throughout to avoid prolonged hypotension or cardiac arrhythmias
- The esophageal mobilization extends from the thoracic inlet at the apex of the chest down to the level of the diaphragm
- With the esophageal mobilization completed the operating table is partially rotated to the right to facilitate exposure of the upper abdomen
- Through an upper midline incision, the abdomen is explored for metastatic disease, with particular attention directed toward the liver, upper abdominal lymph nodes and the esophagogastric junction
- Fixation of either the stomach or jejunum to the anterior abdominal wall at the site of a previously placed feeding tube is addressed by separating these organs from the abdominal wall with electrocautery and repairing the defect in either the stomach or bowel
- Peritoneum overlying the esophagogastric junction is incised
- The distal esophagus is carefully mobilized and encircled with a rubber drain
- Mobilization of the stomach is performed by dividing the left gastric, left gastroepiploic, and short gastric vessels between the spleen and the stomach
- The right gastroepiploic and right gastric vascular arcades are carefully preserved
- Accessible upper abdominal lymph nodes (left gastric, celiac axis, esophagogastric junction) are resected for purpose of staging
- The second portion of the duodenum is carefully mobilized from its retroperitoneal location to facilitate the subsequent upward reach of the stomach
- A gastric drainage procedure (pyloromyotomy or pyloroplasty) is performed to avoid problems with gastric outlet obstruction after division of the vagus nerves which occurs during the esophagectomy
- A feeding jejunostomy tube is placed for postoperative nutritional support and is well secured to the bowel and anterior abdominal wall with sutures
- The operating table is rotated back to its original position, and with upward traction on the mobilized esophagus, the stomach is delivered through the hiatus and into the chest

- The esophagus is separated from the stomach using a surgical stapling device applied several cms distal to the esophagogastric junction
- The gastric staple suture line is oversewn with a running suture
- The maximum length to which the stomach will reach superiorly is carefully assessed
- The esophagus is divided with a stapler at a point as high as possible above the area of disease which will allow a tension free esophagogastric anastomosis
- The esophagus is removed from the field and submitted to pathology
- An intrathoracic esophagogastric anastomosis is constructed in two layers of interrupted 4-0 suture
- A nasogastric tube inserted by the anesthetist is carefully guided through the anastomosis and into the intrathoracic stomach for postoperative gastric decompression
- To minimize tension on the esophagogastric anastomosis, the stomach is suspended in the posterior mediastinum by placing several sutures between the adjacent mediastinal pleura and the gastric wall
- After a careful inspection for hemostasis, the chest is irrigated with saline
- A chest tube is inserted through a separate low interspace incision and is sutured to the skin; the tube is connected to a drainage system
- The ipsilateral lung is expanded
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated
- The operating table is rotated to the right to provide exposure to the abdomen
- Several sutures are placed between the stomach and the diaphragmatic hiatus to prevent subsequent intrathoracic herniation of bowel
- After a careful inspection for hemostasis the abdominal wound is closed in layers in the usual fashion

Post-op same day work through discharge from recovery:

- Sterile dressing are applied to the incisions
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Obtain and examine postoperative chest x-ray to assess expansion of the lungs and placement of the chest and nasogastric tubes
- Write orders for post-op labs, films, medications, diet, and patient activity
- Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Treat cardiac arrhythmias (in up to 20% of patients)
- Discuss patient progress with referring physician (verbal and written)

- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral and oral feedings
- Obtain and evaluate postoperative barium esophagogram to document anastomotic healing and satisfactory emptying of intrathoracic stomach
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.
Specialty(s): Society of Thoracic Surgeons

Sample Size: 115 Response Rate: (%): 23% Median RVW: 40.00

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Targeted Physicians

25th Percentile RVW: 35.00 75th Percentile RVW: 40.00 Low: 30.00 High: 50.00

Median Pre-Service Time: 110.00 Median Intra-Service Time: 410.00

25th Percentile Intra-Svc Time: 360.00 75th Percentile Intra-Svc Time: 600.00 Low: 180.00 High: 600.00

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>60.00</u>	
Critical Care:	<u>60</u>	<u>99291x1</u>
Other Hospital Visits:	<u>256</u>	<u>99231x6, 99232x2, 99233x2</u>
Discharge Day Mgmt.:	<u>45</u>	<u>99239x1</u>
Office Visits:	<u>61</u>	<u>99213x2, 99212x1</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small bowel reconstruction, including bowel mobilization, preparation, and anastomosis(es)	32.65

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 43117	<u>Reference Service</u> <u>1 CPT:</u> 43361
Median Pre-Time	55.00	55.00
Median Intra-Time	420.00	420.00
Median Immediate Post-service Time	60.00	60.00
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	256	
Median Discharge Day Management Time	45	
Median of Aggregate Office Visit Times	61	

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.44	4.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.33
Urgency of medical decision making	4.22	4.11

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	4.67
Physical effort required	4.67	4.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.78	4.89
Outcome depends on the skill and judgement of physician	4.89	4.56
Estimated risk of malpractice suit with poor outcome	4.22	4.56

INTENSITY/COMPLEXITY MEASURES

CPT Code

43117

Reference

Service 1

43361

Time Segments (Mean)

Pre-Service intensity/complexity	4.44	4.44
Intra-Service intensity/complexity	4.67	4.78
Post-Service intensity/complexity	4.67	4.78

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty STS 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 STS Frequency 559

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 STS Frequency 441

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 77.8% No 22.2%

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree 0.0% I do not agree 100.0%**
- b. **Patients requiring this service are now:
more complex (more work) 100.0% less complex (less work) 0.0% no change 0.0%**
- c. **The usual site-of-service has changed:
from outpatient to inpatient 0.0% from inpatient to outpatient 0.0% no change 100.0%**

CPT Code: 43122

Global : 090

Current RVW: 29.11
Recommended RVW:40.00

CPT Descriptor: Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastronomy, with or without pyloroplasty

Survey Vignette (Typical Patient)

A 72-year-old man is referred for esophageal resection and reconstruction. His history includes progressive dysphagia and a 3 cm long adenocarcinoma of the gastroesophageal junction that had been treated with radiation and chemotherapy. A percutaneous gastrostomy had previously been placed for nutritional support. Preoperatively, the surgeon reviews the laboratory and x-ray/imaging studies; evaluates operative risk, particularly from a cardiac and pulmonary standpoint; and communicates with and obtains informed consent from the patient and/or family. At operation, through a left thoracoabdominal incision, the distal esophagus and proximal stomach are mobilized, the previously performed gastrostomy closed, and a pyloroplasty performed. A feeding jejunostomy tube (separately billable/reportable) is inserted. The distal esophagus and proximal stomach containing the tumor are resected. Alimentary continuity is reestablished by mobilizing the stomach into the chest and performing an esophagogastric anastomosis just below the aortic arch. Drains are placed as necessary. Postoperative care of the patient includes monitoring of ventilator settings, hemodynamics, fluid balance, and chest thoracostomy drainage. The chest tube and neck drain are removed when appropriate. Oral feeding is resumed after return of bowel function the patient's diet is advanced, intravenous fluid is discontinued, and discharge plans are completed. The patient is discharged after he is afebrile, wound healing is satisfactory, and he is maintaining adequate nutrition with oral and/or jejunostomy tube feedings. Office visits are conducted as necessary through the 90-day global period to insure that no delayed gastrointestinal problem, wound complications, or infections occur, and to remove staples and sutures. *[Please note that physician work related to insertion/removal of the jejunostomy feeding tube is separately reportable/billable. Do not consider this work when completing the survey questions.]*

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Pre-operative work-up, including: History and physical examination; review of chest x-rays; review of CT scan and other staging studies (esophageal endoscopic ultrasonography-EUS; brain, bone, PET scans, barium esophagram, endoscopy report, etc.); review of laboratory results (CBC, electrolytes, renal and liver function); review of pathology biopsy results; and cardiology/pulmonary assessment as indicated
- Review planned incisions and procedure

Pre-service work – Day of surgery;

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Place bladder catheter
- Remove previously placed gastrostomy–jejunostomy feeding tube and suture skin opening closed
- Position patient in the right lateral decubitus position
- Place axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung
- Place padding and support beneath head/neck
- Place padding/pillows beneath and laterally around patient, particularly extremities, to prevent neuropraxia

- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work – Skin to skin:

- A left posterolateral thoracotomy is performed in the 6th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the 7th rib posteriorly to facilitate spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles of the 6th and 7th ribs)
- The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung
- Single lung ventilation of the contralateral lung is instituted to facilitate the mediastinal dissection
- The left lung and mediastinum are carefully palpated to assess the esophageal pathology and associated adenopathy and any unsuspected pulmonary nodules
- The inferior pulmonary ligament is divided with electrocautery and the lung retracted superiorly
- Lymph nodes contained within the inferior pulmonary ligament are resected and submitted to pathology
- The distal esophagus encircled with a rubber drain
- The tumor is palpated to assess its size and mobility
- Once resectability of the tumor has been determined a 1-2 cm rim of diaphragmatic hiatus muscle is resected in continuity with the esophagogastric junction using the electrocautery for hemostasis
- The thoracotomy skin incision is carried anteriorly across the costal arch and onto the anterior abdominal wall to the level of the left rectus muscle sheath
- The left costal arch is divided sharply, and hemostasis of the associated arteries beneath it obtained with interrupted suture ligatures
- With the ribs and costal arch retracted with the rib spreader, the diaphragm and contiguous abdominal wall musculature are incised with electrocautery in line with the skin incision, and the peritoneal cavity entered
- The abdomen is explored for metastatic disease, with particular attention directed toward the liver, upper abdominal lymph nodes and the esophagogastric junction
- Fixation of either the stomach or jejunum to the anterior abdominal wall at the site of the previously placed feeding tube is addressed by separating these organs from the abdominal wall with electrocautery and repairing the defect in either the stomach or bowel
- Mobilization of the stomach is performed by dividing the left gastric, left gastroepiploic, and short gastric vessels between the spleen and the stomach
- The right gastroepiploic and right gastric vascular arcades are carefully preserved
- Accessible upper abdominal lymph nodes (left gastric, celiac axis, esophagogastric junction) are resected for purpose of staging
- If possible, the second portion of the duodenum is carefully mobilized from its retroperitoneal location to facilitate the subsequent upward reach of the stomach
- A gastric drainage procedure (pyloromyotomy or pyloroplasty) is performed to avoid problems with gastric outlet obstruction after division of the vagus nerves which will accompany the esophagectomy
- A feeding jejunostomy tube is placed for postoperative nutritional support and is well secured to the bowel and anterior abdominal wall with sutures
- The thoracic esophagus is divided with a surgical stapler sufficiently high to achieve an adequate margin of resection above the tumor
- The lesser curvature of the stomach is cleaned of adjacent fat and vessels between clamps and ties
- The proximal stomach is divided with a surgical stapler and the distal esophagus, contained tumor, and proximal stomach removed from the field
- The gastric staple suture line is oversewn with an inverting running synthetic suture
- The mobilized stomach is drawn into the thorax, and alimentary continuity is reestablished by anastomosing the esophagus to the stomach in two layers of interrupted 4-0 suture
- A nasogastric tube is inserted by the anesthetist and carefully guided through the anastomosis by the surgeon for subsequent gastric decompression
- The intrathoracic stomach is suspended from the adjacent pleura with interrupted sutures to minimize tension on the anastomosis

- The edges of the diaphragmatic hiatus are sutured to the stomach to minimize the chance of subsequent herniation of intraabdominal viscera into the chest alongside the intrathoracic stomach
- The diaphragmatic incision is closed carefully with interrupted sutures reinforced with a "whip" stitch to minimize the chance of subsequent disruption
- The abdominal musculature is reapproximated in layers
- The previously divided costal arch is carefully aligned and reapproximated with heavy interrupted suture
- After a careful inspection for hemostasis, the chest is irrigated with saline
- A chest tube is placed through a separate low interspace incision and secured to the skin
- The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles
- The extrathoracic chest wall musculature is closed in layers with running suture
- Subcutaneous tissue and skin are approximated

Post-op same day work through discharge from recovery:

- Sterile dressing are applied to the incisions
- Dictate operative note for patient's chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Obtain and examine postoperative chest x-ray to assess expansion of the lungs and placement of the chest and nasogastric tubes
- Write orders for post-op labs, films, medications, diet, and patient activity
- Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Write and summarize orders for floor nurse
- Write discharge order unless done by anesthesiologist

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiography
- Treat cardiac arrhythmias (in up to 20% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral and oral feedings

- Obtain and evaluate postoperative barium esophagogram to document anastomotic healing and satisfactory emptying of intrathoracic stomach
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient, check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Keith Naunheim, MD
 Joseph Putnam, MD
 Charles Shoemaker, MD

Specialty(s): Society of Thoracic Surgeons
 American Society of General Surgeons
 American College of Surgeons

Sample Size: 54 **Response Rate:** 37 (68%) [general surgery 6 / thoracic surgery 31]

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	33.50	39.00	40.00	40.00	50.00
Pre-Service			105		
Intra-Service	160	240	310	360	420
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate Same Day	48				
Other Same Day	60	99291x1			
After Day of Surgery:					
Critical Care	60	99291x 1			
Other Hospital	207	99233x1; 99232x3; 99231x4			
Discharge Day Mgmt	40	99239			
Office Visits	99	99214x1; 99213x2; 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW	RUC Rec RVW
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	90	30.02	40.00

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	43122	43117
Count	37	34
Pre-service time	105	95
Intra-service time	310	360
Same Day Immediate Post-service time	48	60
Same Day Other Post-service time (*critical care)	45*	45*
Post Total critical care time (not same day)	45	45
Post Total other hospital visit time (not same day)	207	248
Discharge management time	40	40
Total office visit time	99	90

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.74	4.84
Intra-service	4.76	4.94
Post-service	4.71	4.77

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.62	4.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.76	4.77
Urgency of medical decision making	4.39	4.45

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.82	4.87
Physical effort required	4.79	4.97

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.94	5.00
Outcome depends on the skill and judgment of physician	4.91	4.90
Estimated risk of malpractice suit with poor outcome	4.24	4.19

ADDITIONAL RATIONALE

Additional discussion for the family of four esophagectomy codes. Note that CPT 43117 was previously reviewed by the RUC and is the primary reference for the other three surveyed codes.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty (transhiatal)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty

43117 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagostomy, with or without pyloroplasty (Ivor Lewis)

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagostomy, with or without pyloroplasty

Of the four surveyed esophagectomy codes, CPT 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including repositioning and redraping. The other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to CPT 43112, they each include a gastric drainage procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both CPT 43117 and CPT 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. CPT 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare. While CPT 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. A more detail discussion of the differences and similarities between these codes is presented in the attached article "Comparison of Three Techniques of Esophagectomy Within a Residency Training Program" (*Ann Thor Surg* 1994;57:319-325).

For this family of four "all inclusive" codes, there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. Given this course of thought and the discussion above, it is our opinion that the median RVWs for this family of codes ranks them correctly. We recommend the survey median RVW for each code: CPT 43107 (med RVW = 40.00); CPT 43112 (med RVW = 43.50); CPT 43117 (med RVW = 40.00); and CPT 43122 (med RVW = 40.00).

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: cardiothoracic surgery	Commonly	<u>Sometimes</u>	Rarely
Specialty: general surgery	Commonly	<u>Sometimes</u>	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.

Data not available.

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: cardiothoracic surgery	1999 Medicare Frequency:	154
Specialty: general surgery	1999 Medicare Frequency:	320

Do many physicians perform this service across the United States? Yes No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

1. Has the work of performing this service changed in the past 5 to 10 years?

- 27 Yes
- 8 No
- 2 no response

Surveyee Comments:

More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/Barretts adenocarcinoma) making the intraoperative work more complex.

2. Patients requiring this service are now:

- 29 more complex (more work)
- 0 less complex (less work)
- 6 no change
- 2 no response

Surveyee Comments:

Patients presenting with GEJ CA have more extensive disease due to failed attempts at more conservative treatment options. Seeing patients of advanced age returning for "re-do" operations. More preoperative studies to review. Multimodality treatment options make preoperative decision-making more complex. More ventilator and diagnostic tools and drugs may increase preoperative and postoperative work. More perioperative counseling is required due to neoadjuvant chemoradiation protocols. Prior chemoradiation treatment results in more tedious and difficult intraoperative work. Better anesthesia and new technology have led to patients of more advanced age and with more comorbidities presenting for surgery than previously. Patients of advanced age and previous surgeries and prior chemoradiation treatments for comorbid diseases present fragile and immunocompromised. Postoperative technology advances require more complex management of fluid and ventilator. Patients coming to surgery have been delayed with neoadjuvant therapies and may have more periesophageal fibrosis. Patients are more obese (have reflux/barretts adenocarcinoma) making the intraoperative work more complex.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Orthopaedic Surgery

The American Academy of Orthopaedic Surgeons (AAOS) brought 42 codes forward for the Five-Year review process. The survey results for twenty codes on the original list of 42 procedures did not justify a recommendation for an increase in the work value, therefore AAOS recommended that the current RVW be maintained. Of the 22 procedures that AAOS did recommend, all were recommendations for increases in the work value. The 22 procedures that AAOS recommended were grouped into 8 categories; Arthroscopy, Pediatric, Foot and Ankle, Upper Extremity, Orthopaedic Oncology, Fractures, and Fractures with Bone Graft. Summaries of the RUC recommendations, in which the full RUC survey was utilized for these procedures, are shown below.

- AAOS presented 2 Arthroscopy procedures, each of which the RUC recognized the additional work involved in comparison to its reference code. The RUC also justified the RVU increases using a building block methodology.
- AAOS presented 2 Pediatric procedures in which the RUC viewed as undervalued. The reevaluation of these two codes corrects rank order anomalies and accounts for the complexity of the procedures. The RUC believed the survey results reflected the complexity of the patient, physician time and work necessary in performing these procedures.
- AAOS presented 2 Foot and Ankle procedures. The RUC recognized that there were differences in one of the procedure's CPT descriptor that was never valued previously, and understood the reevaluation of the second code would correct a rank order anomaly. By reviewing past and present survey statistics, RUC members were able to justify the increase in one of the Foot and Ankle procedures brought forward.
- AAOS presented 2 Upper Extremity codes, each of which create rank order anomalies. The RUC recognized that by increasing the RVUs of these 2 procedures, specific rank order anomalies would be corrected, and could be justified by survey results.
- AAOS presented 10 Orthopaedic Oncology procedures, 7 of which were recommended back to CPT for descriptor changes, 1 procedure's recommendation corrected a rank order anomaly, and 2 procedure's recommendations reflected the complexity and physician work from the survey results.
- AAOS presented 3 Fracture procedures, each of which currently create rank order anomalies. The RUC recognized that by increasing the values for these 3 fracture procedures, specific rank order anomalies would be corrected and could be justified by survey results.
- AAOS presented 1 Fracture with Bone Graft procedure in which the RUC understood that the work of obtaining the bone graft had not been incorporated into the current RVU, and the survey results supported the RUC's action in recommending an increase in the RVU.

The RUC recognized that for all of the 22 codes that AAOS discussed during the Five-Year review, the survey results supported the arguments to correct rank order anomalies.

American Academy of Ophthalmology

The American Academy of Ophthalmology (AAO) brought seven codes to the Five-Year review for revision. Of the seven codes brought to this Five-Year review, the specialty society requested that the current RVU's be maintained for four of the codes and the work RVU of code 65855 be decreased, and the RUC concurred.

- The AAO requested and the RUC agreed, that code 65855 (Trabeculoplasty by laser surgery, one or more sessions) be changed from a 090 day global to a 010 day global. The AAO surveyed 50 glaucoma specialists and survey results indicated there are only two 99212 postoperative office visits, not three postoperative office visits, which occur in the first ten days after surgery. The AAO had previously requested the Health Care Financing Administration (HCFA) to change the global period of this code without success, and brought the issue to the Five-Year review so the RUC could make a formal recommendation for a change in the global period. The RUC recommended that the global period of code 65855 be changed from a 90 day global to a ten day global. To account for one less 99212 postoperative visit, the RUC subtracted the work RVU of 99212 (.45) from the existing work RVU of 4.30 to calculate a new RVU of 3.85 for CPT code 65855.
- The AAO presented codes 67218 (Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)) and 92018 (Ophthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete), and the RUC agreed to accept the recommended increases in RVUs. The RUC accepted the specialty's recommendation based on the survey results and the RVUs of the reference codes presented. Additionally, for code 92018, the specialty society agreed to seek clarification with CPT regarding the diagnostic procedures included in the service.
- The AAO also recommended, and the RUC agreed, to maintain the current work RVUs of codes 66180, 66986, 67028, and 67904 as no compelling evidence was presented by the specialty to recommend an increase in the RVUs.

American Urological Association

The American Urological Association (AUA) brought four codes forward for the Five-Year review process. The AUA utilized the full RUC survey for all codes presented, and believes that the total work value does not account for all of the in-hospital and office based post-operative care. The AUA also explained that the typical patient is now much more complex and requires more overall physician work than when these procedures were reviewed previously, however, supporting data was not provided by the specialty.

The RUC questioned AUA arguments for an increase in RVUs noting that from the survey's typical patient, description of work, and its results, there was no compelling evidence for recommending an increase for most of their codes. RUC members had a difficult time understanding why these procedures required more physician time and work, as the surveys did not contain supporting data. The RUC attempted to use a building block approach without success at reaching the median RVU from AUA's survey.

The RUC recommended no change for three of the four codes presented by AUA, as there was a lack of compelling evidence of a change. However, AUA presented compelling evidence to the RUC for code 50230 being undervalued when performed with vena caval thrombectomy. The RUC noted that the code descriptor for code 50230 includes the term “and/or vena caval thrombectomy. As this procedure may now be performed with the vena caval thrombectomy or without, the RUC agreed to refer this code back to CPT to separate out these two distinct services so each may be reported and valued appropriately.

American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) brought 29 codes forward for the Five-Year Review process. For these codes, the ACOG did not believe the work values accurately reflected the amount of physician work included in providing the service. For 17 of the 29 codes presented, a full RUC survey was utilized through ACOG’s database of members. Twelve additional codes were presented based on comparisons of other codes that presented anomalies, and previous RUC recommendations not recognized by HCFA.

Of the 17 codes presented with survey data; the RUC accepted 7 of the specialty’s recommendations to increase the RVUs, increased 9 other codes below the level recommended by the specialty, and the RUC maintained the existing RVU for one code for the lack of compelling evidence. The specialty provided building block approaches to most of these surveyed codes, which the RUC modified and used to justify any increase in the work values.

Of the 12 codes presented without survey data; the RUC accepted the specialty’s recommendation to increase the RVUs of 7 codes, increased 3 other codes below the specialties recommendation, and maintained one code at its current level. The specialty presented, and the RUC corrected, a variety of rank order anomalies, that were apparent in some of the family of codes. The RUC also reaffirmed previous RUC actions that were not recognized in the past by HCFA.

AMA/Specialty Society RVS Update Committee

RBRVS Five-Year Review

RUC Recommendations - Workgroup 5

CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
20205	Biopsy, muscle; deep	2.35	2.35	The AAOS believes that this code requires the same surgical approach and the same amount of work as 20005 Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated (RVU = to 3.42).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs to be clarified to capture the types of patients and size of deep muscle biopsy performed.	5
20245	Biopsy, bone, excisional; deep (eg, humerus, ischium, femur)	3.95	8.50	Code 20245 requires the same type of surgical approach and requires the same amount of work as 27607 Incision (eg, osteomyelitis or bone abscess), leg or ankle (RVU = to 7.97)	Compared to the reference service code 27635 (Excision or curettage of bone cyst or benign tumor, tibia or fibula) (7.78 RVW), code 20245 also requires the same amount of work in dissecting the soft tissues and opening the bone. However, code 20245 requires the surgeon to leave the operating room and take the specimen to pathology to review the frozen section slides. The RUC also noticed the current rank order anomaly with code 20240 (Biopsy, bone, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur) (3.23 RVW). The RUC and specialty recommended the 25th percentile of 8.50 RVUs to reflect the increase in work and correct the rank order anomaly.	1
21800	Closed treatment of rib fracture, uncomplicated, each	0.96	0.96	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	No compelling evidence was provided to suggest recommending an increase in the RVU. Therefore, the RUC recommends that the current RVU of 0.96 be maintained.	2
23076	Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular	7.63	7.63	Code 23076 requires a similar or more complicated approach and an equal amount of work and time when compared to 23450 Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation (RVU = 13.40).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. Therefore, the RUC agreed that this is a definitional problem that CPT should clarify.	5

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	16.92	21.10	The AAOS believes the current RVW presents a rank order anomaly, with hemiarthroplasty valued higher than the total shoulder procedure. The total should be nearly double the intra-service time of the hemiarthroplasty. The work of 23472 is equivalent to that of 23616, Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity; with proximal humeral prosthetic replacement (RVU = 21.27). The work of a total shoulder is also similar to that of a total hip arthroplasty (27130, RVW = 20.12) or a primary total knee arthroplasty (27447, RVW = 21.48) and should receive a similar RVW. AAOS believes that there was not appropriate weight given to the intensity of intra-service physician work nor with the comparison of this code with 27130.	The current RVW of code 23472 presents a rank order anomaly with code 23470 (Arthroplasty, glenohumeral joint; hemiarthroplasty) (17.15 RVW) as 23470 is valued higher than the total shoulder procedure (code 23472). To correct this anomaly, the RUC agreed upon the recommended RVU of 21.10 which appropriately reflects the extra work in replacing both components in the shoulder and corrects the rank order anomaly.	1
23485	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	13.43	13.43	The work of 23485 is equivalent to the work of 23480 (Osteotomy, clavicle, with or without internal fixation (RVW = 11.18)) plus that of 20902 (Bone graft, any donor area; major or large (RVW = 7.55)). Code 20902 is modifier -51 exempt and its value was not reduced.	The survey results for code 23485 did not justify a recommendation for an increase in the work RVU. Therefore, the RUC recommends that the current 2000 RVU of 13.43 be maintained as no compelling evidence was provided to recommend an increase in the RVU.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
23585	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation	8.96	8.96	The pre-surgical work of evaluating, planning, and positioning the patient for scapular fracture surgery (23585) is far more complex than for open treatment of proximal humerus fracture, code 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity; with proximal humeral prosthetic replacement (RVU = 21.27). The surgical exposure is similar in difficulty although the anatomical knowledge for 23585 is less frequently exposed and therefore, less familiar for 23616. The surgical hazards are quite similar, although the risk of intrathoracic injury is greater for fixation of scapular fractures. The reduction and fixation techniques required are at least as difficult if not more difficult for 23585 than 23616. Increasing knowledge of the outcome of these fractures have lead to more demanding surgery over the last 5 years.	The survey results for code 23585 did not justify a recommendation for an increase in the work RVU. Therefore, the RUC recommends that the current 2000 work RVU of 8.96 be maintained as no compelling evidence was provided to recommend an increase in the work RVU.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies);	9.35	9.35	The evaluation, planning, positioning and surgical exposure is virtually the same for these codes, 23615 and 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosities; with proximal humeral prosthetic replacement (RVU = 21.27). The reduction and fixation techniques required of 23615 are at least as demanding of time, skill and technical perfection as the demands of 23616 for the majority of cases, although some cases are easier. New fixation devices developed over the last five years have increased the complexity of decision making and the number of skills that one must have mastery of to undertake 23615. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review. The AAOS believes there was not appropriate weight given to the intensity of intra-service physician work and the comparison of this code with its reference service code of 23616.	The survey results for code 23615 did not justify a recommendation for an increase in the work RVU. Due to the lack of compelling evidence, the RUC recommends that the current 2000 work RVU of 9.35 be maintained.	2
23630	Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation	7.35	7.35	Code 23630 represents both an acute rupture of the rotator cuff plus an avulsion fracture of the humerus.	The survey results for code 23630 did not justify a recommendation for an increase in the work RVU. Therefore, without compelling evidence, the RUC recommends that the current 2000 work RVU of 7.35 be maintained.	2
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation	10.06	10.06	Code 23680 represents the treatment of a dislocation (23660 Open treatment of acute shoulder dislocation (RVU = 7.49)) and a fracture (23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(ies) (RVU = 9.35). Utilizing the multiple procedure rules, the recommended RVW is equal to that of 23615 plus half that of 23660.	The survey results for code 23680 did not justify a recommendation for an increase in the work RVU. Therefore, with a lack of compelling evidence to recommend an increase, the RUC recommends that the current 2000 work RVU of 10.06 be maintained.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
24076	Excision, tumor, upper arm or elbow area; deep, subfascial or intramuscular	6.30	6.30	Code 24076 utilizes the same surgical approach and requires a similar amount of work and time when compared to 24301 Muscle or tendon transfer, any type, upper arm or elbow; single (RVU = 10.20).	The RUC agreed to refer this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	13.17	13.17	The work of 24435 is equivalent to the work of 24430 (Repair of nonunion or malunion, humerus; without graft (eg, compression technique (RVW = 12.81)) plus that of 20902(Bone graft, any donor area; major or large) (RVW = 7.55)). Code 20902 is modifier -51 exempt and its value is not reduced. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review. The AAOS believes the current rationale and reference service relationship warrants an increase in RVW.	The survey results for code 24435 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 13.17 be maintained.	2
24545	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension	10.46	10.46	The operative reduction and post-operative care are more difficult for 24545 than for 24515 Open treatment of humeral shaft fracture with plate/screws, with or without cerclage (RVU = 11.65). Code 24545 involves application of two plates (instead of one as for 24515) in two planes ninety degrees to each other, as well as mobilization of the ulnar nerve.	The survey results for code 24545 did not justify a recommendation for an increase in the work RVU. Therefore, as there was a lack of compelling evidence, the RUC recommends that the current 2000 work RVU of 10.46 be maintained.	2
25076	Excision, tumor, forearm and/or wrist area; deep, subfascial or intramuscular	4.92	4.92	Code 25076 requires the same surgical approach and involves the same amount of work as 25023 Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve) (RVW = 12.96).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs clarification to capture these kinds of patients and the work being performed.	5

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
26562	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)	9.68	15.00	Currently, 26561 Repair of syndactyly (web finger), each web space; with skin flaps and grafts (RVU = 10.92) has a higher RVW than 26562, which is a rank order anomaly. The physician work for 26562 represents a significant increase in work over 26561.	Currently, code 26561 (Repair of syndactyly (web finger) each web space; with skin flaps and grafts) (RVU = 10.92) has a higher RVU than code 26562 (RVU = 9.68) which creates a rank order anomaly. The work of performing code 26562 includes the work of 26561 plus the work described by 26562. To account for the increase in work between the two codes, the RUC added an increment of 4 RVUs to the current RVU of code 26562 (9.68) which corrects the rank order anomaly. Therefore, the RUC recommends an RVU of 15.00 for code 26562.	1
27048	Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular	6.25	6.25	Code 27048 involves similar surgical approach but usually involves more work and more time than 27030 Arthrotomy, hip, with drainage (eg, infection) (RVW = 13.01).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs clarification to capture these kinds of patients and the work being performed.	5
27075	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis	17.23	35.00	Code 27075 requires a much larger incision, more dissection and as much work and time as 27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft (RVU = 28.52).	The RUC noted that this service is a major operation, as it requires extensive dissection to resect tumors that are very large. The RUC compared this service to the reference service code 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft) (work RVU = 28.52) and noted that the intraservice time was an additional 60 minutes for code 27075. Upon review, the RUC agreed that 27075 more closely reflected the time and work of a pelvic exenteration code (RVU 38.39). The RUC agreed that the survey median of 35.00 RVUs was appropriate for CPT code 27075.	1
27077	Radical resection of tumor or infection; innominate bone, total	23.13	40.00	Code 27077 requires an incision three times longer and involves much more work and time than 27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft (RVU = 28.52),	The RUC noted that this service is a major operation as a 4 foot long incision is made which requires extensive dissection to resect tumors the size of approximately a basketball. The RUC compared this service to the reference service code 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft) (work RVU = 28.52) and noted that the intraservice time was an additional 120 minutes for code 27077. Compared to 27075, this code 27077 requires additional intraservice work as it is the full resection of the pelvis as opposed to a partial resection of the pelvis. Therefore, the RUC agreed that the survey median RVU of 40.00 was appropriate for CPT code 27077.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27216	Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)	15.19	15.19	Although percutaneous, 27216 is truly stereotactic, involving first a reduction of whatever pelvic deformity might be present, and then insertion of one or more screws into a very small safe region of the sacrum, in close proximity to major nerves, arteries, and veins. This code requires extensive pre-operative evaluation of x-rays and CT scans in critically injured patients. This procedure is a rare emergency procedure that requires special training and experience with interpretation of anatomic variations, and stressful complicated interpretation of intraoperative fluoroscopic images. This procedure typically takes two or three times as long as 27245 (Open treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage (RVW = 20.31)), a familiar, frequent procedure using a standard fracture table for reduction, and post-operative care is far more involved than 27245.	The survey results for code 27216 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 15.19 be maintained.	2
27217	Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami)	14.11	14.11	The evaluation, planning, and positioning for these two procedures are very much the same; the surgical exposures have the similar levels of complexity, since the exposure for 27217 consists of essentially the medial 2/3 of the exposure for 27227 (Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation (RVW = 23.45). They require similar times, and have similar risks.	The survey results for code 27217 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 14.11 be maintained.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	20.15	20.15	The evaluation, planning and positioning for 27218 is very similar to 27227 (Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation (RVW = 23.45)) when done through a posterior approach. The complexity, time requirement, and difficulty of reduction and fixation are quite similar. The surgical risks of 27218 in many cases are greater than 27227 because of the proximity of sacral nerve roots and hazards to soft tissues.	The survey results for code 27218 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 20.15 be maintained.	2
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	14.91	14.91	The evaluation, planning and positioning for these two codes are virtually identical. The surgical exposures and reduction techniques are quite similar, although it is sometimes less extensive for 27226. The difficulty of fixation methods and complexity is higher in 27226, because of the problem of stabilizing small or comminuted wall fragments and the risk of intra-articular hardware penetration is higher.	The survey results for code 27226 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 14.91 be maintained.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (direct fracture exposure)	15.60	15.60	Evaluation, planning, and positioning is essentially the same for these two codes, although it is easier for 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft (RVW = 20.12)), because it is an elective procedure and more time is available. Surgical exposures are the same, time requirements and complexity are the same. The treatment of fracture is more difficult than the elective arthroplasty because of the emergent nature of the surgery and because of the damaged tissues - hemorrhagic, swollen, and traumatized tissues make for more difficult surgery. Internal fixation is more difficult than replacement because of the necessity of preserving soft tissue and vascular attachments.	The survey results for code 27236 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 15.60 be maintained.	2
27280	Arthrodesis, sacroiliac joint (including obtaining graft)	13.39	13.39	The exposure for 27280 is similar to that required for a single level lumbar spine fusion (22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique (RVU = 21.00)), since right and left posterior spinal elements are immediately adjacent to each other, and the sacroiliac joint is more difficult to expose and debride. Code 27280 includes obtaining bone graft (20902, RVW = 7.55) and internal fixation, most commonly performed with percutaneously inserted iliosacral screws (27216). Thus, the current RVW of 13.39 is egregiously undervalued.	The survey results for code 27280 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 13.39 be maintained.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27282	Arthrodesis, symphysis pubis (including obtaining graft)	11.34	11.34	Code 27282 includes all the procedures performed in the reference service (27217 Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami (RVW = 14.11)) with the addition of resection of the joint surfaces and obtaining and inserting the bone graft. Fixation is more difficult than that for the typical symphyseal separation, requiring more extensive and risky exposure and fixation to the poor-quality bone of the superior pubic rami.	The survey results for code 27282 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 11.34 be maintained.	2
27284	Arthrodesis, hip joint (including obtaining graft);	16.76	23.45	The surgical exposure and the procedure of 27284 represent virtually identical work to 27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft (RVW = 20.12). There is also not sufficient credit given for the work of obtaining the bone graft. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review. The AAOS believes there was not appropriate weight given to the intensity of intra and post service physician work nor with the comparison of this code to 27130.	The RUC agreed that code 27284 is very similar in intensity and complexity to reference service code 27227 (Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation) (23.45 RVU). The pre, intra- and post-service times are identical to code 27227, therefore, the RUC supported valuing code 27284 at the same work relative value of 23.45. This recommended RVU avoids a rank order anomaly within the family of codes. However, the RUC also recognized that by increasing this value to 23.45, it would create a rank order anomaly with code 27286 (Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy) (16.79 RVW). Therefore, the RUC recommends increasing the RVUs for both codes 27284 and 27286 to 23.45.	4
27328	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular	5.57	5.57	Code 27328 requires the same amount of work and time when compared to code 27334 Arthrotomy, with synovectomy, knee; anterior OR posterior (RVW = 8.70).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	17.72	17.72	The work of 27472 is equivalent to the work of 27470 (Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft) (RVW = 16.07)) plus that of 20902 (Bone graft, any donor area, major or large (RVW 7.55)). Code 20902 is modifier - 51 exempt, and its value is not reduced.	The survey results for code 27472 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 17.72 be maintained.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation	17.92	17.92	Code 27513 represents an extended exposure, extended fixation and increased post-operative care when compared to 27514 (Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation (RVW = 17.30)). Code 27513 was introduced in 1992 and was never surveyed during the original Harvard study. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review based upon an increase given during a 1992 refinement. That refinement was not based upon survey data. The AAOS 1995 survey suggested an increase to be appropriate.	The survey results for code 27513 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 17.92 be maintained.	2
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	15.65	15.65	Compared to 27535 (Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (RVW = 11.50)), code 27536 has significantly increased intra-operative time, the soft tissue injury is always greater, and the hospital length of stay and post-operative course is longer. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review based upon an increase given during a 1992 refinement. That refinement was not based upon survey data. The AAOS 1995 surveys suggested an increase to be appropriate.	The survey results for code 27536 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 15.65 be maintained.	2
27590	Amputation, thigh, through femur, any level;	12.03	12.03	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	The survey results for code 27590 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 12.03 be maintained.	2
27619	Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)	8.40	8.40	Code 27619 involves a more complicated surgical approach, more potential direction of nerves and vessels and a similar amount of work when compared to 27654 Repair, secondary, Achilles tendon, with or without graft (RVU = 10.02).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	14.99	18.20	The work of 27724 is equivalent to the work of 27720 (Repair of nonunion or malunion, tibia (RVW = 11.79) plus that of 20902 (Bone graft, any donor area; major or large) (RVW = 7.55) Code 20902 is modifier -51 exempt, and its value is not reduced. The RUC rejected the AAOS recommendation for an increase in RVW during the first five-year review. Instead, it recommended a more modest increase based upon a rationale that AAOS now believes to be erroneous.	At the last 5 year review, the total work of obtaining a graft was not incorporated in the recommended RVU. Code 27724 includes obtaining the graft as there is no code reported separately for this service. Therefore, the RUC supports adding the incremental work of obtaining a graft (CPT code 20902 Bone graft, any donor area; minor or small (eg, dowel or button)) (7.55 RVW) to arrive at a recommendation of 18.20 RVWs for CPT code 27724. The recommended RVU now accurately reflects the work in obtaining the graft plus the physician work described by code 27724.	1
27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip	9.20	11.00	The physician work involved in the open treatment of a bimalleolar or trimalleolar fracture is essentially equivalent, if not somewhat greater for 27822. The pre and post service work for the two procedures is similar. The reference service code is 27814 Open treatment of bimalleolar ankle fracture, with or without internal or external fixation (RVW = 10.68).	The survey results indicate increased work for code 27822, as the typical patient has internal fixation with repair of both the medial and lateral malleolus performed. The RUC also noted that a rank order anomaly exists between codes 27822 and 27814 (Open treatment of bimalleolar ankle fracture, with or without internal or external fixation) (10.68 RVW). Although the surgeon's work is similar, the intensity is greater for 27822. Therefore, the RUC recommends a RVU of 11.00 for CPT code 27822, which is also the survey 25th percentile RVW. This recommended increase for code 27822 is slightly greater than the RVU for code 27814, correcting the existing rank order anomaly.	1
27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip	11.80	13.00	The proposed increased RVW for 27823 would maintain the current 2.6 RVWS spread between 27823 and 27822, thus avoiding an anomaly in this family of codes.	The RUC compared code 27823 to code 27822 (Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip) (9.20 RVU) and noted there is an additional 30 minutes of intra-operative time for code 27823. This accounts for the extra work of the fixation of the posterior lip. The typical patient has internal fixation with repair of both the medial and lateral malleolus, plus fixation of the posterior lip where one extra threaded screw is placed. The RUC recognized that increasing the RVU of this code to 13.00 avoids a rank order anomaly with 27822 and appropriately reflects the increased work between codes 27822 and 27823.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula	16.23	16.23	The work of 27828 is equivalent to the work of 27827 (Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only (RVW = 14.06)) plus that of 27792 (Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation (RVW = 7.66)). Furthermore, this code was never surveyed in the original Harvard study. Code 27828 was reviewed in the first five-year review, and the AAOS recommended a new RVW of 18.00. This recommendation was rejected by the RUC based upon an increase given during a 1992 refinement. That refinement was not based upon survey data. The AAOS believes the 1995 RVW to be correct, with the addition of approximately 1.00 RVW to account for the increase for E/M services in the post-operative period.	The survey results for code 27828 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 16.23 be maintained.	2
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)	8.88	9.18	Hallux valgus surgery continues to evolve with the development of combined osseous and soft tissue procedures. In current practice, code 28299 typically represents a combined osteotomy of the first metatarsal (28296 Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures) (RVU = 9.18)) and an osteotomy of the proximal phalanx (28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure) (RVU = 5.43). Applying the multiple procedure rule, the appropriate RVU for 28299 would be the full value of 28296 plus half the value of 28310.	The RUC acknowledged that in the descriptor of this code, the terminology "double osteotomy" did not describe the typical patient when this code was surveyed in the original Harvard study, and therefore the value for code 28299 did not include the work of a "double osteotomy". The workgroup compared this code to the reference service code 28296 (Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedure) (9.18 RVW). The RUC agreed that even though there was more intraoperative work (time and intensity) for the second osteotomy, a value equal to 28296 of 9.18 would be appropriate with the understanding that the code be sent to CPT to create language that would define the code as a double osteotomy as opposed to "by other methods."	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	8.34	8.34	The work of 28322 is equivalent to the work of 28485 (Open treatment of metatarsal fracture, with or without internal or external fixation, each) (RVW = 5.71) plus that of 20902 (Bone graft, any donor area; major or large) (RVW = 7.55). Code 20902 is modifier -51 exempt and its value is not reduced.	The survey results for code 28322 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 8.34 be maintained.	2
28420	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)	16.64	16.64	The work of 28420 is equivalent to the work of 28415 (Open treatment of calcaneal fracture, with or without internal or external fixation) (RVW = 15.97) plus that of 20902 (Bone graft, any donor area; major or large) (RVW = 7.55). Code 20902 is modifier -51 exempt and its value is not decreased.	The survey results for code 28420 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 16.64 be maintained.	2
28445	Open treatment of talus fracture, with or without internal or external fixation	9.33	15.62	The pre- and post-service work is similar for open reduction and internal fixation of a talus or calcaneus fracture. The intra-service work, including the surgical exposure and requirement for an anatomic reduction, is similar for the two procedures. An increase of the RVW to 15.97, equal to the calcaneus fracture is felt to be more accurate representation of the physician work involved. The reference service code is 28415 Open treatment of calcaneal fracture, with or without internal or external fixation (RVW = 15.97).	During the last 5 year review, code 28415 (Open treatment of calcaneal fracture, with or without internal or external fixation;) (15.97 RVW) was increased creating a rank order anomaly with code 28445. After reviewing the survey results for 28445, the RUC agreed that the service was very similar in work to the reference code 28415. The RUC recommended the 25th percentile of 15.62 to correct the rank order anomaly and appropriately reflect the work performed by code 28445.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
28705	Arthrodesis; pantalar	15.21	18.80	A pantalar arthrodesis is the combination of an ankle fusion and a triple arthrodesis. Therefore, the work of 28705 is equivalent to the work of 27870 Arthrodesis, ankle, any method (RVU = 13.91) plus that of 28715 Arthrodesis; triple (RVU = 13.10). Applying the multiple procedure rules, the proposed RVW for 28705 is equal to the RVW of 27870 plus one half of the RVW of 28715.	When reviewing the survey results, the workgroup noted that the value of code 28705 did not accurately reflect the work of two distinct services of performing an ankle fusion and triple arthrodesis. Recognizing that this code was undervalued, the RUC took the reference service code 27870 (Arthrodesis, ankle, any method) (RVU = 13.91) and added 4 work units for the additional intraservice work (60 minutes * .065 IWPUT) and then added 1 RVU for one additional postoperative office visit (CPT code 99214). This calculation was used to provide support to the workgroup's final recommendation of 18.80 for code 28705. The RUC used a building block approach three different ways, using different IWPUTs and different postoperative visit levels to arrive at an agreed upon RVU of 18.80.	4
29450	Application of clubfoot cast with molding or manipulation, long or short leg	1.02	2.08	Code 29450 represents significantly more work than 29445 Application of rigid total contact leg cast (RVU = 1.78). Code 29450 includes manipulation of clubfoot for an extended period, temperature-controlled cast application and molding, and temperature-controlled cast removal to prevent burns of delicate neonatal skin.	When reviewing the survey results, the RUC noted that there is increased intraservice time which is a result of manipulating the foot of the patient. When the RUC compared this code to the reference service code 29445 (Application of rigid total contact leg cast) (1.78 RVW), it recognized that code 29450 has greater intensity in that care has to be taken with the temperature of the application of the cast to protect the delicate skin of the patient. Due to the increased work of manipulating the clubfoot and the temperature controlled cast- application and removal by the physician to prevent burning the delicate neonatal skin, the RUC agreed that a RVU of 2.08 was appropriate for code 29450.	1
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	9.46	11.05	The pre and post service work for the two procedures is the same; however the intra-service work for 29883 is approximately double that of 29882 Arthroscopy, knee, surgical; with meniscus repair (Medial or lateral) (RVU = 8.65)	The RUC noted that this code consists of two procedures, medial AND lateral meniscus repair. The RUC noted that code 29883 encompassed the service described by code 29882 (Arthroscopy, knee, surgical; with meniscus repair (medial or lateral)) (8.65 RVW), plus the additional work of the lateral meniscus repair. The RUC noted that the survey results reflected a significant difference in the intraservice time (an additional 40 minutes for code 29883) between the two procedures. The RUC also justified their recommendation by using a building block approach outlined by the presenters. Therefore, the RUC recommends an RVU of 11.05 for code 29883.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	15.13	16.00	The AAOS and AANA believe that this code is undervalued relative to the physician work required to perform the service. Specifically, there is more pre-service time for 29889 in that additional positioning must be done for the "well leg" and positioning must be confirmed for the operated leg with an intra-operative fluoroscopic C-arm. The intra-service work is significantly greater for 29889, as an additional posterior medial incision is necessary for posterior dissection, protection of neuro-vascular structures, handling instruments posterior to the tibia and manipulating and passing the ligament graft. The post-service work is significantly greater for 29889 as there is an additional post-operative day as compared to 29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction (RVW = 13.90). Furthermore, code 29889 requires a more careful monitoring of the post operative physical therapy regimen to prevent stretching of the reconstructed posterior cruciate ligament.	The survey results indicated there was increased pre and intraservice work in performing a posterior repair versus an anterior repair as described by the reference service code 29888 (Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction) (13.90 RVW). The additional work for posterior repair includes making 2 drill holes in the femur which increases the difficulty of the procedure, versus 1 drill hole which is performed for an anterior repair as described by code 29889. The workgroup noted that there is an additional 30 minutes of intraservice time for code 29889 and additional 30 minutes of preoperative time which accounts for positioning the c-arm and assuring you have the correct anatomical location. Due to the increase in post and intraservice work, the RUC agreed that the 25th percentile RVU of 16.00 was appropriate for CPT code 29889.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	12.38	12.38	Code 38571 is identical to 38770 (Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)) (RVW - 13.23) except that it is a bilateral procedure. As a laparoscopic procedure, code 38571 requires more time in the pre-service period than 38770 because the physician must ensure availability and correct functioning of the wide array of laparoscopic equipment. The Intra-service work for 38571 is at least twice as great as for 38770 because it is a bilateral procedure. In addition, the surgeon must operate without the direct, three-dimensional view of the operative site and the tactile sense available for an open procedure, so the laparoscopic procedure is lengthier and demands a higher level of technical skill. The post service work may be somewhat less for 38571 due to a shorter hospital stay, quicker recovery, and a shorter global period.	It was noted by the RUC that this procedure was most commonly performed by Urologists (94%) who did not participate in the survey. The RUC agreed that it was inappropriate to review this code and supported maintaining the current value of 12.38 RVUs as no compelling evidence was provided to support recommending an increase in the RVU.	2
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	14.32	16.59	Code 38572 includes all services as in 38571, but also includes peri-aortic lymph node sampling. The work of the peri-aortic lymph node sampling is equivalent to half of the difference between 38770-50 (19.83 RVW's) and 38780 (Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic and renal nodes (separate procedure) (RVW = 26.59), or 3.33 RVW's.	The RUC agreed that the value of the code should be the same as code 38780 (Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure), as the work of the lymphadenectomy is the same, however, because of the laparoscopic technology, there is increased intraservice physician time due to the greater technical demands of the laparoscopic technique. The RUC accepted a 16.59 RVU which is the 25th percentile. This action aligns the code relative to the physician work RVU of other laparoscopic codes. Therefore, the RUC recommends an RVU of 16.59 for code 38572.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	16.59	16.59	The AUA believes that the total work value does not account for all of the in-hospital and out-of-hospital post-operative care.	<p>The RUC compared the survey results and noted that intraservice work has not changed and was properly valued, however the RUC noted that the postoperative work was not captured correctly in the first survey. The RUC also noted that the frequency data appears to suggest that this procedure is performed more frequently by OB/GYN, however OB/GYN did not participate or comment in the survey. The RUC compared this code to 43108 (Total or near total esophagectomy, without thoracotomy; with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)), which was considerably more work and valued at 34.19 RVUs.</p> <p>The RUC decided that for this recommended increase in RVU to be compelling, there needed to be consensus among the majority of specialties who provide this service that the work has indeed increased. However, as this code was only surveyed by AUA, the RUC agreed that this undermines the compelling nature of the survey results to increase the RVU. The RUC recommends that the current RVU of 16.59 be maintained and that this code be could be referred back to CPT by the specialty to describe work performed for testicular cancer.</p>	2
50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	22.07	22.07	The AUA believes that the total work value does not account for all of the in-hospital and out-of-hospital post-operative care.	The RUC noted that the code descriptor for code 50230 includes the term "and/or vena caval thrombectomy." As this procedure may now be performed with the vena caval thrombectomy or without, the RUC referred this code back to CPT. The RUC suggested that this code should be separated into three distinct services (1) radical nephrectomy with vena caval thrombectomy; (2) radical nephrectomy with renal vein thrombus and (3) radical nephrectomy, so that each service may be reported and valued appropriately.	5
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	37.14	37.14	The AUA believes that the total work value for this code does not account for all of the in-hospital and out-of-hospital post-operative care.	The RUC reviewed the survey results and agreed that there was no compelling evidence presented to suggest a recommended increase in the RVU. The RUC indicated that by accepting an increase in the RVUs of this code could cause a rank order anomaly between codes 51590 (Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis;) (32.66 RVW) and 51595. The workgroup recommended that the current RVU be maintained at 37.14 RVUs.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
51596	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large bowel to construct neobladder	39.52	39.52	The AUA believes that the total work value does not account for all of the in-hospital and out-of-hospital post-operative care.	The RUC reviewed the survey results and agreed that no compelling evidence was presented to suggest a recommended increase in the RVU. The RUC indicated that by accepting an increase in the RVUs of this code could cause a rank order anomaly between codes 51590 (Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis;) (32.66 RVW) and 51596. The RUC recommended that the current RVU be maintained at 39.52 RVUs.	2
56515	Destruction of lesion(s), vulva; extensive, any method	1.88	2.76	Code 56515 is similar to CPT code 54065 (Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagium, herpetic vesicle), extensive, any method) (RVW = 2.42). However, code 56515 requires more post-operative work. Women who have had vulvar lesions destroyed typically experience more severe pain and are at greater risk of infection and breakdown of sutures than men who have undergone destructions of lesions of the penis. Physician management of infection and pain control medication for 56515 typically require one more post-operative visit than 54065. The ACOG urges HCFA to increase the work RVU's for CPT code 56515 to 3.09. The additional 0.63 RVU's compared to 54065 is equivalent to the work of a 99213 office visit.	The RUC agreed that the survey results presented little compelling evidence to suggest recommending the surveyed median RVU of 3.625, as the pre service and intra service time seemed excessive and the procedure's intensity was low. The workgroup however understood that this code had never been surveyed and the only data currently available was from the Harvard studies. The RUC compared this code to 46924 (Destruction of lesions on the anus) (2.76 RVW) and noted both codes had similar work and intraservice time. Therefore, the RUC agreed that the code should be valued the same as 46924 as both codes had comparable work and intraservice time. The RUC recommends an RVU of 2.76.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
56740	Excision of Bartholin's gland or cyst	3.76	4.57	Excision of a Bartholin's gland or cyst can be compared to CPT code 11771 (Excision of pilonidal cyst or sinus; extensive) (RVW = 5.74). Both procedures require deep, careful dissection to identify and remove the cyst. Postoperative care is also similar. The ACOG recommends that HCFA increase the work RVU's for 56740 to 5.74 because the physician work is equivalent to CPT code 11771.	<p>The RUC noted that the survey results lacked compelling evidence to suggest increasing the RVU to the surveyed median RVU of 5.74, as the preservice time seemed excessive. The RUC however understood that this code had never been surveyed, and the only data currently available was from the Harvard studies. The RUC compared this code to 11771 (Excision of pilonidal cyst or sinus; extensive) (5.74 RVW) and used a modified building block approach, similar to ACOG's approach, to recommend 4.57 RVUs.</p> <p>The building block approach was calculated in the following manner: For pre service work they took the discounted RVU of a 99213 visit of .65 RVUs. Added the result of a IWPUT of .03 multiplied by the intraservice time of 45 minutes resulting in 1.35 RVUs. For the immediate post service 99231 visit, .64 RVUs were added For the hospital discharge day management code of 99238, 1.28 RVUs were added For post service work another discounted 99213 RVU of .65 was added</p> <p>$.65+1.35+.64+1.28+.65 = 4.57$</p> <p>The RUC recommends an RVU of 4.57 for code 56740.</p>	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
57100	Biopsy of vaginal mucosa; simple (separate procedure)	0.97	1.20	CPT code 57100 is comparable to CPT code 54100 (Biopsy of penis; (separate procedure)) (RVW = 1.90). Both procedures are limited biopsies performed under local anesthesia. Intra-service work for the vaginal biopsy is actually more difficult and time-consuming because specialized instrumentation is needed to visualize and access the biopsy site. ACOG urges HCFA to correct this example of gender bias in the RBRVS by increasing the work RVU's for CPT code 57100 to 1.90. The physician work associated with performing a biopsy of the vaginal mucosa is at least as great as the work required to perform a biopsy of the penis.	The RUC agreed that the survey results accurately reflected the amount of time and physician work involved in this code. They also applied a building block approach to justify the surveyed 25th percentile society recommendation of 1.20 RVUs. The RUC supported the society's recommendation of 1.20 RVUs.	1
57130	Excision of vaginal septum	2.43	2.43	Excision of a vaginal septum is most comparable to CPT code 45150 Division of stricture of rectum (RVW = 5.67). The time and technical skill required to visualize, access and excise the abnormal tissue from either the rectum or the vagina are equivalent. The ACOG recommends that HCFA increase the work RVU's for 57130 to 5.67 RVU's.	The RUC agreed that no compelling evidence was presented to suggest a recommendation in the increase in RVU for code 57130. Therefore, the RUC recommends that the current RVU of 2.43 be maintained for code 57130.	2
57292	Construction of artificial vagina; with graft	13.09	13.09	The AAP believes that the relative work in performing this service in children is markedly increased because of the necessity of anesthesia, and the physician needs knowledge, training and experience with children and the diseases that affect them specifically.	The RUC agreed that no compelling evidence was presented to suggest a recommendation in the increase in the RVU of code 57292. Therefore, the RUC recommends that the current RVU of 13.09 be maintained for code 57292.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	15.93	15.93	CPT code 57307 represents the combination of CPT code 57305 Closure of rectovaginal fistula; abdominal approach (RVW = 13.77) and code 44320 Colostomy or skin level cecostomy; (separate procedure) (RVW = 12.94). Application of multiple procedure payment rules to 57305 and 44320 yields RVU's of 20.24 based on 2000 RVU's. Therefore, ACOG recommends that HCFA increase work RVU's for 57307 to 20.24 RVU's.	The RUC recommended no change to the current RVU of 15.93 as no compelling evidence was provided to suggest a recommended increase in RVUs. The RUC members noted that this code had a very low frequency and were concerned that general surgery who performs this service 100% of the time, did not comment or survey. The presenters did not perform a survey for this code, but simply presented a building block approach, which the RUC agreed did not provide enough compelling evidence to increase the RVUs. Therefore, the RUC agreed to maintain the current RVU of 15.93 for code 57307.	2
57505	Endocervical curettage (not done as part of a dilation and curettage)	1.14	1.14	The physician work required to perform an endocervical curettage is no greater than the work associated with code 57500 Biopsy, single or multiple, or local excision or lesion, with or without fulguration (separate procedure) (RVW = 0.97). The time, technical skill and stress are equivalent. The ACOG recommends that HCFA decrease the work RVU's for CPT code 57500 to 0.97.	The RUC agreed that no compelling evidence was provided to suggest recommending an increase in the RVU. Therefore, the RUC agreed to maintain the current RVU of 1.14 for code 57505.	2
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	15.24	15.24	The ASGS believes that this code is undervalued relative to the physician work required to perform this service.	The RUC agreed that no compelling evidence was provided to suggest a recommendation in the increase in work RVU. Therefore, the RUC recommends that the current RVU of 15.24 be maintained for code 58150.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocytopexy (eg, Marshall-Marchetti-Krantz, Burch)	15.09	20.60	This procedure combines 58150 (Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)) (RVW = 15.24) and 51840 (Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple) (RVW = 10.71) or 51841 (Anterior vesicourethropexy or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair) (RVW = 13.03) However, the RVU's assigned to 58152 are less than the RVUs for 58150 performed alone. The ACOG recommends that HCFA increase the physician work RVU's for 58152 to at least the level yielded by the application of multiple procedure payment rules to the combination of CPT 58150 and 51840, which yields 20.60 RVU's.	The RUC accepted the specialties rationale for an increase in the work RVU based on evidence that the procedure combines the work of code 58150 (Total abdominal hysterectomy (copus and cervix), with or without removal of tube(s), with or without removal of ovary(s) - 15.24 RVUs) and 518840 (Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple - 10.71 RVUs). The RUC recognized that the RVUs assigned to 58152 are less than the RVUs for 58150 performed alone. The RUC recommended an increase in the RVU of 58152 to 20.60 RVUs.	1
58260	Vaginal hysterectomy;	12.20	12.98	Code 58260 is most comparable to CPT code 58550 (Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy) (RVW = 14.19). Intraservice work associated with 58260 is less because no laparoscopy is performed. However, 58260 typically includes three postoperative office visits within its 90-day global period, while 58550 only includes one office visit because it has been assigned a 10-day global period. The ACOG recommends that HCFA increase work RVU's for 58260 to 12.98. This reflects subtraction of half of the work of CPT code 49320 (Laparoscopy, surgical, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (RVW = 5.10) from the 14.19 RVU's assigned to 58550 and addition of 1.34 RVU's to reflect the work of two additional office visits.	The RUC made their recommendation with the understanding that when this code was surveyed the respondents most frequently chose code 58150 (Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)) (work RVW 15.24) as a reference service. However, the presenters indicated that 58260 vaginal hysterectomy could be more closely compared to 58550 Laparoscopy, surgical with vaginal hysterectomy (work RVW 14.19). The intra service work of code 58260 was less as a laparoscopy is not performed. The RUC noted that CPT code 58260 typically includes 4 post operative visits within the 90 day global period, while code 58550 includes only one visit within its 010 day global. The RUC also agreed that 58260 entailed a higher level of intra-service intensity than the abdominal hysterectomy procedure. The RUC and the presenters agreed that by taking the RVU of 58550 (14.19) and subtracting half of the work of the diagnostic laparoscopy (CPT code 49320 Laparoscopy, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (5.10 RVWs) and adding 1.34 RVUs for the work of two additional office visits would result in an appropriate RVU equal to 12.98. The RUC recommends an RVU of 12.98 for code 58260.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58262	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)	13.99	14.77	This procedure combines 58260 (RVW = 12.20) and 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) (RVW = 11.36). Applying the multiple procedure payment rules to 58260 and 58720 yields 17.88 work RVU's indicating that 58262 is undervalued. The ACOG recommends that HCFA increase the work RVU's for 58262 to 17.88 to accurately reflect the work of its component procedures.	When reviewing the results of the survey, the RUC used code 58260 (Vaginal hysterectomy;) as the anchor for the family of vaginal hysterectomy codes. Code 58262 includes the work of the vaginal hysterectomy plus the removal of tubes and/or ovaries. In view of the RUC recommending to increase the work value of the base code 58260 by 0.78 RVUs, the RUC applied this increment to code 58262 to maintain the relativity within the family of hysterectomy codes. Therefore, the RUC recommends an RVU of 14.77 for code 58262.	4
58263	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s), with repair of enterocele	15.28	16.06	Code 58263 encompasses three distinct procedures, each with its own CPT code; 58260, 58720 and 57268 (Repair of enterocele; vaginal approach (separate procedure) (RVW = 6.76). Applying multiple procedure payment rules to this combination of procedures would yield 21.26 RVU's demonstrating that the current value is inadequate. The ACOG recommends that HCFA increase RVU's assigned to CPT code 58263 to 21.26.	When reviewing the results of the survey, the RUC used code 58260 (Vaginal hysterectomy;) as the anchor for the family of vaginal hysterectomy codes. Code 58263 includes the work of the vaginal hysterectomy plus the removal of tubes and/or ovaries, plus repair of an enterocele. In view of the RUC recommending to increase the work value of the base code 58260 by 0.78 RVUs, the RUC applied this increment to code 58263 to maintain the relativity within the family of hysterectomy codes. Therefore, the RUC recommends an RVU of 16.06 for CPT code 58263.	1
58267	Vaginal hysterectomy; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)	15.00	17.04	CPT code 58267 includes codes 58260 (RVW = 12.20) and 51840 (RVW = 10.71). Applying multiple procedure payment rules to these two procedures yields 17.55 RVW, demonstrating that 58267 is undervalued. The ACOG urges HCFA to increase work RVUs for 58267 to 17.55.	As the presenters had not surveyed this code, the RUC had difficulty justifying the specialty society's recommendation of 18.33 based on their building block approach. The RUC did however, understand that the procedure encompassed three separate components and that the current RVU was significantly undervalued at 15.00. The RUC compared this code to other codes such as 58260 (Vaginal hysterectomy;) (12.20 RVW) and used its own building block approach to recommend a value of 17.04 for code 58267.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58270	Vaginal hysterectomy; with repair of enterocele	13.48	14.26	Code 58270 combines two procedures described by separate CPT codes 58260 (RVW = 12.20) and 57268 (RVW = 6.67). However, the current work RVU for 58270 falls below the value yielded by applying the multiple procedure payment rule to its component procedures, which is 15.58 RVU's. The ACOG recommends that HCFA increase work RVU's for 58270 to 15.58 RVUs.	When reviewing the results of the survey, the RUC used code 58260 (Vaginal hysterectomy;) as the anchor for the family of vaginal hysterectomy codes. Code 58270 includes the work of the vaginal hysterectomy plus the repair of an enterocele. In view of the RUC recommending to increase the work value of the base code 58260 by 0.78 RVUs, the RUC applied this increment to code 58270 to maintain the relativity within the family of hysterectomy codes. Therefore, the RUC recommends an RVU of 14.26 for code 58270.	1
58275	Vaginal hysterectomy, with total or partial colpectomy;	14.98	15.76	Code 58275 combines 58260 (RVW = 12.20) and either 57106 (Vaginectomy, partial removal of vaginal wall) (RVW = 6.36) or 57110 (Vaginectomy, complete removal of vaginal wall) (RVW = 14.29). However, the 2000 work RVUs for 58275 are less than the value that results from applying multiple procedure payment rules to its component procedures. Even using the partial vaginectomy procedure (57106) yields work RVU's of 15.53. If a complete vaginectomy (57110) was performed, the work RVU's would be 20.39. The ACOG recommends that HCFA increase the work RVU's assigned to code 58272 to reflect its component procedures.	When reviewing the results of the survey, the RUC used code 58260 (Vaginal hysterectomy;) as the anchor for the family of vaginal hysterectomy codes. Code 58275 includes the work of the vaginal hysterectomy with total or partial colpectomy. In view of the RUC recommending to increase the work value of the base code 58260 by 0.78 RVUs, the RUC applied this increment to code 58275 to maintain the relativity within the family of hysterectomy codes. Therefore, the RUC recommends an RVU of 15.76 for CPT code 58275.	4
58280	Vaginal hysterectomy, with total or partial colpectomy; with repair of enterocele	15.41	17.01	Code 58280 combines 58260 (RVW = 12.20), either 57106 (RVW = 6.36) or 57110 (RVW = 14.29), and 57268 (RVW = 6.76). However, the 2000 RVU's for 58280 are less than the value that results from applying multiple procedure payment rules to its component procedures. Including the partial vaginectomy procedure yields work RVU's of 18.91. If a complete vaginectomy were performed, the work RVU's would be 23.77. ACOG recommends that HCFA increase the work RVU's assigned to code 58280 to reflect is component procedures.	When reviewing the results of the survey, the RUC used code 58260 (Vaginal hysterectomy;) as the anchor for the family of vaginal hysterectomy codes. Code 58280 includes the work of the vaginal hysterectomy plus total or partial colpectomy with repair of an enterocele. In view of the RUC recommending to increase the work value of the base code 58260 by 0.78 RVUs, the RUC applied this increment to code 58280 to maintain the relativity within the family of hysterectomy codes. To this value, the RUC added .85 RVWs for the incremental work of the enterocele repair, to obtain a value of 17.01. The RUC agreed that this value was appropriate as it maintains the relativity within the family of hysterectomy codes. The RUC recommends an RVU of 17.01 for CPT code 58280.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58285	Vaginal hysterectomy, radical (Schauta type operation)	18.57	22.26	Code 58285 is undervalued in comparison to code 58210 (Radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)) (RVW - 28.85). In some respects, 58285 entails less physician work than 58210, as it does not include a lymphadenectomy and fewer postoperative visits are required. However, performing a radical hysterectomy via a vaginal approach is more time-consuming and demands more technical skill than an abdominal approach. Overall, the difference of 10 work RVU's between the two procedures is too great. The ACOG recommends that HCFA increase work RVU's for 58285 to a level to be determined by further evaluation.	The RUC understood that the reference code 58210 (Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)) (28.85 RVW) would be reported first prior to reporting 58285. The RUC compared this code to other procedures and could not justify an increase in the RVU to 25.00 that the specialty had requested. The RUC however, agreed with the survey results and the presenters arguments that the procedure should be valued between 22.00 and 23.00. The RUC then developed several building block approaches adjusting the IWP/UT below the specialties recommended IWP/UT of .08, to arrive at a RVU of 22.26. The RUC recommends an RVU of 22.26 for code 58285.	4
58323	Sperm washing for artificial insemination	0.23	0.23	Total physician work required for 58323 is similar to the work associated with 57150 Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease (RVW = 0.55) or 56606 Biopsy of vulva or perineum (separate procedure); each separate additional lesion (RVW = 0.55). Sperm washing may require less technical skill than a biopsy. However, the protocol for sperm washing typically requires 10 - 15 minutes of the physician's time which is greater than the minimal amount of time required to perform a biopsy of an "additional" lesion. The ACOG recommends that HCFA increase the physician work RVU's for 58323 to 0.55 RVU's.	The RUC reviewed the survey results and agreed there was little physician work included in performing the service. Since the survey results showed no compelling evidence to recommend an increase in the RVU, the RUC agreed to maintain the current RVU of 0.23 for code 58323.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)	6.36	6.36	Code 58400 is performed to resuspend a prolapsed uterus. Through an abdominal incision, the physician plicates the stretched broad ligaments and may also plicate the round and sacrouterine ligaments. CPT code 58400 includes 49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (RVW = 11.68), in addition to the uterine suspension itself. The ACOG recommends that HCFA increase the work RVU's for 58400 to 11.68 RVU's.	The RUC agreed that no compelling evidence was provided to recommend an increase in the RVU for 58400. The RUC recommends that the current RVU of 6.36 be maintained for code 58400.	2
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	3.84	5.60	Code 58600 is undervalued in comparison to code 58670 Laparoscopy, surgical; with fulguration of oviducts (with or without transection) (RVW = 5.60) and 58671 Laparoscopy, surgical; with occlusion or oviducts by device (eg, band, clip, or Falope ring) (RVW = 5.60). Pre-service work in particula, the in-depth counseling and informed consent process required for a sterilization procedure is identicle regardless of the approach. Post-service work is also identicle, requiring a post-operative visit and follow-up with the surgical pathology report. Intra-service work is somewhat less difficult for the open procedure. Given the overall importance of the pre- and post service work to total work RVU's; however, the 1.76 RVU difference in values between the open 58600 and laparoscopic procedures (58670 and 58671) overstates the difference in work.	When reviewing the survey results, the RUC noted that code 58600 is comparable in work and intraservice time to code 58670 (Laparoscopy, surgical; with fulguration of oviducts (with or without transection) (5.60 RVW). The RUC agreed that it would be difficult to justify recommending a higher RVU above 58670 (5.60) as the two services are similar in time and work. Therefore, the workgroup agreed to recommend an RVU of 5.60 which is equal to the RVU of 58670.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	3.34	5.00	Code 58605 is undervalued in comparison to code 58670 (RVW = 5.60) and 58671 (RVW = 5.60). Pre-service work in particular the in-depth counseling and informed consent process required for a sterilization procedure is identical regardless of the approach. Post-service work is also identical, requiring a post-operative visit and follow-up with the surgical pathology report. Intra-service work is somewhat less difficult for the open procedure. Given the overall importance of the pre- and post-service work to total RVU's; however, the 2.26 RVU difference in values between the open (58605) and laparoscopic procedures (58670/58671) overstates the difference in work.	The RUC reviewed the survey results and compared code 58605 to 58670 (Laparoscopy, surgical; with fulguration of oviducts (with or without transection) (5.60 RVW) and agreed the work was similar. However, the RUC noted that the pre, intra, and post times are slightly less than 58670, as part of 58605 is performed within the postoperative period for a global OB package. The RUC agreed that as code 58605 was comparable to 58670, the times were less, therefore, the RUC could not justify recommending a RVU higher than 5.60. Therefore, the RUC recommended an RVU of 5.00 which is slightly less than 58670 to reflect the slightly lower pre, intra, and post times for code 58605.	1
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	0.63	1.45	Code 58611 is significantly undervalued in comparison to code 58670 and 58671 (RVWs = 5.60). The designation of 58611 as an add-on code is most likely the source of this problem. All pre-service work, including counseling and informed consent, associated with a stand-alone tubal ligation (58670) must be performed. This work is not included in the RVU's assigned to any of the cesarean delivery codes. Code 58611 also includes post-service work not typically performed in conjunction with a cesarean delivery, specifically verification of the pathology report on the fallopian tube segment(s) sent for histologic confirmation. Intra-service work is reduced for CPT code 58611 compared to code 58670 and 58671 because it is performed at the time of another intra-abdominal surgery. However, the 4.97 RVU difference between 58611 and 58670/58671 is far too large. The work RVU's for 58671 of 0.63 are less than a level three office visit and are completely inadequate.	The RUC reviewed the survey results and noted that code 58611 is an add-on code, but requires significant preservice time for consent forms and counseling. To appropriately value this procedure, the RUC took half of the RVU for a level 99124 (.54) to reflect the extra preservice work in counseling and signing consent forms and added this to .945 (13.5 minutes of intraservice time for code 58611 * .07) to obtain a value of 1.48. The RUC agreed that a value of 1.45 appropriately reflects the increase in preservice work for code 58611.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	6.49	12.05	Code 58700 includes code 49000 Exploratory laparotomy, exploratory celiotomy, with or without biopsy(s) (separate procedure) (RVW = 11.68), in addition to the salpingectomy itself. The ACOG recommends that HCFA increase the work RVU's for 58700 to 11.68 RVUs.	The RUC noted that code 58700 is most comparable to code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) (11.36 RVW) as the intraservice times are equal. However, the RUC noted that removing only the fallopian tube demands a higher technical skill than removing both the tube and ovary, due to the fact that when the physician dissects the tube from the ovary and surrounding structures this needs to be performed without compromising the blood supply to the ovary. The RUC agreed that the survey median of 12.05 would be an appropriate value.	1
58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.83	14.00	Physician work for 58740 is approximately equivalent to the work required to perform code 58660 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) (RVW = 11.29). Pre-service work is slightly less for the open procedure due to the greater time requirements to prepare for laparoscopic surgery. Intra-service time and intensity also tend to be greater for the laparoscopic procedure. However, post-service work is typically greater for the open procedure (58740) because of the lengthier recovery period. The ACOG recommends that HCFA increase work RVU's for 58740 to 11.29 RVUs to reflect the overall equivalence in work between 58740 and 58660.	The RUC compared this code to 44005 (Enterolysis (freeing of intestinal adhesion) (separate procedure)) which has an RVU of 13.84 and a Harvard intraservice time of 80 minutes. The RUC noted that code 58740 has greater intraservice time at 120 minutes. The RUC also noted that postoperative work is lengthier due to the recovery period, as this is an open procedure. The RUC agreed that a RVU of 14.00 is appropriate as it reflects the increase in intraservice time and postoperative work.	1
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	5.88	5.88	Code 58805 includes code 49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (RVW = 11.68) in addition to the drainage of the cyst(s). The ACOG recommends that HCFA increase the work RVUs for 58805 to 11.68 RVUs.	The RUC did not believe they were presented with compelling evidence that code 58805 should be changed, and therefore recommends that the current RVU be maintained of 5.88.	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58825	Transposition, ovary(s)	6.13	10.98	Code 58825 involves moving the ovaries behind the uterus and suturing them in place prior to radiation therapy of the pelvis. The procedure is accomplished through an abdominal incision. CPT code 58825 includes 49000 Exploratory laparotomy, exploratory celiotomy, with or without biopsy(s) (separate procedure) (RVW = 11.68) in addition to the transposition of the ovaries.	The RUC believed that this code could be compared to an exploratory laparotomy that currently had a RVU of 11.68, and the survey results supported this argument. The RUC then developed a building block approach with an IWPUT of .07 and calculated an RVU of 10.98. The RUC's recommended RVU aligned the relative work value of code 58825 with other codes with similar physician work.	4
58920	Wedge resection or bisection of ovary, unilateral or bilateral	6.78	11.36	Code 58920 includes the work of 49000 Exploratory laparotomy, exploratory celiotomy, with or without biopsy(s) (separate procedure) (RVW = 11.68), as well as removal of a portion of one or both ovaries. However, work RVU's for 58920 are only 58% of the RVU's assigned to code 49000. The ACOG recommends that HCFA increase work RVU's for 58920 to at least the level of an exploratory laparotomy, 11.68 RVUs.	The RUC acknowledged that in order to correct a rank order anomaly, the code 58920 should have a comparable work RVU as code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)). The procedure 58920 at its current value of 6.78 does not address the work involved in such a procedure, and a rank order anomaly exists. The RUC recommends that code 58920 have the same work RVU as code 58720.	1
58950	Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy;	15.27	16.93	Intraoperatively, code 58950 combines 58720 (RVW = 11.36) and 49255 Omentectomy, epiploectomy, resection of omentum (separate procedure) (RVW = 11.14). The nature of disease being treated (ovarian cancer) typically requires more post-operative work than typically involved with 58720. Application of multiple procedure payment rules to 58720 and 49255 yields 16.93 RVUs. This indicates that 58950 is undervalued, even without consideration of the level of post-operative work associated with a cancer diagnosis.	The RUC noted that code 58950 includes both of the reference service procedure codes 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) (11.36 RVW) and 49255 (Omentectomy, epiploectomy, resection of omentum (separate procedure) (11.14 RVW)). By using the multiple procedure rule, the workgroup obtained a value of 16.93, which was agreed to appropriately reflect the physician work. The RUC took the RVU of code 58720 (11.36) and added 5.57 which is half of the RVU for code 49255 (11.14) to obtain the recommended RVU of 16.93.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
58951	Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	21.81	22.38	Code 58951 combines code 58150 (RVW = 15.24), 49255 (RVW = 11.14) and 38700 (RVW = 13.23). Application of multiple procedure payment rules values this at 28.99. Clearly, CPT code 58951 is undervalued.	When reviewing the survey results, the RUC compared this code to 58285 (Vaginal hysterectomy, radical (Schauta type operation) (18.57 RVW). The RUC agreed that the work was similar and noted that the survey data supports recommending an increase to 22.38, which is the same RVU as code 58285.	4
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	6.89	11.67	Code 59150 is undervalued compared to 59121 (Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy) (RVW = 11.67). Laparoscopic treatment of ectopic pregnancy requires more pre-service time to verify presence and correct functioning of all laparoscopic equipment. The intra-service work of the laparoscopic procedure is more time consuming and requires a higher level of technical skill than the open procedure because of the challenges of operating through the laparoscope. Postoperative recovery from the laparoscopic procedure is quicker, but all patients who have had an ectopic pregnancy require the same postoperative follow-up to ensure that the ectopic pregnancy has resolved. The RUC recommended in 1997 that HCFA increase the work RVUs for 59150 to the same level as 59121. In the October 31, 1997 Final Rule announcing the 1998 Medicare Fee Schedule, HCFA stated that it had accepted the RUC's recommendation for 59150. However, this change has never appeared in the fee schedule in spite of our numerous attempts to have HCFA make the correction.	In April 1997, the RUC recommended that HCFA increase the work RVUs for code 59150 to be the same as 59121 (Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy - 11.67 RVWs). HCFA accepted the RUC's recommendation; however, this change did not appear in the fee schedule. The RUC noted that laparoscopic treatment of ectopic pregnancy requires more preservice time and intraservice time as a result of the increased work in operating through a laparoscope. As such, the RUC reaffirms its position to increase the value for this procedure to that of the reference procedure, 11.67 RVWs. The RUC noted that the language in the descriptor should be clarified to indicate laparoscopic treatment of ectopic pregnancy without either salpingectomy or oophorectomy. The RUC noted that the language "with and without" and "and/or" will soon be addressed by CPT, and new and revised codes may be established, therefore the RUC should readdress this code at a later date.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	7.86	11.49	Code 59151 is undervalued compared to code 59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach (RVW = 11.49). Laparoscopic treatment of ectopic pregnancy requires more pre-service time to verify presence and correct functioning of laparoscopic equipment. The intra-service work of the laparoscopic procedure is more time-consuming and requires higher level of technical skill than the open procedure because of the challenges of operating through the laparoscope. Postoperative recovery from the laparoscopic procedure is quicker, but all patients who have had an ectopic pregnancy require the same postoperative follow-up to ensure that the ectopic pregnancy has resolved.	The RUC reaffirmed its position from April 1997 to increase the work RVU of CPT code 59151. In 1997, the RUC agreed that 59151 was undervalued compared to CPT Code 59120 (Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach-work RVW 11.49). However, CPT code 59151 requires more pre and intra-service work than the open procedure because of the time it takes to verify the correct functioning of the laparoscopic equipment and the higher level of technical skill necessary to use equipment. In the preamble of the October 1997 Final Rule, HCFA accepted the RUC's recommendation to increase the value of code 59151 to that of code 59120. However, this change never appeared in the fee schedule. As such, the RUC supports increasing the RVW of code 59151 to 11.49. The RUC noted that the language "with and without" and "and/or" will soon be addressed, and new or revised codes may be established by CPT, therefore the RUC should readdress this code at a later date.	1
59812	Treatment of incomplete abortion, any trimester, completed surgically	3.25	4.01	Physician work for 59812 is equivalent to the work required for 59820 Treatment of missed abortion, completed surgically; first trimester (RVW = 4.01). Both procedures require a dilation and suction curettage, but there are some differences in the work. In the case of a missed abortion (59820), the cervix typically has not dilated, so this portion of the procedure is more difficult than for a patient who has had an incomplete abortion. However, 59812 can be used in any trimester, while 59820 is limited to first trimester procedures. Performing a suction curettage after the first trimester entails significantly more work and risk. Thus, on balance, total work for both 59812 and 59820 is approximately equal. The ACOG recommends that HCFA increase work RVU's for 59812 to 4.01 to accurately reflect its equivalence in work to code 59820.	The RUC agreed that the physician work for CPT code 59812 is equivalent to the work required for 59820 (Treatment of missed abortion, completed surgically; first trimester, 4.01 RVWs). Although there are some minor differences in the work, the RUC agreed that these procedures are still very similar. As such, the RUC supports increasing the RVW of 59812 to 4.01 equivalent to the work RVW of 59820.	4

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
59870	Uterine evacuation and curettage for hydatidiform mole	4.28	6.01	Code 59870 can best be compared to code 59820 Treatment of missed abortion, completed surgically; first trimester (RVW = 4.01). Although both codes describe a dilation and suction curettage, code 59870 entails more intra- and post-service work because of the nature of the molar pregnancy. The risk of excessive bleeding is significantly higher with a molar pregnancy than with a missed abortion, increasing the intra-service work. In addition, patients who have had a molar pregnancy must be aggressively monitored for development of trophoblastic disease, thus necessitating more post-operative visits and additional physician work for reviewing laboratory tests during the 90-day global period. The 0.27 RVU difference between the values for 59870 and 59820 does not adequately reflect the amount of additional work required.	When reviewing the survey results, the RUC noted that the typical patient is either late in the first trimester or early in the second trimester, when no heart-tones are heard and the uterus is large for the dates. The RUC compared this to code 59820 (Treatment of missed abortion, completed surgically; first trimester) (4.01 RVW) and noted that 59870 has more physician work due to the greater risk of excessive bleeding with a molar pregnancy and increased postoperative work to account for the weekly management of HCG levels until the levels return to normal. The RUC agreed that as a result of the increased physician work and postoperative time, that the survey median RVU of 6.01 was appropriate.	1

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
65855	Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)	4.30	3.85	<p>The AAO requests that the global period for code 65855 (Trabeculoplasty by laser surgery, one or more sessions) be decreased from 90 to day global. The code was given a 90 day global because it was the first laser code introduced and at the time all ophthalmic surgical codes were given a 90 day global. There are no, and still aren't any codes in the ophthalmic section of CPT with less than a 90 day global. When the CPT code was initially proposed, it was feared that treating the trabecular meshwork 360 degrees would be the standard of care. It was feared that such intensive treatment would lead to very high pressure levels so it was thought that two treatment sessions would be needed. In fact, by the time the code was used, no one treated more than 180 degrees and it was done at one setting.</p> <p>At the last Five-year review of work values, the CMD's recommended a decrease in the work RVU from 4.65 to 4.30 and the RUC concurred. The CMD's felt that the intensity of the postop work was less than the initial Harvard Value because of the new drops to blunt the pressure rises. They also stated that the number of post op visits was less. Our last survey showed that the post op visits (3) were the same, but they were of shorter duration (10 minutes vs 20). It should be noted that the initial Harvard value and the last Five-Year review value were based on a single treatment session.</p>	<p>The specialty society came to the 5 year review requesting to change the global period for this code from 090 to 010. The society surveyed 50 glaucoma specialists and survey results indicated there were only two, level two (99212) postoperative office visits, not three postoperative visits. Therefore, the RUC agreed that the global period for CPT code 65855 (Trabeculoplasty by laser surgery, one or more sessions (defined treatment series) should be reduced from a 90 day global to a 10 day global. Also, the RUC subtracted .45 RVW's from the total work RVU (4.30) of code 65855 to account for one less level two postoperative office visit to arrive at a new work RVU of 3.85.</p>	3
66180	Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	14.55	14.55	<p>The AAO believes that this code is undervalued relative to the physician work required to perform the service.</p>	<p>The results of the survey did not justify a recommendation for an increase in work. No compelling evidence was presented to the RUC. Therefore, the workgroup recommends that the current RVU be maintained.</p>	2

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CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
66986	Exchange of intraocular lens	12.28	12.28	The AAO believes that this code is undervalued relative to the physician work required to perform the service.	The survey results for code 66986 did not justify a recommendation for an increase in the work value. No compelling evidence was provided to the RUC to support an increase in the RVU. Therefore, the RUC recommends that the current 2000 work RVU of 12.28 be maintained.	2
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	2.52	2.52	The AAO believes that this code is undervalued relative to the physician work required to perform the service.	The results of the survey did not justify a recommendation for an increase in work. No compelling evidence was provided to the RUC to support an increase in the RVU. Therefore, the RUC recommends that the current RVU 2.52 be maintained.	2
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)	13.52	18.53	The AAO believes that this code is undervalued relative to the physician work required to perform the service.	The RUC noted that code 67218 includes two procedures 67311 (Strabismus surgery, recession or resection procedure; one horizontal muscle) (6.65 RVW) and 67335 (Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery), (2.49 RVW), which has a total physician work of 10.14. However, the presenters indicated they thought the additional work was not incorporated in the original valuation. To correct this survey error, a building block approach was used to arrive at a new RVU that was more reflective of the work of both procedures. The RUC recommends a RVU of 18.53 for CPT code 67218.	1
67904	Repair of blepharoptosis; (tarso)levator resection or advancement, external approach	6.26	6.26	The AAO believes that this code is undervalued relative to the physician work required to perform the service.	The results of the survey did not justify a recommendation for an increase in work. No compelling evidence was provided to the RUC to support an increase in the RVU. Therefore, the RUC recommends that the current RVU 6.26 be maintained.	2
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	1.51	2.50	The AAO believes that this code is undervalued relative to the physician work required to perform the service.	The RUC acknowledged that the preservice work of CPT code 92018 was greater than the standard office procedure because of the need for anesthesia. The RUC discussed the current survey results in detail and concluded that it could not be relied upon. However, the RUC agreed that the RVU should be increased to the RVU that was recommended at the last 5 year review of 2.50, with the understanding that the code would go back to CPT to clarify that code 92018 includes extended ophthalmoscopy gonioscopy.	4

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Survey CPT Code: 20245

Global: 090

Current RVW: 3.95
Recommended RVW: 8.50**CPT Code Descriptor:** Biopsy, bone, excisional; deep (eg, humerus, ischium, femur)

Typical Patient (Vignette): A 60-year-old male presents with a 3-month history of left hip pain with no preceding history of trauma. He was initially seen by his primary care physician and placed on oral anti-inflammatory medication with a presumptive diagnosis of bursitis. His pain continued however and x-rays were obtained which revealed a lytic lesion in the ischio-acetabular region of the left hip. An MRI scan confirmed the mass and demonstrated cortical destruction and soft tissue extension. A CT scan directed needle biopsy was performed but revealed only blood with no diagnostic material. A bone scan was obtained which was positive in the region of the left acetabulum but showed no other lesions. The decision was then made to proceed with an open biopsy.

CLINICAL DESCRIPTION OF SERVICE:**PREOPERATIVE WORK:**

This begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology and laboratory studies; with special attention to review of x-rays, CT scans and MRI scans. A consultation would typically occur with the referring physician to appraise the physician of the patient's situation and, if necessary, discuss appropriate concerns about optimizing the patient's health problems prior to surgery. Communication would take place with the patient (and/or the patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes patient positioning on the operative table; marking the patient for the planned incision to include the previous biopsy site; preoperative scrubbing and gowning as well as prepping and draping of the operative site.

At this time, the surgeon also ensures that all of the surgical instruments and supplies that are necessary are present and available in the operative site.

INTRAOPERATIVE WORK:

With the patient in the lateral decubitus position on a bean bag and the hip and leg draped free, a modified Gibson posterolateral incision is made. This is carried down through the skin and subcutaneous tissue and hemostasis is obtained. The fascia lata is then exposed and is incised longitudinally in line with its fibers. Hemostasis is then obtained and self-retaining retractors are placed in the wound. The trochanteric bursa is divided longitudinally and the posterior portion is retracted posteriorly. The sciatic nerve is exposed and carefully dissected. A vessel loop is placed around the nerve to allow gentle retraction and the nerve is carefully protected throughout the procedure. The leg is internally rotated and the leading edge of the gluteus medius is identified. A rounded periosteal elevator is placed below this muscle and the interval between the gluteus medius and piriformis is dissected. A right angle retractor is placed under the gluteus medius and it is retracted proximally. The piriformis muscle is incised along with the other external rotators and this muscle mass is retracted posteriorly thereby exposing the posterior wall of the acetabulum and ischium. An air-powered burr is then used to create a window posteriorly at the ischio-acetabular junction. Considerable bleeding is then encountered and the surgeon's index finger is placed over the small cortical window to control the excessive bleeding. Curettes are then used to obtain specimen from within the bone. This is placed in a specimen container and the window in the bone is packed with a surgical sponge. Once the surgeon is assured that the undue bleeding is controlled with the sponge blocking the cortical window, he/she breaks scrub, fills out the pathology request with pertinent history and carries the specimen out of the operating suite to the pathology department. Frozen section slides are then prepared and the surgeon reviews these with the attending pathologist in light of the imaging studies and clinical history.

A tentative diagnosis of plasmacytoma is made with the final diagnosis deferred pending appropriate permanent section analysis. While lesional tissue is present in the submitted specimen, The pathologist requests that more specimens be obtained to insure that all-appropriate studies can be performed.

The surgeon then returns to the surgical suite, scrubs and gowns and returns to the surgical field. The retractors are then replaced in the wound having been removed for the frozen section. The sponge packing the bone window is removed and the lesion is again curetted. The specimen so obtained is then sent to the pathology department for permanent section analysis. The area is irrigated and bone cement is then prepared in the usual fashion. Bone cement is then inserted into the bone window to establish hemostasis. The incision is again irrigated and the wound is closed in multiple layers using nonabsorbable sutures in the deep tissues, absorbable sutures in the superficial tissues and staples in the skin

POSTOPERATIVE WORK:

This begins after skin closure in the operating room and includes removal of operative drapes and application of a sterile surgical dressing. The patient is then carefully examined as soon as he is conscious to ensure that motor and sensory function of nerves that were exposed during the operation are intact. Postoperative work also includes monitoring the patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring hemodynamic status; care and removal of drains; careful wound care and observation to avoid or promptly treat wound hematoma; supervision of physical therapy to the patient and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 10 days after the day of operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology and laboratory reports and antibiotic and pain medication adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
Musculoskeletal Tumor Society

Sample Size: 95 **Response Rate:** 35 (37%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	7.80	8.50	13.00	14.00	21.50
Pre-Service			80		
Intra-Service	40	60	90	90	140
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	19	99231x1			
Discharge Day Mgmt	36	99238			
Office Visits	84	99214x1 99213x2			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
7.78	090	27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula;

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 20245 (n=34)	Ref CPT 27635 (n=10)
Pre-service time	80	70
Intra-service time	90	85
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	19	19
Discharge management time	36	30
Total office visit time	84	84

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.50	3.00
Intra-service	4.19	3.00
Post-service	3.84	3.13

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.52	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.61	3.00
Urgency of medical decision making	4.36	3.75

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.30	3.00
Physical effort required	3.67	2.94

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.42	3.31
Outcome depends on the skill and judgment of physician	4.58	3.13
Estimated risk of malpractice suit with poor outcome	4.18	3.31

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Compared to 27635, CPT 20245 requires the same dissection of the soft tissues. Both procedures involve opening the bone. While 27635 typically requires more work within the bone, 20245 requires the surgeon to leave the OR and take the specimen to pathology to review the frozen section slides with the pathologist to provide information regarding the imaging studies and clinical setting. The survey 25th percentile RVW 8.50 is recommended to set this code relative to the reference.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

798	orthopaedic surgery
140	hematology/oncology
65	oral surgery (dentists only)
57	general surgery
38	diagnostic radiology
38	podiatry
36	clinic or group practice (not gppp)
33	plastic & reconstructive surgery
29	nephrology
22	maxillofacial surgery
18	surgical oncology
13	otolaryngology
12	hematology
10	pathology
6	neurosurgery
6	urology
5	medical oncology
4	rheumatology
3	hand surgery
3	vascular surgery
2	anesthesiology
2	cardiology
2	general practice
1	gynecology/oncology
1	internal medicine
1	neurology

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 12 Yes
- 24 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 2 I agree
- 8 I do not agree

c. Patients requiring this service are now:

- 10 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 1 from outpatient to inpatient
- 3 from inpatient to outpatient
- 6 no change

Survey CPT Code: 23472

Global: 090

Current RVW: 16.92
Recommended RVW: 21.10

CPT Code Descriptor: Arthroplasty with glenoid and proximal humeral replacement (e.g. total shoulder)

Typical Patient (Vignette): A 65-year-old with incapacitating arthritis undergoes a total shoulder replacement involving both humeral and glenoid components.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies, with special attention to review of shoulder X-rays or CAT scans; consulting with the referring physician, if necessary, and other health care professionals; arranging for intraoperative imaging/fluoroscopy for documentation; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also include pre-operative scrubbing; ordering pre-operative antibiotics; arranging for intra-operative placement of x-ray cassettes for films; positioning; with care to position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. It is necessary to have an array of implants ready for possible use in the operating room is necessary. An estimate of the appropriate size component is determined by templating of the joint with radiographs.

INTRAOPERATIVE:

A deltopectoral incision is made from the mid clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the supraspinatus tendon, which is incised longitudinally and retracted, for later repair. Careful retraction around neurovascular structures during the case including the axillary and musculocutaneous nerve is imperative. A capsulectomy is meticulously made for later repair over the anterior one-half of the shoulder. Dislocation of the shoulder joint is performed with intraoperative inspection and assessment of the humeral head and glenoid fossa. Precise resection of the proximal humeral head is done utilizing an alignment jig. The glenoid fossa is carefully prepared to accept to properly aligned glenoid component. This component is fixed in place with cement or screws. Scrupulous preparation and cleansing of the humeral canal is necessary prior to placement of the prosthetic humeral component. Cementing or press-fit of the humeral component within the humeral shaft is done. Judgment and technical skill is necessary to carefully align the humeral component in the proper degree of retroversion to prevent postoperative subluxation or dislocation. The rotator cuff and anterior capsule are repaired. Frequently a subacromial decompression and acromioplasty with resection of the coracoacromial ligament is done. Reattachment of the subscapularis tendon is next done followed by re-approximation of the deltopectoral interval and closure of the subcutaneous tissue and skin.

POSTOPERATIVE:

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings. Postoperative work also includes monitoring patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. The shoulder is immobilized at the patient's side, with the physician instructing the patient to perform isometric exercises to avoid muscle atrophy. Communication with the family and other health care professionals (including written and oral reports and orders); all hospital visits and services performed by the surgeon, including monitoring physiotherapy and assessing range of motion

progress; and antibiotic and pain medication management are also part of the postoperative work. Assistive exercises are begun as soon as the patient is comfortable. Specific orders must be made by the physician for the physical therapist to avoid passive stretching of the shoulder. Dislocation of the prosthetic shoulder in the postoperative period must be avoided by carefully supervising the physical therapy program and by providing thorough patient education. The progression to active exercise depends on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair.

Discharge day management includes the surgeon's final examination of the patient; instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including evaluation of periodic imaging reports; assessment of physiotherapy progress; and antibiotic and pain medication adjustments. The entire post operative exercise program lasting up to three months must be carefully monitored to gain the best result of the surgery. The musculature about a shoulder with a long-term chronic affliction may be very poor causing rehabilitation to be difficult and prolonged. The post operative care of every patient must be individualized and must be continually monitored.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Shoulder and Elbow Surgeons

Sample Size: 134 **Response Rate:** 31 (23%)

Type of Sample: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	16.00	21.00	22.50	25.04	35.00
Pre-Service			60		
Intra-Service	90	120	165	180	240
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	68	99232x1	99231x2		
Discharge Day Mgmt	36	99238			
Office Visits	84	99213x3	99212x1		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
17.15	090	23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
14.69	090	27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
18.68	090	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 23472 (n=30)	Ref CPT 23470 (n=17)
Pre-service time	60	60
Intra-service time	165	100
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	68	38
Discharge management time	36	30
Total office visit time	84	84

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.83	3.00
Intra-service	4.87	4.10
Post-service	3.595	3.30

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	3.30
Urgency of medical decision making	2.70	2.60

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.91	3.90
Physical effort required	4.57	3.70

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.30	3.80
Outcome depends on the skill and judgment of physician	4.78	4.50
Estimated risk of malpractice suit with poor outcome	3.83	3.40

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

This code was presented during the previous five-year review. The RUC workgroup rejected the recommendation, indicating that the Harvard data were not dissimilar to survey times. What the previous workgroup did not consider was that Harvard "results" were incorrect and created an anomaly. The difference in Harvard time for total shoulder to hemi-shoulder should have resulted in total shoulder being valued higher than hemi-shoulder. This did not happen. Harvard could not have applied a logical algorithm to the raw data to produce a relative value for a total shoulder arthroplasty, involving the preparation of **two** joint surfaces, lower than a hemi-arthroplasty (requiring the preparation of only **one** articular surface). This erroneous calculation by Harvard has led to the creation of the anomaly noted among the shoulder arthroplasty RVW's.

The current RVW presents a rank order anomaly, with a hemiarthroplasty valued higher than the total shoulder procedure. The total shoulder requires much greater intraoperative work. The relationship between a shoulder hemiarthroplasty and a total shoulder arthroplasty is similar to the difference between a hip hemiarthroplasty and a total hip arthroplasty. The RVW for 27130 (total hip) minus 27125 (hemi-hip) is 3.99 [18.68-14.69]. Adding this RVW to 23470 (hemi-shoulder) results in an RVW of 21.14. The addition of 3.99 for 65 minutes of intraoperative time is also reasonable. The survey 25th percentile RVW of 21.10 is recommended as this very closely approximates the hip total/hemi relationship and corrects the rank order anomaly between shoulder total/hemi procedures.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

3,672	orthopaedic surgery
78	clinic or group practice (not gppp)
58	hand surgery
9	general practice
8	general surgery
4	physical medicine and rehabilitation
1	family practice
1	internal medicine
1	nurse practitioner

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 17 Yes
- 10 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 16 I do not agree

c. Patients requiring this service are now:

- 16 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 17 no change

Survey CPT Code: 26562

Global: 090

Current RVW: 9.68

Recommended RVW: 15.00

CPT Code Descriptor: Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)

Typical Patient (Vignette): A 12-month-old child presents with a complex complete syndactyly of the long and ring fingers.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies. During this time a consultation with the referring pediatrician is carried out to discuss the management of any medical problems the child might have. The operative risks and benefits are discussed with the family and informed consent is obtained. The surgeon verifies that the necessary surgical instruments and supplies are present and available. Preoperative work also includes positioning the patient on the operative table; application of a tourniquet to the arm; application of a heating blanket, prepping and draping of the operative sites; surgeon's scrubbing and gowning. The multiple skin flaps are outlined on the syndactylized digits so as to maximize the skin coverage of the soon to be released fingers. Proximal flaps are outlined that will permit the creation of a third web space. The arm is exsanguinated using a Martin bandage and a pneumatic tourniquet is inflated.

INTRAOPERATIVE WORK:

The skin is incised and the skin flaps are developed. The common nail is split longitudinally. Any underlying bone bridges are transected using osteotomes and saws. Care is taken to protect the neurovascular bundles and the extensor and flexor mechanisms. The dissection is carried out proximally to the common digital artery. The digital nerves are identified and protected. The tourniquet is released and hemostasis accomplished. The flaps are rotated and sewn into position. The soft tissue advancement is carried out along the lateral aspect of the nail organ of the long and ring fingers. Templates are made of the areas on the long and ring fingers that are not covered by flaps. The templates are then transferred to the groin area where full-thickness skin grafts are harvested and defatted. The skin grafts are then meticulously sewn into position using a tie-over-stent dressing.

POSTOPERATIVE WORK:

This Postoperative work includes application of a sterile surgical dressing and a long arm cast. It also includes removal of the operative drapes. The patient is then carefully examined as soon as he is conscious to ensure that motor and sensory function of the involved upper extremity are intact. The Postoperative work also includes monitoring the patient's recovery in the recovery room; communication with the family and other health care professionals (including written and oral reports and patient care orders). Discharge day management includes the surgeon's final examination of the patient and instructions for continuing care and preparation of discharge records. Included in the postoperative work are the office visits for this procedure for 90 days after the day of operation. These services including removal of sutures, periodic evaluation of wound healing and hand function, review of laboratory reports and antibiotic and pain medication adjustments.

SURVEY DATA**Presenter(s):** Laura Tosi, MD**Specialty(s):** American Association of Orthopaedic Surgeons
American Society for Surgery of the Hand**Sample Size:** 148 **Response Rate:** 25 (17%) (rarely performed procedure)**Type of Sample:** random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	11.20	14.00	15.00	17.02	25.60
Pre-Service			75		
Intra-Service	90	120	150	173	300
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	36	99238			
Office Visits	130	99214x1 99213x4			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.92	090	26561	Repair of syndactyly (web finger) each web space; with skin flaps and grafts

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 26562 (n=25)	Ref CPT 26561 (n=18)
Pre-service time	75	65
Intra-service time	140	120
Immediate Post-service time	30	25
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	30
Total office visit time	130	99

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.89	2.50
Intra-service	4.56	3.55
Post-service	3.67	3.27

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.89	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.79	3.42
Urgency of medical decision making	2.50	2.42

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.84	3.83
Physical effort required	3.58	3.33

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.37	3.58
Outcome depends on the skill and judgment of physician	4.63	3.75
Estimated risk of malpractice suit with poor outcome	3.89	3.58

ADDITIONAL RATIONALE Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

The current relationship between 26561 and 26562 is a rank order anomaly. CPT 26562 represents greater total work (pre-, intra-, and post-operative) when compared with 26561. The difference in Harvard times between 26561 and 26562 should have resulted in 26562 being valued higher than 26561. This did not happen. We cannot imagine the algorithm Harvard applied to the raw data indicating 26562 as more work than 26561 that resulted in the opposite Medicare fee schedule rvu's, and thereby creating an anomaly. We recommend the survey median RVW of 15.00 for 26562 to correct this anomaly and correctly value this code relative to 26561 for the additional total work. We also point out that this procedure is not a "Medicare" procedure and is actually "typically" performed by pediatric hand surgeons.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

0 frequency

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

- a. **Has the work of performing this service changed in the past 5 years?**
 - 8 Yes
 - 15 No
- b. **This service represents new technology that has become more familiar (i.e., less work).**
 - 1 I agree
 - 4 I do not agree
- c. **Patients requiring this service are now:**
 - 4 more complex (more work)
 - 0 less complex (less work)
 - 4 no change
- d. **The usual site-of-service has changed:**
 - 0 from outpatient to inpatient
 - 4 from inpatient to outpatient
 - 4 no change

Survey CPT Code: 27075

Global: 090

Current RVW: 17.23
Recommended RVW: 35.00

CPT Code Descriptor: Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis

Typical Patient (Vignette): An 18-year-old male presents with a 6-month history of vague low back pain. The pain was intermittent initially and x-rays of the lumbar spine and pelvis were requested by the patient's primary care physician and were within normal limits. The patient was treated with oral anti-inflammatory medication and the pain initially responded but then returned one month later at which time it was noted to be progressively severe and constant. Physical examination at that time revealed a large mass in the left ileum, which was tender to palpation. X-rays now revealed a lytic lesion in the ileum and a MRI scan revealed a 14-centimeter iliac mass with intrapelvic and extrapelvic extension. An open biopsy was performed and the diagnosis of osteosarcoma was confirmed. The patient underwent preoperative chemotherapy and a decision was then made to proceed with wide resection.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

This begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology and laboratory studies; with special attention to review of x-rays, CT scans and MRI scans. A consultation would typically occur with the referring physician to appraise the physician of the patient's situation and, if necessary, discuss appropriate concerns about optimizing the patient's health problems prior to surgery. Communication would take place with the patient (and/or the patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes patient positioning on the operative table; marking the patient for the planned incision to include the previous biopsy site; preoperative scrubbing and gowning as well as prepping and draping of the operative site.

At this time, the surgeon also ensures that all of the surgical instruments and supplies that are necessary are present and available in the operative site.

INTRAOPERATIVE WORK:

An attending Urologist performs a cystoscopy once general anesthesia is established and inserts a left ureteral stent and a Foley catheter. The patient is placed in the lateral decubitus position on a beanbag. A skin incision is then made from the pubic symphysis over the inguinal ligament and over the superior bony rim of the pelvis going back posteriorly to the sacro-iliac joint. A second incision is then made over the lateral aspect of the proximal femur extending proximally to the mid lateral aspect of the first incision creating a large laterally based "T". This is carried down sharply through the skin and subcutaneous tissues and hemostasis is obtained. The anterior portion of the incision is then taken down through the inguinal ligament from the pubic symphysis to the anterosuperior iliac spine. The femoral artery and vein are exposed and carefully dissected. Vessel loops are carefully placed around the femoral artery and vein in the pelvis so that proximal control can be maintained. The abdominal wall muscles are then dissected extraperiosteally from their insertion on the wing of the ileum. These muscles are retracted proximally. In the course of doing this, the lateral femoral cutaneous nerve is identified, dissected and protected throughout the case. Dissection is then carried down over the iliacus muscle, which will be left with the resection specimen to form the medial wide margin. In the lower portion of the pelvis, the ureter is palpated and this is facilitated by the previously placed ureteral stent. The ureter is carefully swept posteriorly and the peritoneum is retracted away from the mass. Dissection is then carried through the iliacus muscle but the psoas muscle is left intact. The femoral nerve is exposed within the anterior aspect of the psoas muscle. A vessel loop is placed around it and it is carefully protected throughout the case. Dissection is then carried posteriorly over the posterior

aspect of the iliac wing back to the sacro-iliac joint again staying extraperiosteal to keep away from the tumor. The muscles originating from the anterior aspect of the pelvis are then dissected extraperiosteally and these include the tensor fascia lata, sartorius and rectus femoris muscles. Several perforating vessels are typically encountered here and are dissected, ligated and incised. The lateral incision is then incised through the fascia lata and anterior and posterior flaps are fashioned. The gluteus maximus muscle is split in line with its fibers and the gluteus maximus is then separated from the underlying gluteus medius and minimus and is then retracted anteriorly and posteriorly. The gluteus medius is separated from the underlying gluteus minimus, which is maintained with the specimen to serve as the lateral wide margin. This dissection is carried back to the sciatic notch and the gluteal vessels and nerves to the medius and maximus are preserved while the branches to the minimus are sacrificed. The sciatic notch is then exposed from within the pelvis and from without. A large Penrose drain is then drawn through the sciatic notch to protect the underlying vessels and nerves. The sciatic nerve is then dissected inside and outside the pelvis so that it is visualized throughout this region. Posteriorly, the posterior aspect of the ileum is then exposed followed by exposure of the sacral ala by dissection of the paraspinous muscles to expose the posterior aspect of the sacral ala. Final exposure of the planned areas for the bone cuts above the acetabulum and along the sacrum are performed. A Steinman pin is then placed through the supra-acetabular bone perpendicular to the long axis of the body with a second pin through the ala to outline the bone cuts and to make sure that the cuts will go through normal uninvolved bone to guarantee wide bone margins. With the portable x-ray obtained and showing the pins in good position. An oscillating saw is then used to make the bone cuts which are then completed with a curved periosteal elevator and a mallet so as not to damage the underlying nerves and vessels. Once these cuts are completed, the ileum can be mobilized by careful incision of the remaining soft tissue attachments. Careful hemostasis is then obtained. And the wound is copiously irrigated. Two suction drains are then left deep in the wound and brought out proximally. The gluteus medius and maximus are repaired to the abdominal wall muscles with nonabsorbable suture. The remaining soft tissue is then repaired in layers with interrupted sutures and the skin with skin staples.

POSTOPERATIVE WORK:

This begins after skin closure in the operating room and includes removal of operative drapes and application of a sterile surgical dressing. The patient is then carefully examined as soon as he is conscious to ensure that motor and sensory function of nerves that were exposed during the operation are intact. Postoperative work also includes monitoring the patient stabilization in the recovery room and subsequently in an intensive care unit where these patients typically spend several days; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring hemodynamic status; care and removal of drains; careful wound care and observation to avoid or promptly treat wound hematoma; supervision of physical therapy to the patient and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology and laboratory reports and antibiotic and pain medication adjustments.

SURVEY DATA**Presenter(s):** Laura Tosi, MD**Specialty(s):** American Association of Orthopaedic Surgeons
Musculoskeletal Tumor Society**Sample Size:** 95 **Response Rate:** 36 (38%)**Type of Sample:**

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	22.00	30.00	35.00	38.00	80.00
Pre-Service			120		
Intra-Service	120	240	300	360	720
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	60				
Critical Care	0				
Other Hospital	158	99233x1	99232x2	99231x3	
Discharge Day Mgmt	36	99238			
Office Visits	53	99213x1	99212x2		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.52	090	27134	Revision of total hip arthroplasty, both components, with or without autograft or allograft

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 27075 (n=34)	Ref CPT 27134 (n=23)
Pre-service time	120	90
Intra-service time	300	240
Immediate Post-service time	60	30
Total critical care time	0	0
Total other hospital visit time	158	117
Discharge management time	36	30
Total office visit time	53	53

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.97	4.00
Intra-service	4.97	4.14
Post-service	4.88	3.55

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.94	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.94	3.64
Urgency of medical decision making	4.94	3.14

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	5.00	4.25
Physical effort required	4.94	4.35

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	4.05
Outcome depends on the skill and judgment of physician	5.00	4.18
Estimated risk of malpractice suit with poor outcome	4.70	3.95

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The survey median RVW of 35.00 is recommended for 27075.

This is a huge operation. The incision is typically at least 30 inches long and requires extensive and tedious dissection. Visualization of the femoral, obturator, and sciatic nerves and the femoral and gluteal blood vessels is necessary. This represents significantly more work (time/intensity) than 27134.

Additionally, valuing the increments supports this median survey value: The hospital and office visits alone equal 9.68 RVWs leaving 25 RVWs for preoperative time (120 min), intraoperative time (300 min) and immediate same day (60 min).

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

72	orthopaedic surgery
15	plastic & reconstructive surgery
11	general surgery
7	clinic or group practice (not gppp)
4	surgical oncology
2	family practice
2	urology
1	gynecology/oncology
1	neurosurgery
1	obstetrics/gynecology
1	pathology
1	thoracic surgery

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 13 Yes
- 20 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 2 I agree
- 10 I do not agree

c. Patients requiring this service are now:

- 12 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 1 from outpatient to inpatient
- 0 from inpatient to outpatient
- 12 no change

Survey CPT Code: 27077

Global: 090

Current RVW: 23.13
Recommended RVW: 40.00

CPT Code Descriptor: Radical resection of tumor or infection; innominate bone, total

Typical Patient (Vignette): A 20-year-old male presents with a 7-month history of vague low back pain. The pain was intermittent initially and x-rays of the lumbar spine and pelvis were requested by the patient's primary care physician and were within normal limits. The patient was treated with oral anti-inflammatory medication and the pain initially responded but then returned one month later at which time it was noted to be progressively severe and constant. Physical examination at that time revealed a large mass in the left ileum, which was tender to palpation. X-rays now revealed a lytic lesion in the ileum and acetabulum extending into the pubis and ischium. A MRI scan revealed a 17-centimeter innominate mass with intrapelvic and extrapelvic extension. An open biopsy was performed and the diagnosis of osteosarcoma was confirmed. The patient underwent preoperative chemotherapy and a decision was then made to proceed with wide resection.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

This begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology and laboratory studies; with special attention to review of x-rays, CT scans and MRI scans. A consultation would typically occur with the referring physician to appraise the physician of the patient's situation and, if necessary, discuss appropriate concerns about optimizing the patient's health problems prior to surgery. Communication would take place with the patient (and/or the patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes patient positioning on the operative table; marking the patient for the planned incision to include the previous biopsy site; preoperative scrubbing and gowning as well as prepping and draping of the operative site. At this time, the surgeon also ensures that all of the surgical instruments and supplies that are necessary are present and available in the operative site.

INTRAOPERATIVE WORK:

An attending Urologist performs a cystoscopy once general anesthesia is established and inserts a left ureteral stent and a Foley catheter. The patient is placed in the lateral decubitus position on a beanbag. A skin incision is then made from the pubic symphysis over the inguinal ligament and over the superior bony rim of the pelvis going back posteriorly to the sacro-iliac joint. A second incision is then made over the lateral aspect of the proximal femur extending proximally to the mid lateral aspect of the first incision creating a large laterally based "T". This is carried down sharply through the skin and subcutaneous tissues and hemostasis is obtained. The anterior portion of the incision is then taken down through the inguinal ligament from the pubic symphysis to the anterosuperior iliac spine. The femoral artery and vein are exposed and carefully dissected. Vessel loops are carefully placed around the femoral artery and vein in the pelvis so that proximal control can be maintained. The abdominal wall muscles are then dissected extraperiosteally from their insertion on the wing of the ileum. These muscles are retracted proximally. In the course of doing this, the lateral femoral cutaneous nerve is identified, dissected and protected throughout the case. Dissection is then carried down over the iliacus muscle, which will be left with the resection specimen to form the medial wide margin. In the lower portion of the pelvis, the ureter is palpated and this is facilitated by the previously placed ureteral stent. The ureter is carefully swept posteriorly and the peritoneum is retracted away from the mass. Dissection is then carried through the iliacus muscle and through the psoas muscle also to facilitate exposure of the pubis. The femoral nerve is exposed within the anterior aspect of the psoas muscle. A vessel loop is placed around it and it is carefully protected throughout the case. Dissection is then carried posteriorly over the posterior aspect of the iliac wing back to the sacro-iliac joint again staying extraperiosteal to keep away from the tumor. The muscles originating from the anterior aspect of the

pelvis are then dissected extraperiosteally and these include the tensor fascia lata, sartorius and rectus femoris muscles. Several perforating vessels are typically encountered here and are dissected, ligated and incised. The lateral incision is then incised through the fascia lata and anterior and posterior flaps are fashioned. The gluteus maximus muscle is split in line with its fibers and the gluteus maximus is then separated from the underlying gluteus medius and minimus and is then retracted anteriorly and posteriorly. The gluteus medius is then separated from the underlying gluteus minimus, which is maintained with the specimen to serve as the lateral wide margin. This dissection is carried back to the sciatic notch and the gluteal vessels and nerves to the medius and maximus are preserved while the branches to the minimus are sacrificed. The sciatic notch is then exposed from within the pelvis and from without. A large Penrose drain is then drawn through the sciatic notch to protect the underlying vessels and nerves. The sciatic nerve is then dissected inside and outside the pelvis so that it is visualized throughout this region. Posteriorly, the posterior aspect of the ileum is then exposed followed by exposure of the sacral ala by dissection of the paraspinous muscles to expose the posterior aspect of the sacral ala. Dissection is then carried around the hip capsule circumferentially and the anterior and posterior circumflex vessels are identified, ligated and incised. The ligamentum teres is incised and the hip joint is dislocated. The insertion of the iliopsoas muscle on the lesser is identified and incised. Dissection is then carried down the outside of the ischium detaching the origin of the hamstring muscles and being careful to remain in the extraperiosteal plane to keep away from the underlying tumor. Dissection is then carried over the pubis and the femoral artery and vein are skeletonized in this area and carefully retracted anteriorly. The inner wall of the pubis is then dissected and the pubis is separated from the bladder in the space of Retzius. The obturator vessels and nerves are visualized in the pelvis and ligated and incised. The origin of the adductor muscles is then dissected extraperiosteally and the obturator vessels and nerves are identified, ligated and incised in the adductor muscles outside the pelvis. A large Penrose drain is placed around the pubic symphysis to protect the bladder during subsequent bone cuts. Final exposure of the planned areas for the bone cuts through the pubic symphysis and along the sacrum are performed. An oscillating saw is then used to make the bone cuts, which are then completed with a curved periosteal elevator and a mallet so as not to damage the underlying nerves and vessels. Once these cuts are completed, the innominate bone can be mobilized by careful incision of the remaining soft tissue attachments. Careful hemostasis is then obtained and the wound is copiously irrigated. Two suction drains are then left deep in the wound and brought out proximally. The gluteus medius and maximus are repaired to the abdominal wall muscles with nonabsorbable suture. The remaining soft tissue is then repaired in layers with interrupted sutures and the skin with skin staples.

POSTOPERATIVE WORK:

This begins after skin closure in the operating room and includes removal of operative drapes and application of a sterile surgical dressing. The patient is then carefully examined as soon as he is conscious to ensure that motor and sensory function of nerves that were exposed during the operation are intact. Postoperative work also includes monitoring the patient stabilization in the recovery room and subsequently in an intensive care unit where these patients typically spend several days; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring hemodynamic status; care and removal of drains; careful wound care and observation to avoid or promptly treat wound hematoma; supervision of physical therapy to the patient and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology and laboratory reports and antibiotic and pain medication adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
Musculoskeletal Tumor Society

Sample Size: 95 **Response Rate:** 36 (38%)

Type of Sample: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	29.00	33.13	40.00	45.00	100.00
Pre-Service			120		
Intra-Service	150	300	360	420	1,200
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	60				
Critical Care	0				
Other Hospital	169	99233x1	99232x3	99231x2	
Discharge Day Mgmt	36	99238			
Office Visits	84	99214x1	99213x2		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
28.52	090	21734	Revision of total hip arthroplasty; both components, with or without autograft or allograft

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 27077 (n=34)	Ref CPT 21734 (n=26)
Pre-service time	120	90
Intra-service time	360	240
Immediate Post-service time	60	30
Total critical care time	0	0
Total other hospital visit time	169	117
Discharge management time	36	30
Total office visit time	84	53

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	5.00	4.00
Intra-service	5.00	4.13
Post-service	5.00	3.63

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.94	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.64
Urgency of medical decision making	4.94	3.28

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	5.00	4.24
Physical effort required	4.97	4.36

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	4.12
Outcome depends on the skill and judgment of physician	5.00	4.28
Estimated risk of malpractice suit with poor outcome	4.70	3.88

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The survey median RVW of 40.00 is recommended for 27075.

This procedure defines the largest operation described by any single CPT code for all of orthopaedics. This is a huge operation. The survey respondents, who are all fellowship trained tumor surgeons, indicated a median intraoperative time of six hours. This procedure requires the same long incision as 27075, but significantly more intraoperative work to widely resect the ischium, pubic rami, and acetabulum. It requires careful exposure and visualization of the femoral, gluteal, and obturator and lateral femoral cutaneous nerves and the ureter. The typical size of the tumor mass is 15-20 cm or larger. Many masses also extend across the midline within the pelvis. That this code is currently valued lower than 27134 is an anomaly.

Additionally, valuing the increments supports this median survey value: The hospital and office visits alone equal 10.97 RVWs leaving 29 RVWs for preoperative time (120 min), intraoperative time (360 min) and immediate same day (60 min).

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

9 orthopaedic surgery
2 plastic & reconstructive surgery

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 15 Yes
- 18 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 2 I agree
- 13 I do not agree

c. Patients requiring this service are now:

- 14 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 1 from outpatient to inpatient
- 0 from inpatient to outpatient
- 14 no change

Survey CPT Code: 27284

Global: 090

Current RVW: 16.76
Recommended RVW: 24-50
23.45 RUC**CPT Code Descriptor:** Arthrodesis, hip joint (including obtaining graft);**Typical Patient (Vignette):** A 17-year-old male with a painful hip secondary to chondrolysis undergoes a hip arthrodesis.**CLINICAL DESCRIPTION OF SERVICE:****PREOPERATIVE WORK:**

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of radiographs and scaled radiographs if necessary for sizing, ordering and review of hip aspiration/arthrogram if necessary, and review of preoperative laboratory tests; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; arranging for intra-operative cell saver; positioning the patient on a fracture table to keep the affected extremity horizontal; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

INTRAOPERATIVE WORK:

An anterior iliofemoral approach to the hip is used. This may be very tedious and time consuming if prior surgery had been done. After exposing and dislocating the joint, the articular cartilage is excised from the femoral head and from the acetabulum down to bleeding cancellous bone. All inflammatory synovium or bone cysts are débrided. It is imperative to remove all necrotic bone from the femoral head.

The hip is then reduced and the hip aligned properly. Sterilized goniometers are frequently used to measure this position precisely. Local bone graft may be used or local muscle-bone pedicle graft. Additionally bone may be taken from the iliac crest. Subperiosteal elevation of the muscle is reflected off the outer cortex. Then the iliac crest is split with an osteotome and removes the outer cortex and using the gouge to remove cancellous bone in the posterior superior iliac spine. After completely removing all of this cancellous bone, we thoroughly irrigate the wound with antibiotic containing solution. The bone is set aside, protected in a sterile fashion for later on in the procedure. Internal fixation is generally used with x-ray monitoring. A heavy "cobra head plate" may be affixed to the pelvis above the hip with screws followed by fixation with screws and a compression device to the lateral shaft. The wound is then closed in layers over suction drains.

POSTOPERATIVE WORK:

This work begins after skin closure in the operating room and includes application of sterile dressing. A cast is considered necessary even if internal fixation is used in greater than 50% of cases. A one and one half-hip spica cast is applied. This may be modified with hinged knees or using a "pantaloons" modification. Immobilization is continued until there is solid bony fusion. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab reports; care and removal of drains and dressings; supervision of physical or occupational therapy; ordering and reviewing postoperative X-rays; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care including home health care,

and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Careful follow-up is needed after ambulation is begun since femoral fractures usually in the subtrochanteric area have been reported in up to 15% of patients associated with trivial trauma.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
Orthopaedic Trauma Association

Sample Size: 272 **Response Rate:** 85 (31%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	18.00	22.98	24.50	27.25	35.65
Pre-Service			80		
Intra-Service	60	150	180	240	300

Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	87	99232x1 99231x3
Discharge Day Mgmt	36	99238
Office Visits	69	99213x3

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
23.45	090	27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation
28.52	090	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 27284 (n=71)	Ref CPT 27227 (n=26)
Pre-service time	80	80
Intra-service time	180	180
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	87	87
Discharge management time	36	30
Total office visit time	69	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.83	4.00
Intra-service	4.46	4.47
Post-service	3.65	3.71

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.12	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	4.05
Urgency of medical decision making	2.85	4.11

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.59	4.68
Physical effort required	4.49	4.53

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.29	4.42
Outcome depends on the skill and judgment of physician	4.65	4.63
Estimated risk of malpractice suit with poor outcome	4.08	3.95

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

CPT 27284 was reviewed during the previous five-year review. However, the workgroup indicated that the survey data was very similar to Harvard and recommended no change in RVUs. The rationale presented at that review compared this code with 27130 (total hip). We tried to indicate at that time that the work was more demanding than 27130 (more intensity and more time) and should at least be valued similar to 27130 (as that was the code most frequently cited as a reference on the survey).

At that same five-year review, CPT 27134 (revision hip) was reviewed and increased. We chose not to include this code on our reference list because it was under review at the same time. This procedure (27134) and CPT 27227 (acetabular fracture repair) accurately compare to the total work of 27284. We again reiterate that the current value for 27284 is too low and is an anomaly. The intraoperative work is more intense than 27130 and similar to 27227. The postoperative work is more than 27130 and less than 27134. The survey median RVW of 24.50 is recommended as this accurately ranks 27284 more than 27130, similar to 27227, and less than 27134, correcting the rank order anomaly.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

14 orthopaedic surgery
2 clinic or group practice (not gppp)
1 internal medicine

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

23 Yes

58 No

b. This service represents new technology that has become more familiar (i.e., less work).

5 I agree

18 I do not agree

c. Patients requiring this service are now:17 more complex (more work)0 less complex (less work)

6 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

23 no change

Survey CPT Code: 27724

Global: 090

Current RVW: 14.99
Recommended RVW: 18.20

CPT Code Descriptor: Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)

Typical Patient (Vignette): A 35-year-old football player sustained a fracture of his mid-shaft tibia during a game one year ago. The fracture healed, with a 30 degree varus angulation. After bone healing, the malunion is corrected by an osteotomy, plating, with an autograft from the iliac crest applied to the nonunion site.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to creation of pre-operative planning sketches traced from X-rays of the malunited and normal tibia, which shows the planned level of bone cuts, placements of implants, expected correction and has a written surgical tactic (if a nonunion, may need bone scans or indium scans to R/O infection); consulting other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Pre-operative work also includes pre-operative scrubbing ordering pre-operative antibiotics; arranging for intra-operative portable radiographs; possible neurologic function monitoring; blood products (standby-type and cross); positioning and tourniquet placement (for correction of a tibial malunion, the patient is positioned supine on a radiolucent table, with a bump under the hip and a pneumatic tourniquet around the upper leg, the pre-operative plan drawings made by the surgeon must be brought into the room and placed up on the viewbox, and the iliac crest should be prepped to allow bone graft harvest); supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

INTRAOPERATIVE WORK:

After inflation of the tourniquet, a straight incision is made anteriorly through the skin just lateral to the crest of the tibia and centered over the deformity. Full thickness skin and subcutaneous tissue flaps must be carefully developed, with very gentle handling of the tenuous soft tissue envelope in this region. Exposure of the tibia may be done subperiosteally or extraperiosteally, but it needs to be circumferential at the level of the osteotomy cut in order to allow protection of the neurovascular structures posterior to the bone. Excessive stripping should be avoided, yet exposure must be adequate to allow a safe osteotomy, and this requires experience and judgment. Once the bone is exposed, the osteotomy is performed using an oscillating saw, at the level and orientation as indicated on the preoperative plan. Neurovascular structures are protected with retractors. Prior to correction of the deformity, the fibula may need to be osteotomized, and this may usually be done with an osteotome through a small incision (but not percutaneously). In the case of an oblique osteotomy, the deformity is corrected by rotating the distal fragment around the axis of the osteotomy using a femoral distractor on the appropriate side. For correction of a varus deformity, the distractor is placed medially. Three dimensional alignment and length is corrected, a clamp is placed across the osteotomy, and a lag screw used to compress the cut surfaces. Usually intraoperative films showing the ankle and knee are obtained to verify alignment. If satisfactory, the bone contours may be fine-tuned, a neutralization plate shaped to fit the anteromedial surface of the tibia, and attached with cortical screws. Bone graft, either simultaneously or previously harvested from the iliac crest is placed around the osteotomy site. The wound is irrigated, Hemovac drains placed, and the soft tissues carefully closed in layers. If an extensive valgus deformity or excessive shortening exists, correction is often done using somatosensory evoked potential monitoring to reduce the risk of stretch injury to the nerves.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes application of dressings and splints or a cast. Postoperative work also includes: monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status and function, wound status and healing (tenuous soft tissues); care and removal of suction drains; adjustments of removable splint; supervision of rehabilitation and ambulation; and use of bone stimulator for nonunion; ordering and reviewing radiographs to assess alignment, position, healing; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure; including removal of sutures and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. The surgeon orders physical therapy and directs the ambulation recovery program dependent on the rate of bone healing.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
Orthopaedic Trauma Association
American Orthopaedic Foot and Ankle Society

Sample Size: 149 **Response Rate:** 38 (26%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	13.00	16.04	18.20	19.63	31.90
Pre-Service			90		
Intra-Service	70	140	180	180	300
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	49	99232x1	99231x1		
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
11.79	090	27720	Repair of nonunion or malunion, tibia; without graft, (eg, Bone graft, any donor area; major or large
7.55	090	20902	Bone graft, any donor area; major or large

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 27724 (n=36)	Ref CPT 27720 (n=22)
Pre-service time	90	90
Intra-service time	180	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	49	49
Discharge management time	36	30
Total office visit time	61	61
<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>		
TIME SEGMENTS		
Pre-service	3.70	3.36
Intra-service	4.23	3.73
Post-service	3.52	3.36
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.45
Urgency of medical decision making	2.94	2.95
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.19	3.77
Physical effort required	4.19	3.73
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.29	3.91
Outcome depends on the skill and judgment of physician	4.32	3.91
Estimated risk of malpractice suit with poor outcome	4.03	3.82

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

This code was reviewed by the RUC during the previous five-year review. The RUC workgroup rejected the survey recommendation that was made and instead recommended a more modest increase based upon a rationale of comparable codes that we now believe to be erroneous. We believe that the total work of 27724 is exactly equal to the work of 27720 plus 20902. (Note that 20902 is modifier -51 exempt, and its value is not reduced.) The sum of the RVWs for these two codes is 19.34 [11.79 + 20902]. This supports the survey median RVW of 18.20 that is recommended for this code.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :
[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

450 orthopaedic surgery
14 clinic or group practice (not gppp)
1 anesthesiology
1 hand surgery
1 physical medicine and rehabilitation

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

8 Yes
24 No

b. This service represents new technology that has become more familiar (i.e., less work).

3 I agree
5 I do not agree

c. Patients requiring this service are now:

- 5 more complex (more work)
- 0 less complex (less work)
- 3 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 7 no change

CPT Code: 27822

Global : 090

Current RVW: 9.20

Recommended RVW: 11.00

CPT Descriptor: Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip

Typical Patient (Survey Vignette): A 27-year-old female sustains a trimalleolar ankle fracture after falling down an embankment. Open reduction, internal fixation of the medial and/or lateral malleolus is performed.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before surgery until the time of the procedure, when the skin incision is actually made. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, examination of ipsi- and contralateral lower extremities; consulting with referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; supervising the organizing fluoroscopic equipment; positioning the patient on the operating table, application of a thigh tourniquet, supervising prepping and draping of the patient; preoperative scrubbing, marking the patient for the planned incision, exsanguination of the extremity and inflation of the tourniquet.

INTRAOPERATIVE WORK:

In order to perform open reduction of a trimalleolar ankle fracture, two surgical incisions are utilized. In almost all situations, both the medial and lateral malleolus are surgically repaired, and internal fixation is commonly utilized. One incision is placed over the distal fibula, and a second incision is placed over the medial malleolus. The skin is sharply incised, and hemostasis is obtained. The incisions are carried down to the fibula and tibia respectively, with care being taken to avoid injury to the neurovascular structures. The medial and lateral malleoli are exposed by subperiosteal dissection. The fracture fragments are identified and fracture hematoma is removed. Under direct visualization, the fibular fracture fragments are reduced and held temporarily with pins or clamps. After an anatomic reduction is obtained, the fracture is repair using rigid internal compression fixation. The medial fracture fragments are then reduced and temporarily held with pins or clamps. Rigid internal compression fixation is then utilized for permanent fracture fixation. In this procedure, the posterior lip is not repaired, either because it is small, or it is not significantly displaced. Fluoroscopy is then utilized to confirm that the reduction is anatomic and that the hardware has been appropriately placed. The tourniquet is deflated, hemostasis is obtained, and the wound is washed. The wound is then closed in layers over a suction drain.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes cleaning of the extremity, application of the postoperative dressing and application of a splint or cast. Postoperative work also includes monitoring patient stabilization in the recovery room; writing of postoperative physician orders and medical records; dictation of an operative report; communication with the family and other health care professionals; and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication and physical therapy management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day the operation

are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports; office visits for evaluation of the patient, and assessment of their return to active function; phone calls to the patient, family, physical therapist, and other health care professionals; and pain medication and physical therapy and activity adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society
Orthopaedic Trauma Association

Sample Size: 173 **Response Rate:** 48 (28%)

Type of Sample:

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.68	11.00	11.50	12.25	17.90
Pre-Service			80		
Intra-Service	45	75	90	120	150
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	38	99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	99	99214x1 99213x2 99212x1			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.68	090	27814	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 27822 (n=43)	Ref CPT 27814 (n=36)
Pre-service time	80	75
Intra-service time	90	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	38	38
Discharge management time	36	30
Total office visit time	99	76

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.19	2.75
Intra-service	3.47	3.06
Post-service	2.81	2.58

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.50
Urgency of medical decision making	3.09	2.94

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.56	3.19
Physical effort required	3.07	2.86

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.16	2.75
Outcome depends on the skill and judgment of physician	3.58	3.28
Estimated risk of malpractice suit with poor outcome	3.35	2.94

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

A rank order anomaly exists between 27822 and 27814. Although the surgeon's work is similar, the intensity is greater for 27822. The survey 25th percentile RVW of 11.00 is recommended. This is slightly greater than the RVW for 27814 and corrects the current rank order anomaly.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

4,595	orthopaedic surgery
103	clinic or group practice (not gppp)
20	general surgery
14	general practice
13	podiatry
11	hand surgery
6	internal medicine
4	anesthesiology
2	cma, anesthesia assistant
2	diagnostic radiology
2	family practice
2	urology
1	cardiology
1	pediatric medicine
1	physical medicine and rehabilitation
1	physician assistant
1	psychiatry
1	vascular surgery

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 8 Yes
- 30 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 7 I do not agree

c. Patients requiring this service are now:

- 6 more complex (more work)
- 0 less complex (less work)
- 2 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 3 from inpatient to outpatient
- 5 no change

Survey CPT Code: 27823

Global: 090

Current RVW: 11.80
Recommended RVW: 13.00

CPT Code Descriptor: Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip

Typical Patient (Vignette): A 27-year old female sustains a trimalleolar ankle fracture after falling down an embankment. Open reduction, internal fixation of the medial and/or lateral malleolus is performed, as well as the posterior lip.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before surgery until the time of the procedure, when the skin incision is actually made. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, examination of ipsi- and contralateral lower extremities; consulting with referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; supervising the organizing fluoroscopic equipment; positioning the patient on the operating table, application of a thigh tourniquet, supervising prepping and draping of the patient; preoperative scrubbing, marking the patient for the planned incision, exsanguination of the extremity and inflation of the tourniquet.

INTRAOPERATIVE WORK:

In order to perform open reduction of a trimalleolar ankle fracture, with fixation of the posterior lip, two or three surgical incisions are utilized. In almost all situations, both the medial and lateral malleolus are surgically repaired, and internal fixation is commonly utilized. One incision is placed over the distal fibula, and a second incision is placed over the medial malleolus. The posterior fragment may be approached using extensive dissection through the medial incision, or through an additional posterior incision. The skin is sharply incised, and hemostasis is obtained. The incisions are carried down to the fibula and tibia respectively, with care being taken to avoid injury to the neurovascular structures. The medial and lateral malleoli are exposed by subperiosteal dissection. The fracture fragments are identified and fracture hematoma is removed. Under direct visualization, the fibular fracture fragments are reduced and held temporarily with pins or clamps. After an anatomic reduction is obtained, the fracture is repair using rigid internal compression fixation. The medial fracture fragments are then reduced and temporarily held with pins or clamps. Rigid internal compression fixation is then utilized for permanent fracture fixation. In this procedure, the posterior lip is repaired. This requires additional visualization of the posterior fragment through extensive dissection using the medial incision, or a separate incision placed posteriorly. Exposure of the posterior fragment is more difficult, as the posterior tibial neurovascular bundle lies directly over the fracture fragment. After visualization the fracture is anatomically reduced and repaired using rigid compression fixation. Fluoroscopy is then utilized to confirm that the reduction is anatomic and that the hardware has been appropriately placed. The tourniquet is deflated, hemostasis is obtained, and the wound is washed. The wound is then closed in layers over a suction drain.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes cleaning of the extremity, application of the postoperative dressing and application of a splint or cast. Postoperative work also includes monitoring patient stabilization in the recovery room; writing of postoperative physician orders and medical records; dictation of an operative report; communication with the family and other health care professionals; and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication and physical therapy management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records.

Additionally, all post-discharge office visits for this procedure for 90 days after the day the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports; office visits for evaluation of the patient, and assessment of their return to active function; phone calls to the patient, family, physical therapist, and other health care professionals; and pain medication and physical therapy and activity adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society
Orthopaedic Trauma Association

Sample Size: 169 **Response Rate:** 48 (28%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWW	11.00	12.50	13.00	14.00	18.50
Pre-Service			80		
Intra-Service	70	90	120	140	240
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	49	99232x1	99231x1		
Discharge Day Mgmt	36	99238			
Office Visits	84	99213x3	99212x1		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.68	090	27814	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 27823 (n=43)	Ref CPT 27814 (n=28)
Pre-service time	80	75
Intra-service time	120	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	49	38
Discharge management time	36	30
Total office visit time	84	76

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.35	2.57
Intra-service	4.05	2.96
Post-service	2.84	2.43

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.35	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	2.43
Urgency of medical decision making	3.23	2.86

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.11
Physical effort required	3.60	2.82

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.47	2.57
Outcome depends on the skill and judgment of physician	3.95	3.07
Estimated risk of malpractice suit with poor outcome	3.44	2.93

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

CPT 27823 is more work than 27822 and 27814. It was previously recommended that the RVW for 27822 should be higher than 27814 with a recommendation of 11.00. The survey median RVW of 13.00 is recommended. The additional intraoperative work for 27823 (30 min) compared with 27822 supports this recommendation and correctly ranks these procedures.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :
[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

905	orthopaedic surgery
20	clinic or group practice (not gppp)
7	podiatry
5	general surgery
5	hand surgery
4	urology
3	general practice
1	family practice
1	physical medicine and rehabilitation

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

8 Yes
27 No

b. This service represents new technology that has become more familiar (i.e., less work).

2 I agree
6 I do not agree

c. Patients requiring this service are now:

- 6 more complex (more work)
- 0 less complex (less work)
- 2 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 2 from inpatient to outpatient
- 6 no change

Survey CPT Code: 28299

Global: 090

Current RVW: 8.88
Recommended RVW: 44.85
9.18 RUC

CPT Code Descriptor: Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)

Typical Patient (Vignette): A 44-year old female has a complex hallux valgus deformity that has not responded to conservative treatment. The deformity is surgically corrected with a double osteotomy of the metatarsal and proximal phalanx.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before surgery until the time of the procedure, when the skin incision is actually made. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, examination of ipsi- and contralateral lower extremities; consulting with referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; supervising the organizing fluoroscopic equipment; positioning the patient on the operating table; application of a thigh tourniquet, supervising prepping and draping of the patient; preoperative scrubbing, marking the patient for the planned incision, exsanguination of the extremity and inflation of the tourniquet.

INTRAOPERATIVE WORK:

In order to perform a hallux valgus correction with double osteotomy, two operative procedures must be performed. First a chevron osteotomy of the distal first metatarsal with correction of the hallux valgus, followed by an osteotomy of the proximal phalanx to correct additional angular deformity. A long medial incision is made, centered over the hallux medial eminence extending from the proximal interphalangeal joint to the mid metatarsal shaft. The interval between the dorsal and plantar nerves is developed down to the joint capsule of the metatarsal phalangeal joint. The joint capsule is incised and the joint is inspected for evidence of arthritic changes. Under direct visualization, the joint is distracted and the lateral joint capsule is incised by reaching across the joint and cutting the capsule. This allows correction of the capsular deformity. By subperiosteal dissection, the distal aspect of the metatarsal is exposed, including the medial eminence. Using a power saw, the medial eminence is then removed. A chevron shaped osteotomy (V-shaped) is then performed across the metatarsal neck. After completion of the cut, the distal fragment is displaced laterally and impacted into the proximal fragment. Once the desired amount of correction is obtained, internal fixation hardware is inserted to maintain the bone position.

At this point, attention is then directed towards the proximal phalanx and the angular deformity that is present. The proximal phalanx is exposed by subperiosteal dissection. Using a power saw, a displacement osteotomy is then performed near the base of the proximal phalanx. The osteotomy is then displaced and internal fixation hardware is inserted to maintain the bone position. After completion of both osteotomies, fluoroscopy is utilized to verify the correction and hardware placement. The tourniquet is deflated, and hemostasis is obtained. The wound is washed. Closure is performed in layers, with special attention being paid to the capsular closure to prevent recurrence, or overcorrection of the deformity.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes cleaning of the extremity, application of the postoperative dressing and application of a splint or cast. Postoperative work also includes monitoring patient stabilization in the recovery room; writing of postoperative physician orders and medical records; dictation of an operative report; communication with the family and other health care professionals; and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication and physical therapy management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records.

Additionally, all post-discharge office visits for this procedure for 90 days after the day the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports; office visits for evaluation of the patient, and assessment of their return to active function; phone calls to the patient, family, physical therapist, and other health care professionals; and pain medication and physical therapy and activity adjustments. Postoperative office care in this procedure is greater than most procedures. During the first six weeks, the patient is seen weekly, to retape the forefoot and help control the correction in order to avoid recurrent deformity, or overcorrection. During the next six weeks, the patient is seen every two weeks to monitor their progressive range of motion and return to full activity.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society
American Podiatric Medical Association

Sample Size: 126 **Response Rate:** 42 (33%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	11.15	11.85	12.18	24.00
Pre-Service			75		
Intra-Service	60	86	90	105	180
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	36	99238x1			
Office Visits	84	99213x3	99212x1		

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
9.18	090	28296	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
5.43	090	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 28299 (n=42)	Ref CPT 28296 (n=35)
Pre-service time	75	70
Intra-service time	90	60
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	30
Total office visit time	84	107

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.40	3.00
Intra-service	3.98	3.24
Post-service	3.18	2.97

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.14
Urgency of medical decision making	2.26	2.29

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.22	3.65
Physical effort required	3.54	3.24

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.71	3.06
Outcome depends on the skill and judgment of physician	4.17	3.63
Estimated risk of malpractice suit with poor outcome	3.69	3.49

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Although the survey descriptor cites "double osteotomy" as an example of "other method," this was not the "typical patient" until recently and the value for this "other method" code was most likely not based on double osteotomy. In fact, the Harvard study did not include the phrase (eg, double osteotomy) in its survey. When this code was originally valued, it is most likely that the orthopaedic surgeons responding may not have known what "other methods" might be employed.

Current practice for hallux valgus surgery continues to evolve with the development of combined osseous and soft tissue procedures. In current practice, 28299 has changed so that typically a double osteotomy is performed (first metatarsal and proximal phalanx). The survey median RVW is recommended and can be justified using two reference comparisons.

28299 requires more intraoperative work (both time and intensity) than 28296 for a second osteotomy. The additional 30 minutes compared with 99291 would equal 2.00 rvu's. This added to the RVW for 28296 equals 11.18 rvu's [9.18 + 2.00 = 11.18].

Using the multiple procedure rule, 50 percent of the RVW for 28310 is 2.71 which represents the work value for one osteotomy. Adding this increment to the current value for 28299 to account for the "typical" double osteotomy in current practice equals 11.59 rvu's [8.88 + 2.71 = 11.59].

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :
[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,233 podiatry
235 orthopaedic surgery
6 ASC
4 clinic or group practice (not gppp)
3 general surgery
2 anesthesiology
1 internal medicine
1 plastic & reconstructive surgery

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 16 Yes
- 26 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 4 I agree
- 12 I do not agree

c. Patients requiring this service are now:

- 9 more complex (more work)
- 0 less complex (less work)
- 7 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 11 from inpatient to outpatient
- 5 no change

Survey CPT Code: 28445

Global: 090

Current RVW: 9.33
Recommended RVW: 15.62

CPT Code Descriptor: Open treatment of talus fracture, with or without internal or external fixation

Typical Patient (Vignette): When high speed car chase ends abruptly against a telephone pole, a 35-year-old man suffers a displaced talar neck fracture as he tries to slam on the brakes. The body of the talus is extruded from the ankle joint, the medial malleolus is fractured, and the lateral foot skin is stretched and tented. He is taken promptly to the OR for reduction and fixation, which is performed through medial and lateral incisions with screw fixation from posterior to anterior.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Beginning after the decision to operate is made, the surgeon focuses on safely getting the patient to the operating room as rapidly as possible, because of the risk of skin necrosis, as well as long term healing and avascular necrosis problems that increase as reduction is delayed. The surgeon must reassess the patient's physical examination to look for possibility of life-threatening missed injuries, as well as to monitor the patient's injured limb, neurovascular status, and skin. Ankle and foot x-rays of the injured and opposite sides are obtained, and interpreted by the surgeon, and a preoperative plan is developed based upon location of fracture lines, comminution, and associated local injuries such as the frequently accompanying medial malleolus fracture. A CAT scan may, if possible, be obtained urgently to provide further definition of the injury and to assist with preoperative planning. Typically the surgeon must negotiate with anesthesia and operating room personnel to obtain emergency operating room access. The surgeon must obtain a C-arm fluoroscope and technician, as well as necessary surgical fixation equipment. He stands by during anesthesia and positions the patient supine on a radiolucent table. The surgeon applies a pneumatic tourniquet to the proximal thigh, and scrubs the foot, prepares it with antiseptic solution, and applies sterile drapes from the thigh to the toes, with the leg free. Padding under the patient's buttock is applied by the surgeon to facilitate access to the lateral side of the ankle.

INTRAOPERATIVE WORK:

Medial and lateral incisions are required for adequate access to the talar neck. The laterally extruded body is identified in the lateral incision, and any remaining soft tissue attachments are carefully preserved while bone fragments and hematoma are removed from fracture site, tibiotalar and subtalar joints, and the talar body is repositioned into the ankle mortise. The talar head and neck portion is then realigned relative to the body, and tediously reduced with provisional fixation using K-wires inserted through both medial and lateral wounds from anterior to posterior, with confirmation of reduction by direct vision, and by C-arm fluoroscopic radiography, interpreted by the surgeon, who must also position the foot and C-arm appropriately to obtain the necessary radiographs. The reduction is adjusted and corrected as necessary until it is as close to anatomic as possible. This is confirmed with repeated x-rays. Once the satisfactory reduction has been achieved and confirmed, a posterolateral incision is made for access to the posterior talar body, and K-wires are inserted with fluoroscopic guidance from the posterior body into the anterior neck. Two such wires are required, one or both of which may be used as guide wires for cannulated screws to fix the fracture. A cannulated drill is inserted cautiously with x-ray control to ensure that reduction is maintained. The drill is advanced through the dense bone of the talar body, and into the neck and head of this bone. The wire length is measured with the aid of the fluoroscope and a depth gauge, an appropriate screw is chosen, and its hole prepared with an appropriate cannulated drill over the wire, following which the screw is inserted and the fracture site compressed, the other wire or screw maintaining rotational control during and after screw insertion. The guide wire is removed if a screw has been placed, or cut short, and left to control rotation. The surgeon again confirms reduction, interpreting multiple C-arm fluoroscopic images. The surgeon must position patient and fluoroscope to obtain these. Following this, the tourniquet is

deflated, the wounds irrigated, the medial malleolus reduced and fixed as a separately coded procedure, and both wounds are closed in layers using interrupted sutures for the deep fascia and ankle capsule, and interrupted nylon sutures for the skin. During closure the wounds are infiltrated with long acting local anesthetic for analgesia. Stability and range of motion are assessed during closure and ankle joint ligaments repaired as necessary.

PREOPERATIVE WORK:

Postoperative work begins with cleaning and drying the skin and applying sterile dressings, abundant padding, and a short leg splint. The surgeon monitors the patient during reversal of anesthesia, and accompanies him to the recovery room, where he discusses the patient's status with the anesthesia team and recovery room nurses, and medical consultants as necessary by telephone. The surgeon also meets/calls the patient's family to discuss the injury, operative findings, and procedure. The surgeon writes postoperative orders, and a brief operative note, and dictates a detailed operative note.

Anticoagulation may be indicated to reduce risk of thrombo-embolic problems. If so, the surgeon orders and monitors it as needed for 3-6 weeks, with periodic blood tests.

This patient requires hospitalization, and later in the day the surgeon will visit the patient to examine him, check for pain, alertness, nausea, and modify the care plan if and as needed. The surgeon ensures that the leg is elevated, and that toe range of motion exercises are instituted, and that the patient is instructed in non-weight bearing crutch ambulation gait. The surgeon reviews the plans for rehabilitation and resumption of activities, including prolonged crutch use and non-weight bearing for the first 6-8 weeks at least, and until x-rays show union of the fracture of the talus. Daily hospital visits continue until the discharge day visit.

Office visits begin at 7-10 days and then every 3 or 4 weeks through the first 90 days of postoperative care, which includes dressing changes, suture removal, examination of wound, neurovascular status, swelling and skin integrity, range of motion and joint stability, as well as application of splints or casts or prefabricated braces as necessary. It includes adjustment of analgesia and other medicines as needed; writing prescriptions for medications and therapy and/or home health care assistance. Laboratory studies and x-rays are ordered and interpreted by the surgeon. Surgeon reviews progress and changes in rehabilitation program with the patient (for example, increased but still limited weight bearing and/or resistance exercises, crutch or walker use, etc.). Surgeon reviews and responds to reports or telephone calls from therapists and/or home care providers. The surgeon responds to telephone calls from patient or family members, and documents disability informing employers and insurers regarding work status, prognosis and progress, etc.

SURVEY DATA**Presenter(s):** Laura Tosi, MD**Specialty(s):** American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society
Orthopaedic Trauma Association**Sample Size:** 167 **Response Rate:** 40 (24%)**Type of Sample:** random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	13.00	15.62	16.75	18.00	30.00
Pre-Service			105		
Intra-Service	90	120	125	170	240
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	35				
Critical Care	0				
Other Hospital	68	99232x1 99231x2			
Discharge Day Mgmt	36	99238			
Office Visits	99	99214x1 99213x2 99212x1			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
15.97	00	28415	Open treatment of calcaneal fracture, with or without internal or external fixation;

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 28445 (n=34)	Ref CPT 28415 (n=26)
Pre-service time	105	105
Intra-service time	135	130
Immediate Post-service time	35	35
Total critical care time	0	0
Total other hospital visit time	68	68
Discharge management time	36	30
Total office visit time	99	84

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.42	4.20
Intra-service	4.82	4.80
Post-service	3.88	3.76

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.03	4.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.77
Urgency of medical decision making	4.68	3.54

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.73	4.73
Physical effort required	4.18	4.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.71	4.58
Outcome depends on the skill and judgment of physician	4.71	4.58
Estimated risk of malpractice suit with poor outcome	4.35	4.04

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

The total for this procedure is similar to 28415. During the previous five-year review, 28415 was increased, creating a rank order anomaly. The survey 25th percentile RVW of 15.62 is recommended for 28445 to correct this anomaly.

We also point out that the reference code 28415 is appropriately valued: The balance RVW of 9.97 for the preoperative work (105 min), intraoperative work (130 min) and same day postoperative work (35 min) [i.e., 99232x1, 99231x1, 99239, 99213x3, 99212x1 rvu's subtracted] is more than justifiable.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

150	orthopaedic surgery
19	podiatry
4	clinic or group practice (not gppp)
1	emergency medicine
1	general practice
1	hand surgery

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

13 Yes
21 No

b. This service represents new technology that has become more familiar (i.e., less work).

2 I agree
11 I do not agree

c. Patients requiring this service are now:

- 11 more complex (more work)
- 0 less complex (less work)
- 2 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 1 from inpatient to outpatient
- 12 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

Survey CPT Code: 28705

Global: 090

Current RVW: 15.21
Recommended RVW: ~~20.75~~
18.80 RUC

CPT Code Descriptor: Arthrodesis; pantalar

Typical Patient (Vignette): A 30-year-old laborer with severe post-traumatic arthritis of the tibiotalar and subtalar joints, secondary to an old displaced talus fracture, undergoes a pantalar arthrodesis (ankle arthrodesis and triple arthrodesis).

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before surgery until the time of the procedure, when the skin incision is actually made. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, examination of ipsi- and contralateral lower extremities; consulting with referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; supervising the organizing fluoroscopic equipment; positioning the patient on the operating table, application of a thigh tourniquet, supervising prepping and draping of the patient; preoperative scrubbing, marking the patient for the planned incision, exsanguination of the extremity and inflation of the tourniquet.

INTRAOPERATIVE WORK:

A pantalar arthrodesis is an ankle fusion and triple arthrodesis performed at the same time. Due to the complexity of the deformity present, the work and effort involved is greater than the sum of the two procedures. To perform a pantalar arthrodesis, an extensive incision is made on the lateral side of the ankle along the lateral border of the fibula covering its distal third, extending to the base of the fourth metatarsal, establishing the neural interval between the superficial peroneal nerve and the sural nerve. The distal third of the fibula is subperiosteally dissected. The soft tissue and scar tissue covering the lateral tibiotalar joint are removed and careful sharp dissection reveals the anterior and lateral surfaces of the distal tibia, fibula, and the talus. The sinus tarsi is exposed by mobilizing the sinus tarsi fat pad along with the adjacent origin of the extensor brevis musculature, which is brought up as flap after subperiosteally dissecting the contents of the sinus tarsi out, and sharp and blunt dissection is carried out to a point to where the subtalar posterior facet, middle facet, and anterior facets are carefully visualized. Also, sharp subperiosteal dissection is used to visualize the calcaneal cuboid joint and the lateral portion of the talonavicular joint. Lamina spreaders are placed within the sinus tarsi and within the involved joints, and careful decortication of all the articular surfaces is performed. Another incision is made medially, and after subperiosteal dissection, and remaining articular cartilage is removed from the four articulations. Assessment of the foot position is then carried. This operation, although a combination of a triple and ankle fusion, is more complex than the sum of the parts. These patients have advanced and complex deformities in multiple planes that are difficult to correct. In order to correct the multiplane deformities, wedges of bone are removed from the ankle, subtalar, and transverse tarsal joints to create plantigrade foot. Temporary fixation is carried out with guide wires and fluoroscopy is utilized to confirm position.

At this time, the tightness of the Achilles tendon is assessed, and if necessary, it is lengthened. Once proper position is verified, screw fixation is utilized to provide bony stabilizations and compression of the denuded bone surfaces. Final position is again verified both clinically and fluoroscopically. After good fixation and reassessment of the position, copious irrigation is carried out, and hemostasis is obtained. The wound is closed in layers after drains have been inserted.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes cleaning of the extremity, application of the postoperative dressing and application of a splint or cast. Postoperative work also includes monitoring patient stabilization in the recovery room; writing of postoperative physician orders and medical records; dictation of an operative report; communication with the family and other health care professionals; and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication and physical therapy management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports; office visits for evaluation of the patient, and assessment of their return to active function; phone calls to the patient, family, physical therapist, and other health care professionals; and pain medication and physical therapy and activity adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society

Sample Size: 77 **Response Rate:** 30 (39%)

Type of Sample: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.50	20.00	20.75	23.21	34.56
Pre-Service			75		
Intra-Service	60	150	180	200	240
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	35				
Critical Care	0				
Other Hospital	49	99232x1 99231x1			
Discharge Day Mgmt	36	99238			
Office Visits	99	99214x1 99213x2 99212x1			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
13.91	090	27870	Arthrodesis, ankle, any method
13.10	090	28715	Triple arthrodesis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 28705 (n=30)	Ref CPT 27870 (n=13)
Pre-service time	75	75
Intra-service time	180	120
Immediate Post-service time	35	35
Total critical care time	0	0
Total other hospital visit time	49	38
Discharge management time	36	30
Total office visit time	99	69

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.32	4.08
Intra-service	4.80	4.33
Post-service	3.64	3.54

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.12	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.85
Urgency of medical decision making	2.72	2.92

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.92	4.31
Physical effort required	4.68	4.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.44	4.00
Outcome depends on the skill and judgment of physician	4.84	4.54
Estimated risk of malpractice suit with poor outcome	4.00	3.92

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

A pantalar arthrodesis is the combination of an ankle fusion and a triple arthrodesis. Therefore, the work of 28705 is equivalent to the work of 27870 plus that of 28715. Applying the multiple procedure rule, the proposed RVW for 28705 is equal to the RVW of 27870 plus one half of the RVW of 28715 [$13.91 + 6.55 = 20.46$]. Additionally, this code was presented during the previous five-year review, but an increase was rejected because this code had gone through the 1992 refinement. That refinement was not based upon survey data. Our 1995 surveys suggested an increase to be appropriate and our current surveys suggest that an increase is appropriate. We recommend an RVW of 20.75, which is the survey median. Please note that this is higher than the previous recommendation because the reference procedure 27870 was reviewed and increased during the previous five-year review.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :
[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

153 orthopaedic surgery
46 podiatry
5 clinic or group practice (not gppp)

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

7 Yes
17 No

b. This service represents new technology that has become more familiar (i.e., less work).

2 I agree
5 I do not agree

c. Patients requiring this service are now:

- 6 more complex (more work)
- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 1 from inpatient to outpatient
- 6 no change

Survey CPT Code: 29450

Global: 000Current RVW: 1.02
Recommended RVW: 2.08**CPT Code Descriptor:** Application of clubfoot cast with molding or manipulation, long or short leg

Typical Patient (Vignette): An eight-week-old baby male was born with a Congenital Talipes Equinovarus deformity. He returns to the office for his third corrective clubfoot cast. Because of the patient's age and skin sensitivity it is necessary for the physician to remove the cast personally. The foot is then manipulated and stretched for several minutes by the physician. After careful positioning by the physician, the physician holds the foot and a temperature controlled corrective long leg cast is applied in sections. The physician molds the cast as the plaster hardens. After the physician evaluates the circulation to the foot and cast fit, the physician counsels the family concerning how to evaluate the foot and cast until the next visit and cast removal. If formal evaluation of the foot and x-ray interpretation is done during the same visit this would be done as a distinct and separately documented evaluation and management visit.

CLINICAL DESCRIPTION OF SERVICE:**PREOPERATIVE WORK:**

Meet with family and discuss course of therapy since last visit. Position patient. Inspect cast and foot; remove cast and padding; evaluate skin; allow time to wash baby and calm patient.

INTRAOPERATIVE WORK:

After the skin has been prepped, the foot is manipulated and stretched for several minutes by the physician. After careful positioning by the physician, the physician holds the foot and a temperature controlled corrective long leg cast is applied in sections. The physician molds the cast as the plaster hardens.

POSTOPERATIVE WORK:

After the physician evaluates the circulation to the foot and cast fit, the physician counsels the family concerning how to evaluate the foot and cast until the next visit and cast removal. Dictate note regarding visit. Review report and sign and send to primary care physician. If formal evaluation of the foot and x-ray interpretation is done during the same visit this would be done as a distinct and separately documented evaluation and management visit.

SURVEY DATA**Presenter(s):** Laura Tosi, MD**Specialty(s):** American Association of Orthopaedic Surgeons
Pediatric Orthopaedic Society of North America**Sample Size:** 127 **Response Rate:** 69 (54%)**Type of Sample:** random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	1.40	1.90	2.08	3.16	14.00
Pre-Service			10		
Intra-Service	10	15	20	25	45
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	5				
Critical Care	0	n/a			
Other Hospital	0	n/a			
Discharge Day Mgmt	0	n/a			
Office Visits	0	n/a			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
1.78	000	29445	Application of rigid total contact leg cast
1.02	000	29425	Application of short leg cast (below knee to toes); walking or ambulatory type

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 29450 (n=62)	Ref CPT 29445 (n=43)
Pre-service time	10	5
Intra-service time	20	15
Immediate Post-service time	5	5
Total critical care time	n/a	n/a
Total other hospital visit time	n/a	n/a
Discharge management time	n/a	n/a
Total office visit time	n/a	n/a

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.38	1.83
Intra-service	3.86	2.79
Post-service	2.33	1.90

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.72	2.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.00
Urgency of medical decision making	2.33	2.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.31	2.93
Physical effort required	3.03	2.60

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.00	2.51
Outcome depends on the skill and judgment of physician	4.21	2.73
Estimated risk of malpractice suit with poor outcome	2.95	2.52

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

There is rank order anomaly between 29445 and 29450. CPT 29450 represents significantly more work than 29445 in that it includes manipulation of the clubfoot for an extended period, temperature-controlled cast application and molding, and temperature-controlled cast removal to prevent burns of delicate neonatal skin. We believe the complexity/intensity measurements above show this.

Additionally, CPT 29450 is not valued appropriately relative to another reference CPT 29425 (application of short leg cast). 29450 is more work than 29425 for the same reasons as indicated above and should not have the same value. 29425 is a cast typically used for a nondisplaced ankle or foot fracture or an ankle or foot sprain.

It is likely that physicians unfamiliar with the procedure originally valued this pediatric procedure at an

RVW less than a short leg cast application (29425). The survey median RVW of 2.08 corrects these anomalies and correctly values this pediatric procedure relative to 29425 and 29445.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes

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.

National frequency unavailable; not able to estimate.

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.

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

231	podiatry	3	internal medicine
48	orthopaedic surgery	2	clinic or group practice (not gppp)
12	family practice	1	hand surgery
10	general practice		

Do many physicians perform this service across the United States? Yes

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

- a. **Has the work of performing this service changed in the past 5 years?**
 - 13 Yes
 - 52 No
- b. **This service represents new technology that has become more familiar (i.e., less work).**
 - 0 I agree
 - 13 I do not agree
- c. **Patients requiring this service are now:**
 - 7 more complex (more work)
 - 0 less complex (less work)
 - 6 no change
- d. **The usual site-of-service has changed:**
 - 0 from outpatient to inpatient
 - 0 from inpatient to outpatient
 - 13 no change

Survey CPT Code: 29883

Global: 090

Current RVW: 9.46
Recommended RVW: 11.05

CPT Code Descriptor: Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)

Typical Patient (Vignette): A 35-year-old recreational skier injures his/her knee with peripheral longitudinal tears of both medial and lateral menisci and undergoes an arthroscopic meniscus repair of both using a suture technique.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reviewing the MRI; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient to explain operative risks and benefits and to obtain informed consent. The operative site is marked by the physician. Preoperative work also includes pre-operative scrubbing; supervision of positioning of the patient, applying a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee. The "well leg" is secured on a knee support attached to the operating table thereby holding it out of the way in elevation and abduction. Additional work includes supervising the skin preparation and personally draping the patient, ensuring that the necessary surgical instruments and supplies (cannula system to guide the special 10" suture needles and posterior knee retractors) are present and available in the operative suite; and applying a tourniquet on the upper thigh, if appropriate.

INTRAOPERATIVE WORK:

The arthroscopic instruments are inserted into the knee with gravity or pump inflow through a superior arthroscopic portal and the arthroscope inserted from inferior lateral portal. Instrumentation for the procedure is brought in through an inferior medial patella portal. Video arthroscopy of the procedure with appropriate photographs and videotaping is frequently done. A diagnostic arthroscopy is included as part of this procedure. Any ligament pathology that is corrected is coded separately.

Repairable tears of the medial and lateral menisci that are vertical/longitudinal in direction and located at or near the peripheral attachments are carefully examined with a probe and their length and location are documented.

To repair the medial meniscus, the arthroscope is lateral at the start. Small rasps are inserted from inferior medial or from a supplemental posterior medial portal in order to abrade the peri-meniscal synovium as a means to stimulate blood flow and facilitate healing. A 2 to 3 centimeter posterior medial skin incision is made that allows protection of the posterior neurovascular structures. This posterior medial incision begins at the level of the knee joint and extends proximally and distally. After opening the deep fascia, the surgeon's finger can be passed anterior to the medial head of the gastrocnemius muscle and neurovascular structures and posterior to the capsule of the knee joint. A curved retractor is placed in this position and is kept here throughout the meniscal repair procedure.

The arthroscope is now placed in the anterior medial portal. A curved cannula is inserted through the anterior lateral portal and manipulated across the intercondylar notch into the medial compartment.

Cannulae of differing degrees of curvature are used depending upon the location of the intended suture (more curved for posterior and less curved for anterior) and placed up against the meniscus several millimeters central to the tear. With the help of an assistant, one 10" Keith needle of a double armed set with #2 suture is passed through the cannula, penetrating the meniscus and pushed on through the tear, through the peripheral rim of meniscus and through the posterior medial capsule striking the curved retractor which was previously placed as described above. A needle holder is

inserted through the posterior medial incision and the tip of the needle is retrieved and pulled out through this incision drawing half the suture through the meniscus and capsule. The cannula is now moved approximately 3 mm. away from the first needle passage. The second 10" Keith needle is now passed in a similar manner as the first. When this second needle is retrieved posteriorly and pulled through, a mattress suture placement securing the meniscus tear is accomplished. This may be a horizontal or a vertical mattress suture as the clinical situation dictates. The needles are cut from the suture and the 2 ends of suture are tagged. Injudicious placement of the posterior retractor or errant needle passage can lead to injury to the popliteal or posterior tibial artery. The placement of mattress sutures is repeated in this same manner until the meniscus is completely stabilized using anywhere from 2 to 6 sutures as the length of the tear dictates (the average is 4 sutures). All of the tagging clamps are now gathered together and secured with an Allis clamp.

To repair the lateral meniscus, the arthroscope is initially medial. Small rasps are inserted from inferior lateral or from a supplemental posterior lateral portal in order to abrade the peri-meniscal synovium as a means to stimulate blood flow and facilitate healing. A 2 to 3 centimeter posterior lateral skin incision is made that allows protection of the posterior neurovascular structures. This posterior lateral incision begins at the level of the knee joint and extends proximally and distally. It is placed posterior to the fascial lata and anterior to the biceps femoris (lateral hamstrings) and peroneal nerve. After opening the deep fascia, the surgeon's finger can be passed anterior to the lateral head of the gastrocnemius muscle and neurovascular structures and posterior to the capsule of the knee joint. A curved retractor is placed in this position and is kept here throughout the meniscal repair procedure. The arthroscope is now placed in the anterior lateral portal. A curved cannula is inserted through the anterior medial portal and manipulated across the intercondylar notch into the lateral compartment. Cannulae of differing degrees of curvature are used depending upon the location of the intended suture (more curved for posterior and less curved for anterior) and placed up against the meniscus several millimeters central to the tear. With the help of an assistant, one 10" Keith needle of a double armed set with #2 suture is passed through the cannula, penetrating the meniscus and pushed on through the tear, through the peripheral rim of meniscus and through the posterior lateral capsule striking the curved retractor which previously placed as described above. A needle holder is inserted through the posterior lateral incision and the tip of the needle is retrieved and pulled out through this incision drawing half the suture through the meniscus and capsule. The cannula is now moved approximately 3 mm. away from the first needle passage. The second 10" Keith needle is now passed in a similar manner as the first. When this second needle is retrieved posteriorly and pulled through, a mattress suture placement securing the meniscus tear is accomplished. This may be a horizontal or a vertical mattress suture as the clinical situation dictates. The needles are cut from the suture and the 2 ends of suture are tagged. Injudicious placement of the posterior retractor or errant needle passage can lead to injury to the popliteal or posterior tibial artery. The peroneal nerve is particularly vulnerable to being pierced by the 10" Keith needles. Hence, great care must be exercised during retraction and needle passage. The placement of mattress sutures is repeated in this same manner until the meniscus is completely stabilized using anywhere from 2 to 6 sutures as the length of the tear dictates (the average is 4 sutures). All of the tagging clamps are now gathered together and secured with an Allis clamp.

Holding all the sutures under tension to reduce and hold the meniscus tears, the knee is flexed and extended to ensure stability of the repair. If the meniscus is not stable, additional sutures are placed. Once the surgeon is satisfied, each suture is carefully tied deep in the wound with the knot lying against the knee capsule. The posterior medial and posterior lateral incisions are closed in layers. The arthroscopic portal incisions are each sutured.

POSTOPERATIVE WORK:

Postoperative work begins after the skin closure in the operating room and includes application of sterile dressings and an immobilizing splint. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attentions to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders). Discharge plans include instructions for continuing care, ordering of postoperative pain medication and antibiotics, physiotherapy and preparation of discharge records.

Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
Arthroscopy Association of North America
American Orthopaedic Society of Sports Medicine

Sample Size: 190 **Response Rate:** 36 (19%)

Type of Sample: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.80	11.00	11.05	12.23	15.00
Pre-Service			75		
Intra-Service	60	60	90	90	180
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	36	99238			
Office Visits	76	99213x2 99212x2			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
8.65	090	29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 29883 (n=34)	Ref CPT 29882 (n=25)
Pre-service time	75	50
Intra-service time	90	50
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	30
Total office visit time	76	76

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.30	3.00
Intra-service	4.39	3.50
Post-service	3.17	2.89

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.11
Urgency of medical decision making	3.00	3.05

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.50	4.00
Physical effort required	4.04	3.63

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.04	3.42
Outcome depends on the skill and judgment of physician	4.38	4.00
Estimated risk of malpractice suit with poor outcome	3.27	3.21

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

There is a magnitude anomaly between 29882 and 29883.

The preservice and postservice work is essentially the same for both codes. Additionally, both codes include the work of a diagnostic arthroscopy. The essential difference between the procedures is that 29883 includes an additional repair.

Another way that we can show the difference between the codes is not accurate is to subtract 4.11 RVWs for the postoperative discharge management and office visits from both codes.

29882 RVW 8.65 – 4.11 for HV/OV = 4.54

29883 RVW 9.46 – 4.11 for HV/OV = 5.35

We believe the difference of 0.95 rvu's for one additional repair is not reasonable. The difference should be at least 2.67 for 40 min additional work (comparable to 99291 work). [8.65 + 2.67 = 11.32] This approximates the survey median.

We also point out that the reference code 29882 is appropriately valued: The balance RVW of 4.54 for the preoperative work (50 min), intraoperative work (50 min) and same day postoperative work (30 min) [i.e., discharge management and office visits rvu's subtracted as above] is more than justifiable.

Another way to assess the relative value of the intraoperative portion of "one" repair is to estimate the intraoperative work of 29882 by subtracting the value for a diagnostic arthroscopy and the postoperative office visits. [29882 RVW 8.65 – 5.07(diag arthro) – 1.30 for OV = 2.28] The remainder is 2.28 for the intra work of the repair for 29882. Adding 2.98 to the value for 29882 is 10.93 which again approximates the survey median.

The survey median RVW of 11.05 is recommended. This is 2.40 rvu's higher than 29882 and more accurately sets the difference between the two procedures for the additional intraoperative work.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Sometimes. It is much more common for the pathology to dictate the performance of only one meniscus repair (29882)

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

556	orthopaedic surgery	1	hand surgery
5	clinic or group practice (not gppp)	1	internal medicine
1	ASC	1	peripheral vascular disease
1	anesthesiology		

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

- a. **Has the work of performing this service changed in the past 5 years?**
13 Yes
17 No
- b. **This service represents new technology that has become more familiar (i.e., less work).**
4 I agree
9 I do not agree
- c. **Patients requiring this service are now:**
9 more complex (more work)
1 less complex (less work)
3 no change
- d. **The usual site-of-service has changed:**
0 from outpatient to inpatient
3 from inpatient to outpatient
10 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

Survey CPT Code: 29889

Global: 090

Current RVW: 15.13

Recommended RVW: ~~48.00~~

16.00 RUC

CPT Code Descriptor: Arthroscopically aided posterior cruciate ligament repair/ augmentation or reconstruction

Typical Patient (Vignette): A 21-year-old skier tears the posterior cruciate ligament and requires arthroscopically aided ligament reconstruction.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reports concerning ligament stability examination and review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and or patient's family) to explain operative risks and benefits and to obtain informed consent. The physician marks the operative site. Preoperative work also includes pre-operative scrubbing; positioning the patient, using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee; positioning of a fluoroscopic C-arm used during the intraoperative period, supervising prepping and personally draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite; applying the tourniquet on the upper thigh, if appropriate; and securing the "well leg" on a knee support attached to the operating table thereby holding it out of the way in elevation and abduction.

INTRAOPERATIVE WORK:

A bone/middle third patella tendon/bone autograft (when used) is harvested through an anterior incision using an oscillating saw to remove bone plugs and contiguous middle third patella tendon. (Fresh frozen Achilles tendon allograft may also be used but this requires greater time of "back table" sterile preparation of the graft, than does the patella tendon autograft). When autograft is used, it is included in the work of 29889 and, as stated, the same degree of graft preparation for the patella bone tendon bone graft is required with both auto- and allograft.

After graft preparation is complete, then arthroscopic instruments are inserted into the knee with gravity or pump inflow through a superior arthroscopic portal and the arthroscope inserted from inferior lateral. Instrumentation for the procedure is brought in through an inferior medial patella portal. Video arthroscopy of the procedure with appropriate photographs and videotaping is frequently done. A 2 centimeter posterior medial skin incision is made that allows protection of the posterior neurovascular structures and through this incision one can monitor the instruments passed from the front to the back of the knee joint. This posterior medial incision begins at the level of the knee joint and extends distally approximately 2 centimeters. After opening the deep fascia, the surgeon's finger can be passed anterior to the medial head of the gastrocnemius muscle and neurovascular structures and posterior to the capsule of the knee joint. The posterior cruciate ligament fossa can be palpated through the capsule. Intraoperative x-ray (C-arm fluoroscopy) must be used periodically during the procedure to insure proper placement of drill guides and drills to insure safety to the posterior neurovascular structures. A diagnostic arthroscopy is included as part of this procedure, however, any meniscal pathology that is corrected is coded separately.

A "notch plasty" is performed to enlarge the intercondylar notch using a power burr. The posterior cruciate ligament stumps are debrided with a power instrument leaving remnants to serve as anatomic landmarks. The posterior cruciate ligament fossa is debrided and the posterior capsule is elevated from bone using a special curved knife, rasp and elevator. The surgeon's finger placed posterior medially insures that this latter dissection is done in its proper location and is done safely. This capsular elevation extends approximately 2 centimeters below the posterior tibial ridge. A drill guide is positioned so that the guide wire enters the anterior medial proximal tibia approximately 2 centimeters below the tibial tubercle and exits the tibial ridge posteriorly. The tip of the guide wire is monitored at all times by the fluoroscopic C-arm. The tibial tunnel is made with a cannulated tibial reamer of the appropriate size again using the fluoroscopic C-arm to prevent the reamer from over-penetrating the posterior aspect of the tibia. Soft tissue is carefully removed from the openings of the tunnel. The femoral tunnels are made by passing guide wires from outside the knee using a drill guide to enter the knee joint at points along the lateral wall of the medial femoral condyle which will approach isometric graft placement. The femoral tunnels are reamed to the same size as the graft material with all reaming debris evacuated with motorized instrumentation. A Luque wire is passed through the tibial tunnel into the back of the knee joint. The wire is then pulled out through the femoral tunnel. This may be very difficult and time consuming portion of the procedure since the wire must pass sharply at the posterior aspect of the tibial tunnel at the rear of the knee and then around into the center of the knee joint where it must then be grasped with arthroscopic tools and pulled up into the femoral tunnel. A flexible rasp is then attached to the Luque wire and pulled through both tunnels in order to smooth the tissues around the tunnel edges. The graft material is attached to the end of the flexible rasp with traction sutures and then pulled into position. The graft material is then secured at the tibial tunnel and the femoral tunnels with interference screw or button and suture fixation. Care must be made prior when securing the graft that no impingement on the graft occurs from the surrounding bone during the full range of motion. Further, there must be no bony impingement upon the graft in the intercondylar notch. Testing the knee for proper ligament stability must be done by adjusting the positioning of the graft if ligament stability is not achieved. An interarticular drain is placed and brought out through the skin through one of the arthroscopic portals. The posterior medial skin incision is closed in layers.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, and immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary.

Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; evaluation of periodic imaging reports, if needed; direct patient physiotherapy and assess-physiotherapy progress; and pain medication adjustments. Careful monitoring of the physical therapy regimen is very important to prevent stretching of the reconstructed posterior cruciate ligament.

SURVEY DATA**Presenter(s):** Laura Tosi, MD**Specialty(s):** American Association of Orthopaedic Surgeons
Arthroscopy Association of North America
American Orthopaedic Society of Sports Medicine**Sample Size:** 190 **Response Rate:** 27 (14%)

This low response rate is explainable on the basis of the low frequency with which this procedure is performed. See Frequency Information below.

Type of Sample: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	15.00	16.00	18.00	19.00	30.00
Pre-Service			90		
Intra-Service	90	120	150	169	240
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	36	99238			
Office Visits	122	99214x1 99213x3 99212x1			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
13.90	090	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 29889 (n=32)	Ref CPT 29888 (n=25)
Pre-service time	90	60
Intra-service time	150	120
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	30
Total office visit time	122	114

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.41	3.56
Intra-service	4.86	3.81
Post-service	3.91	3.25

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.32	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.44
Urgency of medical decision making	3.36	3.17

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.92	4.11
Physical effort required	4.64	3.78

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.76	3.94
Outcome depends on the skill and judgment of physician	4.88	4.33
Estimated risk of malpractice suit with poor outcome	4.28	3.78

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Harvard originally incorrectly valued 29888 and 29889 equally, then 29888 was increased in value during the 1992 refinement, but overlooked 29889, creating a rank order anomaly. CPT 29889 was reviewed and increased in value during the previous five-year review. The RUC workgroup reviewing this code, however, did not accept the recommended survey median RVW of 17.75 and instead chose to increase the value of 29889 by using both 29888 (anterior cruciate arthroscopic repair/reconstruction) and 27428 (open ligament reconstruction) as references. RVWs were increased to 14.41 to estimate the extra intra-service time and post-service work.

However, we believe that 29889 is still undervalued. On the basis of surveys and time data from our previous survey and our current survey, a difference of 1.23 rvu's between 29888 and 29889 does not correctly capture the difference in work between these two services.

Additionally, we note that over the last five years (since 1995), using a two bundled ligament graft is an emerging technique that is being used typically. This requires drilling of two femoral tunnels, adding slightly to the intraoperative time and intensity. This also requires increased level of skill to locate the proper tunnel sites.

We reiterate the differences between 29888 and 29889 below:

There is more preoperative time for 29889 in that additional positioning must be done for the "well leg" and positioning must be confirmed for the operated leg with an intraoperative fluoroscopic C-arm.

Intraoperative work (time and intensity) is significantly greater for 29889. An additional posterior medial incision is necessary for posterior dissection, protection of neuro-vascular structures, handling instruments posterior to the tibia and manipulating the passing the ligament graft. Because of the potential iatrogenic harm from injury to popliteal neurovascular structures, a fluoroscopic C-arm is used to place guide wires in the tibial tunnel and to control and prevent the reamer from over-penetrating the posterior aspect of the tibia. [NOTE: We believe the RUC workgroup did not adequately address this added time and especially the increased intraoperative intensity for 29889.]

Postoperative work is greater for 29889. The current survey indicated that both codes typically required five office visits, however, the visits for 29889 were overall at a higher level because 29889 requires a more careful monitoring of the postoperative physical therapy regimen to prevent stretching of the reconstructed posterior cruciate ligament. [The ACL reconstruction (29888) presents a smaller chance of stretching.]

Another way that we can show the difference between the codes is not accurate is to subtract 4.11 RVWs for the postoperative discharge management and office visits from both codes.

29888 RVW 13.90 – 4.52 (dischg&OV) = 9.38

29889 RVW 15.13 – 4.74 (dischg&OV) = 10.39

We believe the difference of 2.01 rvu's for additional preoperative work (30min) and intraoperative work (30min) is not accurate. Using the survey median of 18.00, the difference would be 3.88 rvu's and this more closely approximates the value of this additional work.

We also point out that reference code 29888 is appropriately valued: the balance RVW of 9.38 for the preoperative work (60 min), intraoperative work (120 min) and same day postoperative work (30 min) [i.e., discharge management and office visits rvu's subtracted as above] is more than justifiable.

The survey median RVW of 18.00 is recommended. This is 4.10 rvu's higher than 29888 and more

accurately sets the difference between the two procedures for the additional work.

We further need to emphasize that the surgeons selected by their peers to perform this procedure (and who responded to our survey) are highly skilled and experienced arthroscopic surgeons. The "average" orthopaedic surgeon does not usually perform this procedure. Hence, the median surgical times reflect their high level of competency.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Rarely.

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency: Less than 1,500 per year. This number is estimated by the following data and extrapolation: 3,392 high level male and female athletes over two seasons sustained 87 anterior cruciate ligament (ACL) tears but only 6 posterior cruciate ligament (PCL) tears. Not all PCL's were treated surgically.¹ 810 women collegiate rugby players sustained 21 ACL tears and 2 PCL tears.² It is estimated that there are 80,000 ACL injuries per year and approximately 50,000 ACL reconstruction procedures (29888) done per year. PCL tears are less frequent.³ PCL tears are much less frequent occurring in approximately 5% of knee ligament injuries in the general population. Most PCL tears are not treated surgically. 20% of athletes with PCL deficiencies eventually require reconstruction.⁴ AAOS survey data suggests that some surgeons may perform 30 ACL reconstructions (29888) to every 1 PCL reconstruction (29889).

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

33 orthopaedic surgery
1 clinic or group practice (not gppp)
1 physical medicine and rehabilitation

Do many physicians perform this service across the United States? No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

18 Yes
9 No

b. This service represents new technology that has become more familiar (i.e., less work).

3 I agree
15 I do not agree

c. Patients requiring this service are now:

- 11 more complex (more work)
- 0 less complex (less work)
- 7 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 5 from inpatient to outpatient
- 13 no change

Reference:

1. Myklebust G, et al. Registration of Cruciate Ligament Injuries in Norwegian Top Level Team Handball. Scand J Med Sci Sports. 7 (5): 289. Oct 1997.
2. Levy AS, et al. Knee Injuries in Women Collegiate Rugby Players. Am J Sports Med. 25 (3): 360. May/June 1997.
3. Griffin LY, et al. Noncontact Anterior Cruciate Ligament Injuries: Risk Factors and Prevention Strategies. Journal of American Academy of Orthopaedic Surgeons. 8 (3): 141. May/June 2000.
4. Beaty, JH editor. Orthopaedic Knowledge Update. Knee Ligament Injuries. 533-540.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 38572 Tracking Number: Global Period: 010 Recommended RVW: 48 16.59 RUC

CPT Descriptor: Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: a 60 year old woman underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy for abnormal bleeding and biopsy evidence of endometrial hyperplasia. The final pathology report revealed a deeply invasive adenocarcinoma confined to the uterine corpus. The patient was seen in consultation by a gyn/oncologist who advised her that the risk of pelvic or peri-aortic lymph node metastases was approximately 25% and recommended a bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling. In order to reduce the risk of complications and facilitate the postoperative recovery the physician recommended that the procedure be performed laparoscopically.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Application of uterine manipulator, with possible dilation of cervical canal
- Skin incisions
- Creation of pneumoperitoneum
- Insertion of trocars and instruments
- Endoscopic inspection and evaluation of abdomen and pelvis
- Opening of the retroperitoneal space with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling
- Excision and removal of biopsy specimens, any method
- Hemostasis
- Release of carbon dioxide gas and removal of all instruments and laparoscope
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable

SURVEY DATA:

Presenter(s) Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists, Society of Gynecologic Oncologists

Sample Size: 103 Response Rate: (%): 24 (23%) Median RVW: 18

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 16.59 75th Percentile RVW: 22 Low: 14.5 High: 29

Median Pre-Service Time: 87.5 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 220 Low: 120 High: 300

Median Post-Service Time:

Level of Service by CPT Code
Total Time (List CPT Code & # of Visits)

Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>38</u>	<u>99213, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	16.59

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 38572	<u>Reference Service</u> 1 <u>CPT:</u> 38780
Median Pre-Time	87.5	85
Median Intra-Time	180	150
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	38	20

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	4.18	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	4.19
Urgency of medical decision making	3.82	3.81

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	5.00
Physical effort required	4.68	4.69

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.59	4.69
Outcome depends on the skill and judgement of physician	4.82	4.88

Estimated risk of malpractice suit with poor outcome	4.27	4.88
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INTENSITY/COMPLEXITY MEASURES

CPT Code
38572
Reference
Service 1
38780

Time Segments (Mean)

Pre-Service intensity/complexity	4.09	4.25
Intra-Service intensity/complexity	4.91	4.44
Post-Service intensity/complexity	3.45	3.56

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents believed CPT 38572 to be most comparable to CPT 38780 (Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes – 16.59 RVWs), although 38572 is a bilateral procedure. The survey results demonstrate that intra-service work for 38572 is greater than 38780 because of the greater technical demands of the laparoscopic procedure. The median intra-service time for 38572 was 30 minutes greater than the intra-service time for 38780. In addition, the surgeon must operate without the direct, three-dimensional view of the operative site and the tactile sense available for an open procedure, so the laparoscopic procedure is lengthier and demands a higher level of technical skill. Post-service work for CPT 38572 is somewhat less (by 2 visits) due to a shorter hospital stay, quicker recovery and a shorter global period.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	180 min. x .08 IWP/UT	14.40
Immediate Post-Service	99232	1.06
Hospital	99238	1.28
Office Visits	99213	0.67
	99212	<u>0.45</u>
		19.63

Using the building block approach, the approximate RVWs for this service can be calculated as 19.63, as illustrated above.

Recommended RVU

The comparison to CPT 38780 and the application of the building block methodology both validate the survey median. ACOG recommends the survey median of 18 RVWs for 38572.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns & Gyn Oncologists _____ Commonly X Sometimes _____ Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns & Gyn Oncologists _____ Frequency National data not available _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Ob/Gyns & Gyn Oncologists _____ Frequency National data not available _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 8 No 15

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 4 I do not agree 4
- b. Patients requiring this service are now:
more complex (more work) 4 less complex (less work) 0 no change 4
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 7

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56515 Tracking Number: __ Global Period: 010 Recommended RVW: ~~3.625~~ 2.76 RUC

CPT Descriptor: Destruction of lesions(s), vulva; extensive, any method

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old with biopsy proven carcinoma in situ of the vulva is counseled concerning treatment options which include wide excision versus laser destruction using the CO₂ laser. Because of the multifocal nature of the changes on the vulva, the patient is advised that the laser approach is less morbid and associated with a lower risk of deformity and scarring. Because of this the patient consents to undergoing the laser destruction procedure.

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Skin preparation
- Injection of local anesthesia
- Destruction of multiple or extensive vulvar lesions, any method
- Hemostasis

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required
 - Pain management

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Pain management
 - Removal of drains, catheters, sutures
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 41 (30%) Median RVW: 3.625

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 2.42 75th Percentile RVW: 4.625 Low: 2.42 High: 6

Median Pre-Service Time: 50 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 25 High: 60

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>20</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>23</u>	<u>99213</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
17276	Destruction, malignant lesion, any method, scalp, hands, feet, genitalia; lesion diameter over 4.0 cm	3.20
54065	Destruction of lesion(s), penis (eg condyloma, papilloma, molluscum contagiosum, herpetic vesicle, extensive, any method	2.42

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 56515	Reference Service 1 CPT: <u>54065</u>
Median Pre-Time	50	60
Median Intra-Time	45	30
Median Immediate Post-service Time	20	25
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	23	15

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	3.54	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.00
Urgency of medical decision making	2.92	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.46	3.14
Physical effort required	3.08	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.23	3.00
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Outcome depends on the skill and judgement of physician	3.54	3.14
---	------	------

Estimated risk of malpractice suit with poor outcome	4.69	3.14
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INTENSITY/COMPLEXITY MEASURES

CPT Code
56515

Reference Service 1
54065

Time Segments (Mean)

Pre-Service intensity/complexity	3.31	2.86
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Intra-Service intensity/complexity	3.46	3.14
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Post-Service intensity/complexity	3.00	3.00
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ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Most survey respondents selected CPT 54065 (Destruction of lesion(s), penis...extensive, any method) as a reference service. The ACOG RVS committee felt that this was a poor choice since our respondents do not typically provide this service. The committee therefore selected CPT 17276 (Destruction of malignant lesion, any method, scalp, neck, hands, feet, genitalia; lesion diameter over 4 cm) as the procedure most similar to 56515. CPT code 17276 has an RVW of 3.20. However, this RVW reflects the application of CPT code 17276 not only to lesions of the genitalia but also to less sensitive and more accessible regions of the skin, such as the scalp, neck, hands, and feet. We believe that the RVW for the genital surface alone (such as the vulva) should be higher than for all areas combined.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	45 min. x .05 IWPUT	2.25
Immediate Post-Service	99231	0.64
Hospital	99238	1.28
Office Visit	99213	<u>0.67</u> 6.61

Using the building block approach, the approximate RVWs for this service can be calculated as 6.61, as illustrated above.

Recommended RVU

The comparison to CPT 17276 and the building block method both validate the survey median. ACOG therefore recommends the survey median of 3.625 for 56515.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists 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 Obstetricians/Gynecologists Frequency National frequency data unavailable.

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 Obstetricians/Gynecologists Frequency Approximately 1200

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 10 No 26

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 5 I do not agree 5 .
- b. Patients requiring this service are now:
more complex (more work) 8 less complex (less work) 1 no change 1
- c. The usual site-of-service has changed:
from outpatient to inpatient 1 from inpatient to outpatient 3 no change 5

**AMA/SPECIALTY SOCIETY RVS.UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56740 Tracking Number: ___ Global Period: 010 Recommended RVW: 5.74 4.57 RUC

CPT Descriptor: Excision of Bartholin's gland or cyst

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28 year old presents with a history of previous episodes of a tender, cystic-feeling mass in the area of the Bartholin's gland and duct. Physical examination confirms that the structure in question is not a hydrocele, Skene's gland, cyst, or solid tumor such as fibroma, fibromyoma, lipoma, or hidradenoma, but rather a cyst/abscess of the Bartholin's gland and duct. The patient has previously been treated with incision and drainage, marsupialization and word catheter epithelialization. The patient is advised that, in cases of symptomatic cysts, refractory to other therapies, excision under anesthesia in the operating room is indicated. Because of this the patient consents to undergoing an excision of a Bartholin's gland and duct cyst or cyst/abscess.

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Skin preparation
- Skin incision
- Excision of Bartholin's gland or cyst
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packs, drains, catheters, sutures
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 41 (30%) Median RVW: 5.74

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 5 75th Percentile RVW: 5.75 Low: 2 High: 8

Median Pre-Service Time: 50 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 31.25 75th Percentile Intra-Svc Time: 45 Low: 20 High: 80

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>20</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>23</u>	<u>99213</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58120	Dilatation and curettage, diagnostic and/or therapeutic (nonobstetrical)	3.27
11771	Excision of pilonidal cyst or sinus; extensive	5.74

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 56740	<u>Reference</u> <u>Service 1 CPT:</u> 58120
Median Pre-Time	50	43
Median Intra-Time	45	20
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	36	37
Median of Aggregate Office Visit Times	23	15

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	3.11	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.84	2.67
Urgency of medical decision making	2.82	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.68	2.00
Physical effort required	3.19	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.26	2.00
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Outcome depends on the skill and judgement of physician	3.32	2.00
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Estimated risk of malpractice suit with poor outcome	3.03	1.67
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INTENSITY/COMPLEXITY MEASURES

CPT Code
56740
Reference
Service 1
58120

Time Segments (Mean)

Pre-Service intensity/complexity	2.89	2.33
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Intra-Service intensity/complexity	3.29	2.67
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Post-Service intensity/complexity	2.74	2.33
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ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Survey respondents compared 56740 to CPT 58120 (Dilatation and curettage, diagnostic and/or therapeutic (nonobstetrical), which has an RVW of 3.27. The survey data indicate that the excision of a Bartholin's gland or cyst requires much more physician time, both intra-operatively and post-operatively. The intra-service time for CPT code 58120 is 25 minutes. Survey respondents assigned 56740 an intra-service time of 45 minutes. 56740 demands a higher level of technical skill to remove the gland intact and avoid recurrence. The excision of a Bartholin's gland or cyst is typically performed on patients who have had recurrent infections; thus there is typically extensive scarring in the area. In addition, post-operative work is greater for 56740 than for 58120. The post-operative patient typically experiences a great deal of pain requiring physician management. A drain is also left in the operative site and must be managed.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	45 min. x .05 IWPUT	2.25
Immediate Post-Service	99231	0.64
Hospital	99238	1.28
Office Visit	99213	<u>0.67</u> 6.61

Using the building block approach, the approximate RVWs for this service can be calculated as 6.61, as illustrated above.

Recommended RVU

Comparison of the work associated with 56740 with the work for 58120, as well as the building block results reinforce the survey data. Therefore, ACOG recommends the survey median of 5.74 for 56740.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty__Obstetricians/Gynecologists__ _____Commonly __X__Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty__Obstetricians/Gynecologists__ Frequency_National frequency data unavailable._____

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__Obstetricians/Gynecologists__ Frequency__Approximately 200-300_____

Specialty_____ Frequency_____

Do many physicians perform this service across the United States? __X__Yes _____No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 2 No 32

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 1
- b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 1
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS,
SUMMARY OF RECOMMENDATION

CPT Code: 57100 Tracking Number: __ Global Period: 000 Recommended RVW: 1.2

CPT Descriptor: Biopsy of vaginal mucosa; simple (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old patient who has undergone hysterectomy for carcinoma in situ of the cervix presents with an abnormal pap smear. She is HIV positive and demonstrates visible lesions at the apex of the vagina, which turn white when swabbed with acetic acid. A large speculum is placed to permit adequate visualization of the folds at the apex, the areas of concern are infiltrated with local anesthetic. Biopsies of the area are taken and sent to pathology. Hemostasis is achieved with topical agents and pressure or with electrocoagulation. The patient is discharged from care with appropriate instructions.

Pre-procedure services:

- Proper positioning, prepping and draping of patient
- Catheterization or catheter insertion, when indicated

Procedure services included in the global service when surgically indicated:

- Insertion of speculum
- Biopsy of vaginal mucosa
- Hemostasis
- Wound closure
- Injection of local anesthesia

Post-procedure services:

- Application of dressings and packing
- Securing, removal or replacement of catheters and drains
- Patient evaluation and stabilization
- Dictation of procedure report, when indicated
- Review of laboratory reports, when indicated
- Completion of patient record
- Patient instructions
- Consultation with family, when indicated

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 42 (31%) Median RVW: 1.3

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 1.2 75th Percentile RVW: 2 Low: 0.97 High: 6.17

Median Pre-Service Time: 15 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 6 High: 30

Median Post-Service Time:

Total Time

Level of Service by CPT Code

(List CPT Code & # of Visits)

Immediate Post Service Time: 10

Critical Care: _____

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits: _____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
57454	Colposcopy; with biopsy(s) of the cervix and/or endocervical curettage	1.27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 57100	<u>Reference</u> <u>Service 1 CPT:</u> 57454
Median Pre-Time	15	15
Median Intra-Time	15	15
Median Immediate Post-service Time	10	8.5
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.56	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.44	2.50
Urgency of medical decision making	2.56	4.17

Technical Skill/Physical Effort (Mean)

Technical skill required	2.89	3.00
Physical effort required	2.22	2.28

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.28	2.11
Outcome depends on the skill and judgement of physician	2.56	2.67
Estimated risk of malpractice suit with poor outcome	2.56	2.50

INTENSITY/COMPLEXITY MEASURES

CPT Code
57100

Reference
Service 1
57454

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.65
Intra-Service intensity/complexity	2.78	2.71
Post-Service intensity/complexity	2.22	2.24

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service

Survey respondents compared CPT 57100 to CPT 57454 (colposcopy with biopsy), which has an RVW of 1.27. Overall, our survey respondents reported that the two procedures were approximately equivalent in terms of time and intensity. Although performing a vaginal biopsy is more difficult than performing the cervical biopsy included in 57454, 57100 does not include the work of a colposcopy. Therefore, the overall amount of physician work is approximately the same.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre/Post -Service Time	99214	1.10
Intra-Service	15 min. x .03 IWPUT	<u>0.45</u> 1.55

Using the building block approach, the approximate RVWs for this service can be calculated as 1.55, as illustrated above.

Recommendation

Comparing 57100 to the reference service (57454) and the building block approach both confirm the survey results. Therefore, we are recommending the 25th percentile survey value of 1.2 RVWs for this procedure.

FREQUENCY INFORMATION



How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty__ Obstetricians/Gynecologists ___ Commonly __X__ Sometimes ___ Rarely

Specialty_____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty__ Obstetricians/Gynecologists Frequency__ National data unavailable _____

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__ Obstetricians/Gynecologists Frequency__ National data unavailable _____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? __X__ Yes ___ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 4 No 34

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 3
- b. Patients requiring this service are now:
more complex (more work) 4 less complex (less work) 0 no change 0
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 0 no change 4

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58152 Tracking Number: Global Period: 090 Recommended RVW: 20.60

CPT Descriptor: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocytopexy (eg Marshall-Marchetti-Krantz, Burch)

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 52-year old woman diagnosed with symptomatic uterine leiomyoma who has not yet responded to medical therapy is seen. Endometrial sampling revealed no evidence of hyperplasia or adenocarcinoma. In addition, the patient has documented hypermobility of the bladder neck with stress urinary incontinence. The patient consents to undergo an abdominal hysterectomy with a Burch retropubic colposuspension.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Inspection and evaluation of pelvis and abdomen
- Excision of uterus (corpus and cervix) with/without removal of tube(s), with/without removal of ovary(s)
- Colpourethrocytopexy
- Irrigation of peritoneal cavity and placement of drain
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in the operating room:

- Application of dressing and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operative record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative note
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory and pathology reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period

Review pathology reports
Removal of packs, drains, catheters, sutures, staples

SURVEY DATA:

Presenter(s): Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	_____
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RW</u>
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	15.24
51840	Anterior vesicourethropexy, or urethropexy (eg Marshall-Marchetti-Krantz, Burch), simple	10.71

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
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		
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		
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Outcome depends on the skill and judgement 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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

This procedure combines CPT code 58150 (Total abdominal hysterectomy...) and 51840 (Anterior vesicourethropexy, simple). However, the RVWs assigned to 58152 are currently less than the RVWs for 58150 performed alone. The current RVW for 58152 does not reflect:

- additional pre-service physician counseling beyond the counseling provided for a hysterectomy
- the work of performing the urethropexy, as well as the significant intra-service risk of bladder or ureter injury
- post-operative catheter care
- two additional visits in the post-operative period.

This additional work is equivalent to at least half the work of 51840.

Recommended RVW

ACOG's recommendation for CPT code 58152 is based on the application of the multiple procedure payment rules, which yields the following result:

$$15.24 \text{ (CPT code 58150)} + \frac{1}{2}(10.71) \text{ (CPT code 51840)} = 20.60 \text{ RVWs}$$

ACOG therefore recommends an RVW of 20.60 for this procedure.



FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty_Obstetricians/Gynecologists 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_Obstetricians/Gynecologists Frequency_National data unavailable._____

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_Obstetricians/Gynecologists Frequency__ 1500_____

Specialty_____ Frequency_____

Do many physicians perform this service across the United States? Yes No

CPT Code: 58152

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___

b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change___

c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58260 Tracking Number: ___ Global Period: 090 Recommended RVW: 12.98

CPT Descriptor: Vaginal hysterectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44 year old patient, gravida 1 para 1, presents with menorrhagia and dysmenorrhea unresponsive to medical management. She has failed both oral contraceptives and NSAIDs. On examination her uterus is 6-8 weeks' size and boggy. It is somewhat tender to palpation and has limited descensus. The patient feels strongly about maintaining her ovarian function but requests hysterectomy since her quality of life is significantly impaired by her symptoms. She is therefore scheduled for vaginal hysterectomy without removal of the ad nexae.

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Hemostasis
- Wound closure and suturing of vaginal cuff

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 85 Response Rate: (%): 47 (55%) Median RVW: 16.05

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 13.85 75th Percentile RVW: 17.3 Low: 11.59 High: 18

Median Pre-Service Time: 60 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 45 High: 150

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>49</u>	<u>99231, 99232</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>61</u>	<u>99213, 99214</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)	15.24

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 the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58260	<u>Reference</u> <u>Service 1 CPT:</u> 58150
Median Pre-Time	60	60
Median Intra-Time	60	80
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	49	40
Median Discharge Day Management Time	36	25
Median of Aggregate Office Visit Times	61	76

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	3.23	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.33
Urgency of medical decision making	3.00	2.97

Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	3.50
Physical effort required	3.93	4.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	3.63
Outcome depends on the skill and judgement of physician	4.13	3.73
Estimated risk of malpractice suit with poor outcome	4.03	3.93

INTENSITY/COMPLEXITY MEASURES

CPT Code
58260

Reference
Service 1
58150

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.17
Intra-Service intensity/complexity	3.87	3.53
Post-Service intensity/complexity	3.27	3.13

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Survey respondents most frequently chose CPT 58150 (Total abdominal hysterectomy...) as a reference service. The survey data indicated that 58260 required less intra-service time and fewer post-operative visits than 58150. Respondents indicated that the vaginal hysterectomy entailed a higher level of intra-service intensity than the abdominal hysterectomy. The ACOG RVS Committee did not feel that the survey data provided adequate support for either the median or 25th percentile RVU. The committee decided that 58260 could be compared to CPT code 58550 (Laparoscopy, surgical; with vaginal hysterectomy), which has an RVW of 14.19. Intra-service work associated with 58260 is less because no laparoscopy is performed. However, 58260 typically includes 4 post-operative visits within its 90 day global period, as demonstrated by the survey results, while 58550 includes only one office visit because it has been assigned a 10 day global period. If half of the work of the diagnostic laparoscopy (CPT code 49320 – 5.10 RVWs) is subtracted from the work of 58550, the result is 12.98 RVWs.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service Time	99215	1.77
Intra-Service	60 min. x .08 IWPUT	4.80
Immediate Post-Service	99232	1.06
Hospital	99232	1.06
	99231	0.64
	99238	1.28
Office Visit	99214	1.10
	99213	<u>0.67</u>
		12.38

Using the building block approach, the approximate RVWs for this service can be calculated as 12.38, as illustrated above.

Recommended RVU

Comparison to 58550 and the building block method yield comparable results, so ACOG recommends 12.98 RVUs for CPT 58260.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty OB/Gyn 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 OB/Gyn Frequency 198,000 (for all vaginal hysterectomy procedures)

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 OB/Gyn Frequency 13,000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 7 No 28

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 3
- b. Patients requiring this service are now:
more complex (more work) 4 less complex (less work) 0 no change 1
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 6

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58262 Tracking Number: _ Global Period: 090 Recommended RVW: ~~14.87~~
14.77 RUC

CPT Descriptor: Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)

VIGNETTE: A 44 year old patient, gravida 1 para 1, presents with menorrhagia and dysmenorrhea unresponsive to medical management. She has failed both oral contraceptives and NSAIDS. On examination her uterus is 6-8 week's size and boggy. It is somewhat tender to palpation and has limited descensus. The patient has a family history of cancer and desires bilateral salpingo-oophorectomy with hysterectomy since her quality of life is significantly impaired by her symptoms.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Excision of one or both tubes and/or one or both ovaries
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 58262	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time	<input type="text"/>	<input type="text"/>
Median Intra-Time	<input type="text"/>	<input type="text"/>
Median Immediate Post-service Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Critical Care Times	<input type="text"/>	<input type="text"/>
Median of Aggregate Other Hospital Visit Times	<input type="text"/>	<input type="text"/>
Median Discharge Day Management Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Office Visit Times	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
Urgency of medical decision making	<input type="text"/>	<input type="text"/>

Technical Skill/Physical Effort (Mean)

Technical skill required	<input type="text"/>	<input type="text"/>
Physical effort required	<input type="text"/>	<input type="text"/>

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
Outcome depends on the skill and judgement of physician	<input type="text"/>	<input type="text"/>

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
58262

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The ACOG RVS Committee believes that the differential of 1.79 RVUs between the 2000 work RVUs for CPT 58260 (12.20) and 58262 (13.99) is adequate to reflect the additional work of a bilateral salpingo-oophorectomy performed in conjunction with a vaginal hysterectomy. However, our survey for 58260 demonstrated that RVUs for this procedure, the base procedure for the family of vaginal hysterectomy codes, should be increased by 0.78 RVUs (2000 RVUs for 58260 = 12.20, ACOG-recommended RVUs = 12.98). We recommend that 0.78 RVUs be added to the current value of 58262 to maintain relativity within the family of vaginal hysterectomy codes. This yields a recommended value of 14.77 for 58262.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists X Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists Frequency 198,000 (for all vaginal hysterectomy procedures)

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 Obstetricians/Gynecologists Frequency 3923

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No

CPT Code: 58262

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

a. This service represents new technology that has become more familiar (i.e., less work).

I agree __ I do not agree ___

b. Patients requiring this service are now:

more complex (more work) ___ less complex (less work) ___ no change ___

c. The usual site-of-service has changed:

from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58263 Tracking Number: ___ Global Period: 090 **Recommended RVW: 16.06**

CPT Descriptor: Vaginal hysterectomy; with removal of tube(s), and/or ovary(s), with repair of enterocele.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 53 year old postmenopausal patient presents with significant uterine prolapse with enterocele. Small bowel contents are noted in the cul de sac. She has good anterior and posterior vaginal wall support from previous repair surgery and has no problem with urinary incontinence. Due to her menopausal status, vaginal hysterectomy with bilateral salpingo-oophorectomy is scheduled along with repair of the enterocele transvaginally.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Excision of one or both tubes and/or one or both ovaries
- Repair of enterocele
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
58270	Vaginal hysterectomy; with repair of enterocele	13.48
58262	Vaginal hysterectomy; with removal of tube(s) and/or ovary(s)	13.99
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36
57268	Repair of enterocele, vaginal approach (separate procedure)	6.76

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58263	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time	<input type="text"/>	<input type="text"/>
Median Intra-Time	<input type="text"/>	<input type="text"/>
Median Immediate Post-service Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Critical Care Times	<input type="text"/>	<input type="text"/>
Median of Aggregate Other Hospital Visit Times	<input type="text"/>	<input type="text"/>
Median Discharge Day Management Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Office Visit Times	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
Urgency of medical decision making	<input type="text"/>	<input type="text"/>

Technical Skill/Physical Effort (Mean)

Technical skill required	<input type="text"/>	<input type="text"/>
Physical effort required	<input type="text"/>	<input type="text"/>

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality

Outcome depends on the skill and judgement of physician

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
58263

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The ACOG RVS Committee believes that the differential of 3.08 RVUs between the 2000 work RVUs for CPT 58260 (12.20) and 58263 (15.28) is adequate to reflect the additional work of a bilateral salpingo-oophorectomy and enterocele repair performed in conjunction with a vaginal hysterectomy. However, our survey for 58260 demonstrated that RVUs for this procedure, the base procedure for the family of vaginal hysterectomy codes, should be increased by 0.78 RVUs (2000 RVUs for 58260 = 12.20, ACOG-recommended RVUs = 12.98). We recommend that 0.78 RVUs be added to the current value of 58263 to maintain relativity within the family of vaginal hysterectomy codes. This yields a recommended value of 16.06 for 58263.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 198,000 (for all vaginal hysterectomy procedures).

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 Ob/Gyns Frequency 1435

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

a. This service represents new technology that has become more familiar (i.e., less work).

I agree ___ I do not agree ___

b. Patients requiring this service are now:

more complex (more work) ___ less complex (less work) ___ no change ___

c. The usual site-of-service has changed:

from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58267

Tracking Number: ___

Global Period: 090 Recommended RVW: 18.33

17.04 RUC

CPT Descriptor: Vaginal hysterectomy; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control).

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 44 year old patient, gravida 1 para 1 presents with menorrhagia and dysmenorrhea unresponsive to medical management. In addition, she complains of genuine urinary stress incontinence forcing her to wear sanitary pads for protection on a continuous basis. The patient has a history of small bowel resection with multiple high abdominal abscesses, therefore it is recommended that she undergo vaginal hysterectomy followed by retropubic urethropey to avoid an abdominal transperitoneal incision. The vaginal hysterectomy is completed, followed by repositioning the patient for abdominal surgery and the retropubic urethral suspension.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Colpo-urethrocytopexy with or without endoscopic control
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, packs, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of catheter, as applicable
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
51840	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple	10.71

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code**
58267**Reference**
Service 1 CPT:

Median Pre-Time	<input type="text"/>	<input type="text"/>
Median Intra-Time	<input type="text"/>	<input type="text"/>
Median Immediate Post-service Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Critical Care Times	<input type="text"/>	<input type="text"/>
Median of Aggregate Other Hospital Visit Times	<input type="text"/>	<input type="text"/>
Median Discharge Day Management Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Office Visit Times	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
Urgency of medical decision making	<input type="text"/>	<input type="text"/>

Technical Skill/Physical Effort (Mean)

Technical skill required	<input type="text"/>	<input type="text"/>
Physical effort required	<input type="text"/>	<input type="text"/>

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
Outcome depends on the skill and judgement of physician	<input type="text"/>	<input type="text"/>

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
58267

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

In contrast to our recommendations for 58262 and 58263, the ACOG RVS Committee believes that the differential of 2.80 RVUs between the 2000 work RVUs for CPT 58260 (12.20) and 58267 (15.00) is not adequate to reflect the additional work of performing a colpo-urethrocytostomy (CPT 51840) in conjunction with a vaginal hysterectomy. As noted in our recommendation for CPT 58152, current RVUs do not reflect

- additional pre-service physician counseling beyond the counseling provided for a hysterectomy
- the work of performing the urethropey, as well as the significant intra-service risk of bladder or ureter injury
- post-operative catheter care
- two additional visits in the post-operative period.

This additional work is equivalent to at least half the work of 51840. Application of the multiple procedure payment rules in this scenario yields the following result:

$$12.98 \text{ (ACOG recommendation for CPT code 58260)} + \frac{1}{2}(10.71) \text{ (CPT code 51840)} = 18.33 \text{ RVWs.}$$

Based on the above arguments, ACOG recommends an RVW of 18.33 for this procedure. This recommendation maintains a consistent approach to valuing the additional work of performing a colpo-urethrocytostomy with a hysterectomy, whether by vaginal (58267) or abdominal (58152) approach.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 198,000 (for all vaginal hysterectomy procedures)

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 Ob/Gyns Frequency 1000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58270

Tracking Number:

Global Period: 090 **Recommended RVW:** 14.26

CPT Descriptor: Vaginal hysterectomy; with repair of enterocele.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 43 year old premenopausal patient presents with significant uterine prolapse with obvious enterocele. Small bowel contents are noted in the cul de sac. She has good anterior and posterior vaginal wall support from previous repair surgery and has no difficulty with urinary incontinence. She feels strongly about maintaining her ovarian function, but has significant symptoms related to the prolapse and enterocele. She is taken to surgery for vaginal hysterectomy with repair of the enterocele.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Repair of enterocele
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____



KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
57268	Repair of enterocele, vaginal approach (separate procedure)	6.76

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code**
58270**Reference**
Service 1 CPT:

Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
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		
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 judgement of physician		

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
58270

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The ACOG RVS Committee believes that the differential of 1.28 RVUs between the 2000 work RVUs for CPT 58260 (12.20) and 58270 (13.48) is adequate to reflect the additional work of an enterocele repair (57268) performed in conjunction with a vaginal hysterectomy. However, our survey for 58260 demonstrated that RVUs for this procedure, the base procedure for the family of vaginal hysterectomy codes, should be increased by 0.78 RVUs (2000 RVUs for 58260 = 12.20, ACOG-recommended RVUs = 12.98). We recommend that 0.78 RVUs be added to the current value of 58270 to maintain relativity within the family of vaginal hysterectomy codes. This yields a recommended value of 14.26 for 58270.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 198,000 (for all vaginal hysterectomy procedures)

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 Ob/Gyns Frequency 1700

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58275

Tracking Number: __

Global Period: 090 Recommended RVW: 15.73
15.76 RUC

CPT Descriptor: Vaginal hysterectomy; with total or partial colectomy.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 33 year old patient has carcinoma in situ of the cervix which involves the entire posterior lip of the cervix and extends onto the posterior fornix. In addition, she has vaginal intraepithelial neoplasia associated with the cervical lesion. The patient is taken for vaginal hysterectomy along with excision of the posterior vaginal mucosa involved with the dysplastic process. Reparative surgery is performed to avoid shortening and decreased caliber of the vagina.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Partial or total excision of vaginal canal
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, packs, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Consultation with patient
 - Removal of catheter, as applicable

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
57106	Vaginectomy, partial removal of vaginal wall	6.36
57110	Vaginectomy, complete removal of vaginal wall	14.29

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 58275	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time	<input type="text"/>	<input type="text"/>
Median Intra-Time	<input type="text"/>	<input type="text"/>
Median Immediate Post-service Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Critical Care Times	<input type="text"/>	<input type="text"/>
Median of Aggregate Other Hospital Visit Times	<input type="text"/>	<input type="text"/>
Median Discharge Day Management Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Office Visit Times	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
Urgency of medical decision making	<input type="text"/>	<input type="text"/>

Technical Skill/Physical Effort (Mean)

Technical skill required	<input type="text"/>	<input type="text"/>
Physical effort required	<input type="text"/>	<input type="text"/>

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
Outcome depends on the skill and judgement of physician	<input type="text"/>	<input type="text"/>

INTENSITY/COMPLEXITY MEASURES

CPT Code
58275

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The ACOG RVS Committee believes that the differential of 2.78 RVUs between the 2000 work RVUs for CPT 58260 (12.20) and 58275 (14.98) is adequate to reflect the additional work of a partial colpectomy (57106) performed in conjunction with a vaginal hysterectomy. However, our survey for 58260 demonstrated that RVUs for this procedure, the base procedure for the family of vaginal hysterectomy codes, should be increased by 0.78 RVUs (2000 RVUs for 58260 = 12.20, ACOG-recommended RVUs = 12.98). We recommend that 0.78 RVUs be added to the current value of 58275 to maintain relativity within the family of vaginal hysterectomy codes. This yields a recommended value of 15.76 for 58275.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 198,000 (for all vaginal hysterectomy procedures)

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 Ob/Gyns Frequency < 300

Specialty Frequency

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58280 Tracking Number: ___ Global Period: 090 Recommended RVW: 17.01

CPT Descriptor: Vaginal hysterectomy, with total or partial colectomy; with repair of enterocele.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 33 year old patient has carcinoma in situ of the cervix which extends onto the vaginal fornices. She is gravida 5, para 4 and has significant uterine prolapse along with an enterocele. After management options were reviewed, she elected vaginal hysterectomy with excision of that portion of the upper vagina involved with the dysplastic process. In addition, the enterocele is repaired to permit proper support of the revised vaginal apex.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Visualization of cervix
- Application of tenaculum
- Administration of fluid (saline, local anesthesia, vasoconstrictive agents)
- Excision of uterus and cervix
- Repair of enterocele
- Partial or total excision of vaginal canal
- Hemostasis
- Wound closure

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packs, drains, catheters
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

Total Time

Level of Service by CPT Code

(List CPT Code & # of Visits)

Immediate Post Service Time:

Critical Care:

Other Hospital Visits:

Discharge Day Mgmt.:

Office Visits:

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58260	Vaginal hysterectomy	12.2
58275	Vaginal hysterectomy; with total or partial colpectomy	14.98
58270	Vaginal hysterectomy; with repair of enterocele	13.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code**
58280**Reference**
Service 1 CPT:

Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
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		
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 judgement of physician		

INTENSITY/COMPLEXITY MEASURES

CPT Code
58280

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

The 2000 work RVUs for the family of vaginal hysterectomy codes implicitly establishes work values for an enterocele repair performed in conjunction with a vaginal hysterectomy (1.28 RVUs, see recommendation for CPT 58270) and a partial colpectomy performed with a vaginal hysterectomy (2.78, see recommendation for CPT 58275). The enterocele repair and colpectomy are independent components of 58280. That is, there is no overlap in the intra-operative physician work for these components. However, 2000 work RVUs for 58280 do not adequately recognize this work, adding only 3.21 RVUs instead of 4.08 RVUs to the RVUs for 58260. In addition, our survey for 58260 demonstrated that RVUs for this procedure, the base procedure for the family of vaginal hysterectomy codes, should be increased by 0.78 RVUs (2000 RVUs for 58260 = 12.20, ACOG-recommended RVUs = 12.98). We recommend the following approach to establish a value for 58280:

- 12.98 (ACOG recommendation for CPT code 58260)
- + 2.78 (colpectomy performed with vaginal hysterectomy)
- + 1.28 (enterocele repair performed with vaginal hysterectomy)

This approach yields 17.04 RVUs, ACOG's recommendation for 58280.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 198,000 for all vaginal hysterectomy procedures

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 Ob/Gyns Frequency < 400

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58285 Tracking Number: ___ Global Period: 090 Recommended RVW: ~~25~~ 22.26 RUC

CPT Descriptor: Vaginal hysterectomy, radical (Schauta type operation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old woman with biopsy proven invasive squamous cell carcinoma clinically confined to the cervix (Stage IBI) was advised about treatment options including primary surgery or radiation therapy. Discussion of the possible surgical approaches included either a radical abdominal hysterectomy with bilateral pelvic lymphadenectomy or a radical vaginal hysterectomy with a bilateral extraperitoneal total pelvic lymphadenectomy. Because of the reduced morbidity associated with the radical vaginal hysterectomy the patient opted for this approach.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Obtaining exposure with retractors and necessary incisions
- Visualization of cervix and upper vagina
- Excision of uterus and cervix
- Excision of upper vagina, paracolpos, and parametria
- Lateral mobilization of ureters
- Hemostasis
- Wound closure and suturing of vaginal cuff

Postoperative services in operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packs, drains, catheters
-

SURVEY DATA:

Presenter(s) Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists, Society of Gynecologic Oncologists

Sample Size: 103 Response Rate: (%): 18 (17%) Median RVW: 28.85

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 25 75th Percentile RVW: 31.75 Low: 2 High: 45

Median Pre-Service Time: 87.5 Median Intra-Service Time: 205

25th Percentile Intra-Svc Time: 157.5 75th Percentile Intra-Svc Time: 240 Low: 120 High: 360

Median Post-Service Time:

	Level of Service by CPT Code	
	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>0</u>	
Other Hospital Visits:	<u>79</u>	<u>99232 x 2, 99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>38</u>	<u>99213, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphodenectomy and para aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s).	28.85

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58285	<u>Reference Service</u> 1 <u>CPT:</u> 58210
Median Pre-Time	87.5	85
Median Intra-Time	205	210
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	79	55
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	38	55

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	3.78	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	2.83
Urgency of medical decision making	4.00	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	2.86
Physical effort required	3.14	2.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	2.69
Outcome depends on the skill and judgement of physician	4.62	2.94

Estimated risk of malpractice suit with poor outcome	3.51	2.86
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INTENSITY/COMPLEXITY MEASURES

CPT Code
58285
Reference
Service 1
58210

Time Segments (Mean)

Pre-Service intensity/complexity	3.76	2.89
Intra-Service intensity/complexity	3.81	2.80
Post-Service intensity/complexity	3.62	2.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents indicated that CPT code 58285 is most comparable to CPT code 58210 (radical abdominal hysterectomy – 28.85 RVWs). In some respects, 58285 entails less physician work than 58210; for example, it does not include a lymphadenectomy. However, survey results demonstrate comparable pre-, intra- and post-service times for both procedures. Survey respondents also rated 58285 at significantly higher levels of complexity and intensity than 58210.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	205 min. x .08 IWPUT	16.40
Immediate Post-Service	99232	1.06
Hospital	99232 x 2	2.12
	99231	0.64
	99238	1.28
Office Visits	99213	0.67
	99212	0.45
		24.39

Using the building block approach, the approximate RVWs for this service can be calculated as 24.39, as illustrated above.

Recommended RVU

Application of the building block approach indicates that the survey median of 28.85 is probably too high. ACOG therefore recommends the 25th percentile survey value of 25.00 RVWs for 58285.

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gynecologic Oncologists Commonly Sometimes Rarely

Specialty Obstetricians/Gynecologists Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns and Gyn Oncologists Frequency 198,000 for all vaginal hysterectomy procedures

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 Gynecologic Oncologists Frequency 30

Specialty Obstetricians/Gynecologists Frequency 11

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 4 No 12

a. This service represents new technology that has become more familiar (i.e., less work).
I agree 3 I do not agree 1

b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 3

c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 0 no change 4

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58600 Tracking Number: ___ Global Period: 090 Recommended RVW: 5.6

CPT Descriptor: Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year old woman desires an elective sterilization. After receiving proper counseling and signing an informed consent, she is scheduled for surgery. Under anesthesia, a colpotomy/mini-laparotomy incision is made and the fallopian tube(s) are doubly ligated and a specimen is excised and sent to the pathologist.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Application of tenaculum and instruments
- Surgical incision
- Identification and ligation of fallopian tubes, any method
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 31 (23%) Median RVW: 6.46

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 5.6 75th Percentile RVW: 9 Low: 5.3 High: 11.5

Median Pre-Service Time: 50 Median Intra-Service Time: 35

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 15 High: 60

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>20</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>23</u>	<u>99213</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	5.6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58600	<u>Reference</u> <u>Service 1 CPT:</u> 58670
Median Pre-Time	50	49
Median Intra-Time	35	35
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	36	23
Median of Aggregate Office Visit Times	23	15

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.42	2.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.10
Urgency of medical decision making	2.04	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.85	3.15
Physical effort required	2.88	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.78	2.75
Outcome depends on the skill and judgement of physician	2.89	2.69
Estimated risk of malpractice suit with poor outcome	3.75	4.00

INTENSITY/COMPLEXITY MEASURES

CPT Code
58600

Reference
Service 1
58670

Time Segments (Mean)

Pre-Service intensity/complexity	2.77	2.58
Intra-Service intensity/complexity	3.03	3.00
Post-Service intensity/complexity	2.58	2.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

CPT code 58600 is most comparable to CPT code 58670 (laparoscopy with fulguration of oviducts – 5.6 RVWs). Both procedures have the same degree of complexity and comparable pre-, intra-, and post-operative physician times, as demonstrated by our survey results. Pre-service work, which encompasses legally mandated patient counseling, informed consent, and documentation for sterilization procedures, is particularly important. This work is identical regardless of the surgical approach used to perform the sterilization.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99214	1.10
Intra-Service	35 min. x .08 IWPUT	2.80
Immediate Post-Service	99231	0.64
Hospital	99238	1.28
Office Visit	99213	<u>0.67</u> 6.49

Using the building block approach, the approximate RVWs for this service can be calculated as 6.49, as illustrated above.

Recommended RVU

Although the building block method yielded a value similar to the survey median of 6.46, the ACOG RVS Committee did not believe that the survey data showing equivalent amounts of physician time and levels of intensity between 58600 and 58670 justified this value. ACOG therefore recommends the 25th percentile survey value of 5.6 RVWs for 58600. This value is identical to the RVW for 58670.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Obstetricians/Gynecologists 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: Obstetricians/Gynecologists Frequency__ 662,000 (all tubal ligation procedures)___

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: Obstetricians/Gynecologists Frequency < 100 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 3 No 25

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 2
- b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 2
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 1

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58605 Tracking Number: ___ Global Period: 090 Recommended RVW: 5

CPT Descriptor: Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year old woman has just delivered a healthy baby and desires elective sterilization. After receiving proper counseling and signing an informed consent, she is prepared for the surgery. Under anesthesia, a colpotomy/mini-laparotomy incision is made and the fallopian tube(s) are doubly ligated and a specimen is excised and sent to the pathologist.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Insertion of speculum
- Application of tenaculum and instruments
- Surgical incision
- Identification and ligation or transection of fallopian tube(s)
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of sutures, staples
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 35 (26%) Median RVW: 5.75

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 5.6 75th Percentile RVW: 8.81 Low: 5 High: 13

Median Pre-Service Time: 40 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 15 High: 60

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>15</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>38</u>	<u>99231 x 2</u>
Discharge Day Mgmt.:	<u>0</u>	<u>0</u>
Office Visits:	<u>15</u>	<u>99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	5.6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58605	<u>Reference</u> <u>Service 1 CPT:</u> 58670
Median Pre-Time	40	50
Median Intra-Time	30	35
Median Immediate Post-service Time	15	17.5
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	38	23
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	15	15

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.47	2.47
Urgency of medical decision making	2.16	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.33
Physical effort required	2.87	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.76	3.20
Outcome depends on the skill and judgement of physician	2.95	3.00

Estimated risk of malpractice suit with poor outcome	3.89	3.87
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INTENSITY/COMPLEXITY MEASURES

CPT Code
58605

Reference
Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.81	2.57
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Intra-Service intensity/complexity	2.97	3.21
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Post-Service intensity/complexity	2.58	2.71
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ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

58605 is most comparable to CPT 58670 (Laparoscopy, surgical; with fulguration of oviducts – 5.6 RVWs). Both procedures have comparable levels of complexity. However, the pre-, intra-, and post-service physician times are slightly less for 58605. The lower physician times for 58605 reflect the fact that the procedure is performed within the post-service period for either the global obstetric package for a vaginal delivery (59400 or 59610) or a vaginal delivery only code (59410 or 59614). Thus, there is some overlap in post-operative care. Specifically, a separate hospital discharge service is not required. However, the pre-service counseling and informed consent process is not typically part of the pre-service work for a vaginal delivery. Immediate post-service work, as well as an additional hospital visit on the day of the procedure, and an additional office visit 2 weeks after the procedure are not included in typical post-partum care.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99214	1.10
Intra-Service	30 min. x .08 IWPUT	2.40
Immediate Post-Service	99231	0.64
Hospital	99231	0.64
Office Visit	99212	<u>0.45</u> 5.23

Using the building block approach, the approximate RVWs for this service would be 5.23, as illustrated above. Note that, in contrast to the building block method for 58600, this does not include a separate hospital discharge because of the overlap with the delivery.

Recommended RVU

Therefore, ACOG recommends an RVW of 5.00 for this procedure, which was the minimum value submitted by our survey respondents.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency 662,000 (all tubal ligation procedures)

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 Ob/Gyns Frequency < 100

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 1 No 31

a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 1

b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 0

c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 0 no change 1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESSSM
SUMMARY OF RECOMMENDATION

CPT Code: 58611 Tracking Number: Global Period: ZZZ Recommended RVW: 3 1.45 RUC

CPT Descriptor: Ligation or transection of fallopian tube(s), when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year old woman is undergoing an elective repeat cesarean delivery. During her prenatal care, she received proper counseling and signed an informed consent. After the delivery of the baby and subsequent repair of the uterus, the fallopian tube(s) are doubly ligated and a specimen is excised and sent to the pathologist.

Description of Work:

Intraoperative services included in the global service when surgically indicated:

Identification and ligation or transection of one or both fallopian tubes, any method

Postoperative services in operating room:

Completion of operating room record

Postoperative services in the recovery room:

Not applicable

Postoperative services prior to discharge:

Inclusion of operative description within operative report

Postoperative services in the office:

Not applicable

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%): 33 (24%) Median RVW: 3.65

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 3 75th Percentile RVW: 5 Low: 1 High: 18

Median Pre-Service Time: N/A Median Intra-Service Time: 13.5

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15 Low: 5 High: 105

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>N/A</u>	_____
Critical Care:	<u>N/A</u>	_____
Other Hospital Visits:	<u>N/A</u>	_____
Discharge Day Mgmt.:	<u>N/A</u>	_____
Office Visits:	<u>N/A</u>	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RW</u>
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	5.6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 58611	<u>Reference</u> <u>Service 1 CPT:</u> 58670
Median Pre-Time	N/A	N/A
Median Intra-Time	13.5	35
Median Immediate Post-service Time	N/A	N/A
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.32	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.24	2.46
Urgency of medical decision making	2.18	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	2.65	3.17
Physical effort required	2.46	3.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.70	3.08
Outcome depends on the skill and judgement of physician	2.78	2.90
Estimated risk of malpractice suit with poor outcome	3.83	3.79

INTENSITY/COMPLEXITY MEASURES**CPT Code**
58611**Reference**
Service 1
58670**Time Segments (Mean)**

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	2.67	3.17
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Survey respondents compared 58611 to 58670, with a median RVU of 3.65. The ACOG RVS Committee felt that respondents had overvalued the procedure, possibly due to an imperfect understanding of how to value an add-on procedure. 58611 does not fit neatly into the add-on concept, which assumes that the add-on has no significant pre- or post-service work in excess of the pre- and post-service work of the primary procedure being performed at that time. Although 58611 does not add substantially to the post-service work of a cesarean delivery (59510, 59515, 59618 or 59622), it does include significant pre-service work not included in the RVUs assigned to the cesarean delivery codes. Most of the pre-service work, including counseling and informed consent, associated with a stand-alone tubal ligation (eg 58670) must be performed for 58611 also. The committee decided that the work associated with 58611 could best be approximated in the following way:

- Pre-service work is roughly equivalent to 99213 at .67 RVUs. Note that this is reduced compared to the 99214 equivalent for pre-service work of the stand-alone tubal ligation codes (see recommendations for 58600 and 58605).
- Intra-service work is comparable to 1.5 x CPT 44955 (Appendectomy; when done for indicated purpose at time of other major procedure – 1.53 RVUs). The value for 44955 is multiplied by 1.50 because 58611 is a bilateral procedure.
- $99213 (.67 \text{ RVUs}) + 1.5 \times 44955 (1.53) = 2.96$

ACOG therefore recommends 3.00 RVUs, the 25th percentile survey RVU for 58611.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty OB/GYNS 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 OB/GYNS Frequency 662,000 (all tubal ligation procedures)

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 OB/GYNS Frequency < 100

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 1 No 28

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 1
- b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 0
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 0 no change 1

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58700 Tracking Number: ___ Global Period: 090 Recommended RVW: 12.05

CPT Descriptor: Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old female presents with complaints of mid-cycle pain, dysparunia and dysmenorrhea that has gotten progressively worse and is not responding to medical therapy. She had an appendectomy for a ruptured appendix with peritonitis at the age of 18. She has now been trying to conceive for 18 months without success. She has previously undergone a bilateral neosalpingostomy, however a recent HSG shows severely damaged tubes with evidence of bilateral salpingitis isthmica nodosa and bilateral nonpatent hydrosalpinges. The patient is now taken to the operating room. After general anesthesia, an examination under anesthesia is performed. An exploratory laparotomy is performed which shows large nonpatent hydrosalpinges. Both the left and right fallopian tubes are removed. She receives routine post-operative care during the 90-day global period.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Excision of fallopian tube(s), complete or partial, unilateral or bilateral
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of sutures, staples
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 85 Response Rate: (%): 49 (57%) Median RVW: 12.05

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 11.09 75th Percentile RVW: 13.12 Low: 9 High: 17

Median Pre-Service Time: 75 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 52.5 75th Percentile Intra-Svc Time: 90 Low: 45 High: 120

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>32.5</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>49</u>	<u>99231, 99232</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>53</u>	<u>99214, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58700	Reference Service 1 CPT: 58720
Median Pre-Time	75	55
Median Intra-Time	60	60
Median Immediate Post-service Time	32.5	25
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	49	40
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	53	45

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	3.66	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.45
Urgency of medical decision making	3.29	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.35
Physical effort required	3.43	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	5.00
Outcome depends on the skill and judgement of physician	3.60	3.40
Estimated risk of malpractice suit with poor outcome	3.80	3.60

INTENSITY/COMPLEXITY MEASURES**CPT Code**

58700

Reference**Service 1****58720****Time Segments (Mean)**

Pre-Service intensity/complexity	3.29	3.15
Intra-Service intensity/complexity	4.49	3.25
Post-Service intensity/complexity	3.23	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

CPT code 58700 is most comparable to CPT code 58720 (salpingo-oophorectomy – 11.36 RVWs). Survey results indicate that 58700 typically requires more pre-service and post-service physician time than 58720. In addition, removing only the fallopian tube demands a higher level of technical skill to successfully dissect the tube from the ovary and surrounding structures without compromising the blood supply to the ovary. Patients who undergo only salpingectomy are also at substantially greater risk of excessive bleeding.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	60 min. x .08 IWPUT	4.80
Immediate Post-Service	99232	1.06
Hospital	99232	1.06
	99231	0.64
	99238	1.28
Office Visits	99214	1.10
	99212	<u>0.45</u>
		12.16

Using the building block approach, the approximate RVWs for this service can be calculated as 12.16, as illustrated above.

Recommendation

Comparison to the reference service (58720) and the building block method both validate the survey median of 12.05. Therefore, ACOG is recommending the survey median of 12.05 RVWs for 58700.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty_Obstetricians/Gynecologists___ ___Commonly ___X___Sometimes ___Rarely

Specialty_____ ___Commonly ___Sometimes ___Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty_Obstetricians/Gynecologists___ Frequency_National data unavailable.____

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_Obstetricians/Gynecologists___ Frequency___100_____

Specialty_____ Frequency_____

Do many physicians perform this service across the United States? ___X___Yes ___No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 12 No 33

a. This service represents new technology that has become more familiar (i.e., less work).
I agree 5 I do not agree 7

b. Patients requiring this service are now:
more complex (more work) 12 less complex (less work) 0 no change 0

c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 10

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58740 Tracking Number: ___ Global Period: 090 Recommended RVW: 14

CPT Descriptor: Lysis of adhesions (salpingolysis, ovariolysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old female presents with complaints of mid-cycle pain and dysmenorrhea that has gotten progressively worse. She had an appendectomy for a ruptured appendix at the age of 18. She has now been trying to conceive for 18 months without success. A recent HSG shows patent tubes. However, there was loculation of contrast around both tubes suggesting peritubal adhesions. The patient is now taken to the operating room. After general anesthesia, an examination under anesthesia is performed, and an instrument for chromotubation is placed in the uterus. An exploratory laparotomy is performed which shows multiple layers of filmy and dense adhesions throughout the pelvis. The tubes and ovaries are adherent to each other as well as to the pelvic sidewall. There are also adhesions between the posterior uterus and rectum. Chromotubation is performed which demonstrates bilateral tubal patency. Meticulous adhesiolysis is performed and at the conclusion of the operative session the tubes, ovaries, and uterus are completely free. A permanent adhesion barrier is utilized on the pelvic sidewall under both ovaries and a resorbable adhesion barrier is used around the tubes and ovaries to try to decrease the reformation of adhesions. She receives routine post-operative care during the 90-day global period.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Lysis of peritubal and periovarian adhesions, any method
- Chromotubation
- Application of materials to prevent adhesions
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, catheters, sutures, staples
- Discharge care

Review of laboratory reports

Patient instructions

Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of sutures, staples

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 85 Response Rate: (%) 49 (57%) Median RVW: 14

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 12.86 75th Percentile RVW: 16.44 Low: 1 High: 23

Median Pre-Service Time: 67.5 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 120 Low: 60 High: 150

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>32.5</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>49</u>	<u>99231, 99232</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>53</u>	<u>99214, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	11.29
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	11.68
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58740	<u>Reference</u> <u>Service 1 CPT:</u> 58660
Median Pre-Time	67.5	80
Median Intra-Time	120	120
Median Immediate Post-service Time	32.5	40
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	49	0
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	53	25

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.40
Urgency of medical decision making	3.14	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	4.10
Physical effort required	3.86	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	3.90
Outcome depends on the skill and judgement of physician	4.30	4.00
Estimated risk of malpractice suit with poor outcome	3.89	3.80

INTENSITY/COMPLEXITY MEASURES

CPT Code
58740
Reference
Service 1
58660

Time Segments (Mean)

Pre-Service intensity/complexity	3.41	3.20
Intra-Service intensity/complexity	4.22	4.00
Post-Service intensity/complexity	3.35	2.90

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Survey respondents selected CPT 58660 (surgical laparoscopy with lysis of adhesions – 11.29 RVWs) as most comparable to 58740. Survey results demonstrate that pre-service work is slightly less for the open procedure (58740), due to the greater time requirements to prepare for laparoscopic surgery. According to the survey respondents, intra-service time and intensity are comparable for the two procedures. However, post-service work is typically greater for the open procedure because of the lengthier recovery period. Survey results demonstrate that there are typically 5 post-operative visits following the day of surgery for 58740. In addition, patients who are selected for the open procedure are typically more complex than those who undergo the laparoscopic procedure. Half of the survey respondents believed the work for performing 58740 has increased over the last 5 years, and the majority of those respondents noted that patients requiring this procedure have become more complex.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	120 min. x 0.08 IWPUT	9.60
Immediate Post-Service	99232	1.06
Hospital	99232	1.06
	99231	0.64
	99238	1.28
Office Visits	99214	1.10
	99212	0.45
		16.96

Using the building block approach, the approximate RVWs for this service can be calculated as 16.96, as illustrated above.

Recommended RVU

The Committee believed that the greater post-operative care requirements for CPT 58740 in comparison to CPT 58660 justify the survey median. ACOG therefore recommends the survey median of 14.00 for 58740.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists _____ 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 Obstetricians/Gynecologists _____ Frequency National data unavailable. _____

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 Obstetricians/Gynecologists _____ Frequency 500 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 21 No 21

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 10 I do not agree 11
- b. Patients requiring this service are now:
more complex (more work) 19 less complex (less work) 0 no change 2
- c. The usual site-of-service has changed:
from outpatient to inpatient 1 from inpatient to outpatient 6 no change 14



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58825 Tracking Number: ___ Global Period: 090 **Recommended RVW: ~~11.36~~**
CPT Descriptor: Transposition, ovary(s). **10.98 RUC**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old woman was recently diagnosed with Hodgkin's disease. Following surgical staging she is advised to undergo pelvic and abdominal radiation therapy. Because of her wish to preserve ovarian function and the potential for future fertility she is advised that bilateral ovarian transposition can be performed in an effort to preserve normal ovarian function. The patient consents to the operative procedure before undergoing radiation treatments.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Repositioning of ovaries and securing them in place
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, staples, sutures
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packs, drains, catheters, staples, sutures
-

SURVEY DATA:

Presenter(s): Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists, Society of Gynecologic Oncologists

Sample Size: 103 Response Rate: (%): 30 (29%) Median RVW: 11.36

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 11.36 75th Percentile RVW: 12.44 Low: 9 High: 20

Median Pre-Service Time: 60 Median Intra-Service Time: 65

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 35 High: 150

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>20</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>49</u>	<u>99232, 99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>38</u>	<u>99213, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58825	Reference Service 1 CPT: 58720
Median Pre-Time	60	62.5
Median Intra-Time	65	60
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	49	40
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	38	23

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.95	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.14
Urgency of medical decision making	3.14	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	2.93
Physical effort required	3.05	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.24	3.00
Outcome depends on the skill and judgment of physician	3.48	3.14
Estimated risk of malpractice suit with poor outcome	3.24	3.14

INTENSITY/COMPLEXITY MEASURES

CPT Code
58825

Reference
Service 1
58720

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	2.93
Intra-Service intensity/complexity	3.38	3.00
Post-Service intensity/complexity	2.95	2.86

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

Survey respondents compared 58825 to 58720 (salpingo-oophorectomy – 11.36 RVWs), and assigned both procedures similar pre-, intra-, and post-service times. However, one additional post-operative visit was assigned to 58825 and intra-service complexity/intensity was rated higher for 58825.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	65 min. x .08 IWPUT	5.20
Immediate Post-Service	99231	0.64
Hospital	99232	1.06
	99231	0.64
	99238	1.28
Office Visits	99213	0.67
	99212	<u>0.45</u>
		11.71

Using the building block approach, the approximate RVWs for this service can be calculated as 11.71, as illustrated above.

Recommended RVU

The comparison to CPT 58720 and application of the building block methodology both validate the survey median. ACOG recommends an RVW of 11.36 for 58825.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Gynecologic Oncologists Commonly Sometimes X Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Gynecologic Oncologists Frequency_ National data unavailable. _____

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: Gynecologic Oncologists Frequency_ Very infrequently provided to Medicare patients.

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes X No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 3 No 21

a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 1

b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) 0 no change 1

c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 1

**AMA/SPECIALTY SOCIETY RVS-UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58920 Tracking Number: ___ Global Period: 090 Recommended RVW: 11.36

CPT Descriptor: Wedge resection or bisection of ovary, unilateral or bilateral.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 26 year old woman undergoes surgery for a 6 cm adnexal mass believed to be of benign origin. At surgery, the ovarian mass appears suspicious, is biopsied, and a diagnosis of malignancy is confirmed. The patient has not consented to any enlargement of the scope of the planned surgery, specifically because of her desire for child-bearing. After surgery the patient is counseled concerning the recommended treatment of her ovarian cancer, as well as the risks and benefits of both the recommended and alternative treatments. The patient agrees to a second operation for the purpose of staging her disease. A wedge resection of the remaining ovary is performed and appropriate treatment is carried out.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Partial excision of the ovary, any method
- Closure of the ovarian defect
- Hemostasis, any method
- Application of material to prevent adhesions
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of sutures, staples
-

SURVEY DATA:

Presenter(s): Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36
58925	Ovarian cystectomy, unilateral or bilateral	11.36
49000	Exploratory laparotomy, exploratory celiotomy, with or without biopsy(s), separate procedure	11.68

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58920	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time	<input type="text"/>	<input type="text"/>
Median Intra-Time	<input type="text"/>	<input type="text"/>
Median Immediate Post-service Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Critical Care Times	<input type="text"/>	<input type="text"/>
Median of Aggregate Other Hospital Visit Times	<input type="text"/>	<input type="text"/>
Median Discharge Day Management Time	<input type="text"/>	<input type="text"/>
Median of Aggregate Office Visit Times	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
Urgency of medical decision making	<input type="text"/>	<input type="text"/>

Technical Skill/Physical Effort (Mean)

Technical skill required	<input type="text"/>	<input type="text"/>
Physical effort required	<input type="text"/>	<input type="text"/>

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
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Outcome depends on the skill and judgment of physician

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
58920

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

ACOG did not conduct a survey on this procedure because of an anticipated low response rate. The ACOG RVS Committee believes that CPT code 58920 is most comparable to CPT codes 58720 (salpingo-oophorectomy – 11.36 RVWs) and CPT 58925 (ovarian cystectomy – 11.36 RVWs). The Committee also notes that 58920 includes the work of CPT 49000 (exploratory laparotomy – 11.68 RVWs), as well as the removal of a portion of one or both ovaries. However, current RVWs for 58920 are significantly less than the RVWs assigned to 49000.

Recommended RVU

Based on comparison to key reference services, ACOG recommends an RVW of 11.36 RVWs for 58920.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency_National data unavailable. _____

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 Ob/Gyns Frequency 20

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ___ Yes X No

CPT Code: 58920

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58950 Tracking Number: ___ Global Period: 090 **Recommended RVW: 16.93**

CPT Descriptor: Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old woman who had undergone a prior vaginal hysterectomy for abnormal bleeding was found to have bilateral pelvic masses. She was seen in consultation and was advised to undergo an exploratory laparotomy. She was counseled about the possibility that an ovarian cancer might be present. At the time of surgery an exploratory laparotomy was performed confirming the presence of bilateral ovarian masses. A bilateral salpingo oophorectomy was performed and a frozen section obtained intraoperatively confirmed the presence of a well differentiated mucinous carcinoma. Because of the high risk of occult metastatic disease to the omentum an omentectomy was also performed.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Inspection and evaluation of pelvis and abdomen
- Excision of both ovaries, both fallopian tubes and omentum
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packs, drains, catheters, sutures, staples
-

SURVEY DATA:

Presenter(s) Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists, Society of Gynecologic Oncologists

Sample Size: 103 Response Rate: (%) 34 (33%) Median RVW: 17.73

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 15.5 75th Percentile RVW: 23.3 Low: 11.5 High: 30

Median Pre-Service Time: 70 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 98.75 75th Percentile Intra-Svc Time: 168.75 Low: 65 High: 200

Median Post-Service Time:

	Level of Service by CPT Code	
	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>79</u>	<u>99232 x 2, 99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>61</u>	<u>99213 x 2, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	11.36
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	11.14

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58950	<u>Reference</u> <u>Service</u> <u>1</u> <u>CPT:</u> 58720
Median Pre-Time	70	55
Median Intra-Time	120	60
Median Immediate Post-service Time	30	25
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	79	40
Median Discharge Day Management Time	36	28
Median of Aggregate Office Visit Times	61	30

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	4.24	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	2.94
Urgency of medical decision making	4.34	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.06	2.88
Physical effort required	3.89	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	2.94
Outcome depends on the skill and judgement of physician	4.14	3.06

Estimated risk of malpractice suit with poor outcome	3.26	2.94
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INTENSITY/COMPLEXITY MEASURES

CPT Code
58950

Reference Service 1
58720

Time Segments (Mean)

Pre-Service intensity/complexity	4.00	3.00
Intra-Service intensity/complexity	4.00	2.82
Post-Service intensity/complexity	4.03	2.65

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents most often compared 58950 to CPT 58720 (salpingo-oophorectomy – 11.36 RVWs) and CPT 49255 (omentectomy, epiploectomy, resection of omentum – 11.14 RVWs). The survey results show twice as much intra-service time and higher intra-service intensity for 58950 as compared to 58720. The nature of the disease being treated (ovarian cancer) typically requires more post-operative work than typically involved with 58720. Survey respondents listed 6 post-operative visits following the day of surgery for 58950 and only 4 for 58720.

Multiple Procedure Payment Rules

Application of multiple procedure payment rules to codes 58720 and 49255 yields the following result:

$$11.36 \text{ (CPT 58720)} + \frac{1}{2}(11.14) \text{ (CPT 49255)} = 16.93.$$

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	120 min. x .08 IWPUT	9.60
Immediate Post-Service	99232	1.06
Hospital	99232 x 2	2.12
	99231	0.64
	99238	1.28
Office Visits	99213 x 2	1.34
	99212	<u>0.45</u>
		18.26

Using the building block approach, the approximate RVWs for this service can be calculated as 18.26, as illustrated above.

Recommended RVU

The comparison to CPT 58720 and application of multiple procedure payment rules validate an RVW slightly lower than the survey median of 17.73. ACOG therefore recommends an RVW of 16.93 for this procedure, which falls between the 25th percentile and median survey values.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gyn Oncologists Commonly Sometimes Rarely

Specialty Ob/Gyns 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 Gyn Oncologists Frequency National data unavailable.

Specialty Ob/Gyns Frequency National data unavailable.

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 Gyn Oncologists Frequency 183

Specialty Ob/Gyns Frequency 396

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 5 No 28

a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 5

b. Patients requiring this service are now:
more complex (more work) 5 less complex (less work) 0 no change 0

c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 4

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58951 Tracking Number: ___ Global Period: 090 Recommended RVW: ~~25.48~~ 22.38 RUC

CPT Descriptor: Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old woman presented to her physician with a fixed pelvic mass and ascites. Her clinical assessment indicated a high probability of ovarian cancer. She was seen in consultation and was advised to undergo an exploratory laparotomy. At the time of surgery bilateral ovarian cancers were identified with metastasis noted in the omentum. She underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy and omentectomy. This portion of the procedure excised all of the visible tumor. Because of a high risk of occult metastatic disease to the pelvic and or paraaortic lymph nodes a bilateral pelvic and limited paraaortic lymphadenectomy was also performed.

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Abdominal incision
- Inspection and evaluation of pelvis and abdomen
- Excision of uterus (corpus and cervix) with removal of tube(s) and ovary(s)
- Excision of omentum
- Pelvic and limited para-aortic lymphadenectomy
- Hemostasis
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packing, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of packing, drains, catheters, sutures, staples

SURVEY DATA:

Presenter(s) Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists, Society of Gynecologic Oncologists

Sample Size: 103 Response Rate: (%) 34 (33%) Median RVW: 28.925

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 28 75th Percentile RVW: 30 Low: 15 High: 46.6

Median Pre-Service Time: 75 Median Intra-Service Time: 200

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 236.25 Low: 150 High: 300

Median Post-Service Time:

	Level of Service by CPT Code	
	<u>Total Time</u>	<u>(List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>32.5</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>139</u>	<u>99232 x 4, 99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>53</u>	<u>99214, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	28.85

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u> 58951	<u>Reference</u> <u>Service</u> 1 <u>CPT:</u> 58210
Median Pre-Time	75	90
Median Intra-Time	200	210
Median Immediate Post-service Time	32.5	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	139	85
Median Discharge Day Management Time	36	25
Median of Aggregate Office Visit Times	53	50

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	4.58	4.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.09
Urgency of medical decision making	4.51	4.09

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.86
Physical effort required	4.63	4.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.74	4.50
Outcome depends on the skill and judgement of physician	4.71	4.64

Estimated risk of malpractice suit with poor outcome	3.86	4.09
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INTENSITY/COMPLEXITY MEASURES

CPT Code
58951

Reference
Service 1
58210

Time Segments (Mean)

Pre-Service intensity/complexity	4.44	4.29
Intra-Service intensity/complexity	4.77	4.86
Post-Service intensity/complexity	4.49	3.95

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents compared CPT 58951 to CPT 58210 (radical abdominal hysterectomy – 28.85 RVWs). Survey respondents assigned slightly lower pre-operative and intra-operative times to 58951. However, 58951 was assigned one more post-operative visit than 58210.

Multiple Procedure Payment Rules

CPT code 58951 combines CPT 58150 (total abdominal hysterectomy – 15.24 RVWs) and CPT 49255 (omentectomy, epiploectomy, resection of omentum – 11.14 RVWs).

Application of multiple procedure payment rules yields the following result:

$$15.24 \text{ (CPT code 58150)} + \frac{1}{2}(11.14) \text{ (CPT code 49255)} = 28.99$$

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	200 min. x .08 IWPUT	16.00
Immediate Post-Service	99232	1.06
Hospital	99232 x 3	3.18
	99231	0.64
	99238	1.28
Office Visits	99214	1.10
	99212	<u>0.45</u>
		25.48

Using the building block approach, the approximate RVWs for this service can be calculated as 25.48, as illustrated above.

Recommended RVU

The results of the building block approach are supported by both the comparison to CPT 58210 and the application of multiple procedure payment rules to CPT 58150 and CPT 49255. ACOG therefore recommends an RVW of 25.48 for 58951.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gynecologic Oncologists Commonly Sometimes Rarely

Specialty Ob/Gyns Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gynecologic Oncologists Frequency National data unavailable.

Specialty Ob/Gyns Frequency National data unavailable.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Gynecologic Oncologists Frequency 257

Specialty Ob/Gyns Frequency 709

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 6 No 25

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 6
- b. Patients requiring this service are now:
more complex (more work) 6 less complex (less work) 0 no change 0
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 0 no change 6



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59150 Tracking Number: ___ Global Period: 090 Recommended RVW: 11.67

CPT Descriptor: Laparoscopic treatment of ectopic pregnancy, without salpingectomy and/or oophorectomy.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 34 year old G1 female with a history of prior tubal surgery present 6 weeks after her last menstrual period with left lower quadrant pain and vaginal spotting. Ultrasound revealed a small amount of fluid in the cul-de-sac and mass suspicious for a left tubal pregnancy. The patient is now taken to the operating room. After induction of general anesthesia, a pelvic examination is performed and a uterine manipulator is placed on the cervix. Laparoscopy is performed and reveals an unruptured left tubal pregnancy. The serosa of the tube is infiltrated with a dilute solution of pitressin. A linear salpingostomy (any method) is performed and hemostasis obtained with microtip bipolar electrosurgical energy. The patient receives follow-up care in the hospital and office during the 90 day global period.

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Application of manipulator, with possible dilation of cervical canal
- Skin incisions
- Creation of pneumoperitoneum
- Insertion of trocars and instruments
- Endoscopic inspection and evaluation of abdomen and pelvis
- Evacuation of hemoperitoneum
- Excision and removal of ectopic pregnancy, any method
- Hemostasis
- Release of carbon dioxide gas and removal of all instruments and laparoscope
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family
- Postoperative services prior to discharge:
- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of sutures, staples

SURVEY DATA:

Presenter(s): Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

Total Time

Level of Service by CPT Code

(List CPT Code & # of Visits)

Immediate Post Service Time: _____

Critical Care: _____

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits: _____



KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	11.67

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 59150	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
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		
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 judgement of physician		
Estimated risk of malpractice suit with poor outcome		

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 Obstetricians/Gynecologists Frequency < 100

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___
- b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___
- c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59151 Tracking Number: Global Period: 090 Recommended RVW: 11.49

CPT Descriptor: Laparoscopic treatment of ectopic pregnancy, with salpingectomy and/or oophorectomy.

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 25-year-old G2P1001 female presented to the emergency room 7 weeks after her last menstrual period with signs and symptoms of an ectopic pregnancy. The patient is now taken to the operating room. After induction of general anesthesia, a pelvic examination is performed. A laparoscopy is performed, revealing that the right tube is dilated in the ampullary portion and actively bleeding from the area of rupture. There are approximately 750 CCS of blood in the pelvis. The tube and ovary are densely adherent to each other. Both the tube and ovary are free from the pelvic sidewall. A right salpingo-oophorectomy is performed. All of the blood is aspirated from the pelvis. The pelvis is copiously irrigated until clear. The patient receives routine Post-Operative care in the hospital and office during the 90 day global period.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative services included in the global service when surgically indicated:

- Application of manipulator, with possible dilation of cervical canal
- Skin incisions
- Creation of pneumoperitoneum
- Insertion of trocars and instruments
- Endoscopic inspection and evaluation of abdomen and pelvis
- Evacuation of hemoperitoneum
- Excision and removal of the fallopian tube and/or ovary, along with or in addition to the ectopic pregnancy, any method
- Hemostasis
- Release of carbon dioxide gas and removal of all instruments and laparoscope
- Wound closure
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packing
- Removal of manipulators, probes and packs, when indicated
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
Review of pathology and laboratory reports, as applicable
Removal of sutures, staples

SURVEY DATA:

Presenter(s): Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: N/A Response Rate: (%): N/A Median RVW: N/A

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: N/A 75th Percentile RVW: N/A Low: N/A High: N/A

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____



KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RW</u>
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	11.49

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> 59151	<u>Reference</u> <u>Service 1 CPT:</u>
Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
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		
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 judgement of physician		

Estimated risk of malpractice suit with poor outcome

INTENSITY/COMPLEXITY MEASURES

CPT Code
59151

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Comparison to Reference Service(s)

As demonstrated by 1997 ACOG survey results, 59151 is undervalued compared to 59120 (Surgical treatment of ectopic pregnancy; tubal or ovarian requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach – 11.49). Laparoscopic treatment of ectopic pregnancy requires more pre-service time to verify presence and correct functioning of all laparoscopic equipment. The intra-service work of the laparoscopic procedure is more time-consuming and requires higher level of technical skill than the open procedure, because of the challenges of operating through the laparoscope. Postoperative recovery from the laparoscopic procedure is quicker, but all patients who have had an ectopic pregnancy require the same postoperative follow-up to ensure that the ectopic pregnancy has resolved.

Recommended RVU

The RUC recommended in 1997 that HCFA increase the work RVUs for 59151 to the same level as 59120. In the preamble to the October 31, 1997 final rule announcing the 1998 Medicare Fee Schedule, HCFA stated that it had accepted the RUC's recommendation for 59151. However, this change has never appeared in the fee schedule in spite of our numerous attempts to have HCFA make the correction. ACOG recommends that HCFA increase work RVUs for 59151 to 11.49.

(Attached are copies of a) ACOG's original recommendations to the RUC on this issue, b) the RUC's recommendations to HCFA on this issue, and c) an excerpt from the October 31, 1997 final rule announcing HCFA's intention to increase the RVW for 59151.)

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists 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__Obstetricians/Gynecologists__ Frequency__National data unavailable.____

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__Obstetricians/Gynecologists__ Frequency__< 100_____

Specialty_____ Frequency_____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes ___ No ___

a. This service represents new technology that has become more familiar (i.e., less work).
I agree ___ I do not agree ___

b. Patients requiring this service are now:
more complex (more work) ___ less complex (less work) ___ no change ___

c. The usual site-of-service has changed:
from outpatient to inpatient ___ from inpatient to outpatient ___ no change ___

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 59812 Tracking Number: _____ Global Period: 090 Recommended RVW: ~~4~~ 4.01 RUC

CPT Descriptor: Treatment of incomplete abortion, any trimester, completed surgically

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24 year old female presents with a positive pregnancy test and heavy vaginal bleeding which started one day prior. By the last menstrual period, she should be 10 weeks pregnant. She denies passing tissue but has had large clots. On exam, she has a dilated cervical os with tissue at the os. The patient undergoes treatment of incomplete abortion and receives routine follow-up care during the 90 day global period.

Description of Pre-Service Work:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative Services: Integral components

- Insertion of speculum and/or retractors
- Serial dilation of cervix with mechanical dilators (57800)
- Emptying uterine cavity of the products of conception using a suction apparatus and/or sharp curette
- Removal of surgical instruments
- Hemostasis
- Injection of local anesthesia

Postoperative services in operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when applicable
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family, when indicated

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of drains, catheters, sutures, staples

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 136 Response Rate: (%) 43 (32%) Median RVW: 4

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 3.75 75th Percentile RVW: 4.01 Low: 3.04 High: 10

Median Pre-Service Time: 55 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 10 High: 45

Median Post-Service Time:

Level of Service by CPT Code

Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 17.5

Critical Care: _____

Other Hospital Visits: 19 99231

Discharge Day Mgmt.: 0 _____

Office Visits: 23 99213

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
59820	Treatment of missed abortion, completed surgically; first trimester	4.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u> 59812	<u>Reference</u> <u>Service 1 CPT:</u> 59820
Median Pre-Time	49	40
Median Intra-Time	20	20
Median Immediate Post-service Time	17.5	20
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	19	18
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	23	20

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.81	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.93
Urgency of medical decision making	3.58	2.96

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.04
Physical effort required	2.67	2.70

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	2.96
Outcome depends on the skill and judgement of physician	3.11	3.11
Estimated risk of malpractice suit with poor outcome	3.14	3.22

INTENSITY/COMPLEXITY MEASURES**CPT Code**
59812**Reference**
Service 1**Time Segments (Mean)**

Pre-Service intensity/complexity	3.83	3.11
Intra-Service intensity/complexity	2.97	3.04
Post-Service intensity/complexity	2.75	2.85

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents estimated physician work for CPT 59812 to be equivalent to the work required for 59820 (treatment of missed abortion, first trimester – 4.01 RVWs). The ACOG RVS Committee noted that both procedures require a dilation and suction curettage, but there are some differences in work. In the case of a missed abortion (59820) the cervix typically has not dilated, so this portion of the procedure is more difficult than for a patient who has had an incomplete abortion. However, 59812 can be used in any trimester, while 59820 is limited to first trimester procedures. Performing a suction curettage after the first trimester entails significantly more work and risk. Thus, on balance, total work for both 59812 and 59820 is approximately equal. Survey results substantiate that pre-, intra-, and post-service times, as well as levels of complexity, are almost identical for the two procedures.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service	99215	1.77
Intra-Service	20 min. x .08 IWPUT	1.60
Immediate Post-Service	99231	0.64
Hospital	99231	0.64
Office Visit	99213	<u>0.67</u> 5.32

Using the building block approach, the approximate RVWs for this service can be calculated as 5.32, as illustrated above.

Recommended RVU

Survey respondents estimated both time and intensity at the same levels for 59812 and 59820. Therefore, the survey median seems justified and ACOG recommends the assignment of 4.00 RVWs for 59812.

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyns 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 Ob/Gyns Frequency National data unavailable.

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 Ob/Gyns Frequency 300

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 2 No 37

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 1
- b. Patients requiring this service are now:
more complex (more work) 0 less complex (less work) 0 no change 1
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 0

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 59870 Tracking Number: ___ Global Period: 090 Recommended RVW: 6.01

CPT Descriptor: Uterine evacuation and curettage for hydatidiform mole

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old G3P1011 presents to the office for a routine follow-up OB visit at 12 weeks and fetal heart tones are not heard. Her uterus is enlarged to 14-16 week size and on ultrasound she has a snowstorm appearance in the uterus and no fetus. Her resting pulse is 110. The patient undergoes uterine evacuation and curettage for hydatidiform mole.

Description of Work:

Preoperative services included in the global service when indicated:

- Proper positioning, prepping and draping of patient
- Placement of appropriate markings, packs or probes
- Catheterization or catheter insertion
- Examination under anesthesia, when indicated

Intraoperative Services: Integral components

- Insertion of speculum and/or retractors
- Serial dilation of cervix with mechanical dilators (57800)
- Emptying uterine cavity of the products of conception using suction apparatus and/or sharp curette
- Removal of surgical instruments
- Hemostasis
- Injection of local anesthesia

Postoperative services in the operating room:

- Application of dressings and packings
- Removal of manipulators, probes and packs, when applicable
- Securing, removal or replacement of catheters and drains
- Completion of operating room record

Postoperative services in the recovery room:

- Patient evaluation and stabilization
- Postoperative orders
- Dictation of operative report
- Consultation with family, when indicated

Postoperative services prior to discharge:

- Hospital visit(s) to assess patient status
- Removal of packs, drains, catheters, sutures, staples
- Discharge care
 - Review of laboratory reports
 - Patient instructions
 - Complete discharge summary/medical records as required

Postoperative services in the office:

- Follow-up visit(s) as clinically indicated during the global period
 - Review of pathology and laboratory reports, as applicable
 - Removal of drains, catheters, sutures, staples
-

SURVEY DATA:

Presenter(s) Sandra Reed, MD and George Hill, MD, and Carolyn Runowicz, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 239 Response Rate: (%): 67 (28%) Median RVW: 6.01

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 5 75th Percentile RVW: 8.185 Low: 3.27 High: 10

Median Pre-Service Time: 70 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 40 Low: 20 High: 60

Median Post-Service Time:

	Level of Service by CPT Code (List CPT Code & # of Visits)	
	<u>Total Time</u>	
Immediate Post Service Time:	<u>20</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>83</u>	<u>99214, 99212 x 3</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
59820	Treatment of missed abortion, completed surgically; first trimester	4.01
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	3.27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u> 59870	<u>Reference</u> <u>Service 1 CPT:</u> 59820
Median Pre-Time	70	50
Median Intra-Time	40	20
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	83	23

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	3.78	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.08
Urgency of medical decision making	4.00	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.15
Physical effort required	3.14	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	3.00
Outcome depends on the skill and judgement of physician	4.62	3.15

Estimated risk of malpractice suit with poor outcome	3.15	3.31
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INTENSITY/COMPLEXITY MEASURES

CPT Code
59870

Reference
Service 1
59820

Time Segments (Mean)

Pre-Service intensity/complexity	3.76	3.31
Intra-Service intensity/complexity	3.81	3.23
Post-Service intensity/complexity	3.62	3.08

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Comparison to Reference Service(s)

Survey respondents most commonly compared CPT code 59870 to 59820 (treatment of missed abortion, completed surgically; first trimester – 4.01 RVWs). The greater intra-service time and intensity for 59870 that are reflected in the survey results are explained by the greater risk of excessive bleeding with a molar pregnancy. The survey results also document significantly greater post-operative work. Due to the risk of patients developing trophoblastic disease, physicians are required to follow protocol that calls for the weekly measurement of HCG levels until there are 3 consecutive normal results, with monthly measurements for a year thereafter. Following a molar pregnancy, HCG levels typically do not return to normal for at least 6 weeks, meaning that the typical patient will require weekly evaluations for 8 weeks, with one more evaluation within the 90 day global period. This protocol typically leads to a total of 9 post-operative evaluations. The survey results suggest that 4 of these 9 evaluations will require face-to-face visits with some additional physician work between visits.

Building Block

<u>Time</u>	<u>Equivalent Service</u>	<u>Work RVUs</u>
Pre-Service Time	99215	1.77
Intra-Service Time	40 min. x .08 IWP/PT	3.20
Immediate Post-Service	99231	0.64
Hospital	99238	1.28
Office Visits	99214	1.10
	99212 x 3	1.35
		9.34

Using the building block approach, the approximate RVWs for this service can be calculated as 9.34, as illustrated above.

Recommended RVU

The comparison to CPT 59820 with consideration of the additional post-operative work, in addition to the building block method, validate the survey median. ACOG recommends the survey median of 6.01 RVWs for 59870.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetricians/Gynecologists _____ Commonly Sometimes _____ Rarely _____

Specialty Gynecologic Oncologists _____ 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 Ob/Gyns and Gyn Oncologists _____ Frequency ~ 16,000 _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Obstetricians/Gynecologists _____ Frequency < 10 _____

Specialty Gynecologic Oncologists _____ Frequency _____

Do many physicians perform this service across the United States? Yes _____ No _____

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 5 No 55

- a. This service represents new technology that has become more familiar (i.e., less work).
I agree 0 I do not agree 4
- b. Patients requiring this service are now:
more complex (more work) 2 less complex (less work) 0 no change 2
- c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 2



AMERICAN ACADEMY OF OPHTHALMOLOGY

THE EYE M.D.S.

Federal Affairs Division

Suite 700
1101 Vermont Avenue, NW
Washington, DC 20005-3570

September 20, 2000

Alexander Hannenberg, MD
Chair, Work Group V
AMA/RUC Five Year Review of Work Values

Re: Shortening Global Period for 65855, trabeculectomy, by laser surgery

Dear Dr. Hannenberg:

As the members of Workgroup #5 requested, we are providing information concerning the number of follow-up visits in the first ten days after performing trabeculectomy by laser surgery (CPT 65855). We have asked HCFA to decrease the 90-day global period to 10 days, and were advised by HCFA to take this issue to the RUC for consideration. To date, we have received tentative support from Workgroup #5 pending that we provide additional data to show that visits tend to occur only in the first 10 days after surgery.

We sent a survey to 50 glaucoma specialists and asked them to indicate the number of times in the first 10 days they saw their trabeculectomy patients and if they saw those patients after the first 10 days. As expected, we learned from the 28 responding ophthalmologists that visits occur almost entirely in the first 10 days. However, we were surprised to learn that virtually every respondent sees those patients only twice in the first ten days, and not three times as the Harvard data indicates. Therefore, we request that in addition to shortening the global period to 10 days for CPT code 65855, we recommend a reduction in the work value to reflect one less second-level follow visit.

Summary

CPT code 65855 with 4.30 RVWs currently, should have its 90 day global period shortened to 10 days, and .45 RVWs should be taken from the current work value to reflect the work for one less office visit (CPT 99212), for a revised RVW of 3.85.

Thank you for your consideration. Please contact me or any of our RUC Representatives for additional information should you require it.

Sincerely,

Michael X. Repka, MD
Chair, AAO Health Policy Committee

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 67218 Tracking Number: Global Period: 090 Recommended RVW: ~~18.91~~ 18.53
RUC

CPT Descriptor: Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A sixty year old male with loss vision in one eye is found to have a retinal detachment secondary to a malignant melanoma. The patient elects to have a radioactive plaque implant for treatment of the tumor. The service includes the initial surgery with the implantation of the plaque removal of the plaque and reattachment of the muscles at a later time.

Or

An eighteen month old child with congenital bilateral retinoblastomas has been previously treated with systemic chemotherapy and is now referred for sequential aggressive local therapy with a cobalt plaque for a larger tumor in the left eye. The procedure includes the return to the OR for removal of the plaque.

Description of Pre-Service Work: The patient's medical history and physical history are reviewed. The pre operative A and B mode ultrasounds are reviewed to look at the tumor and for signs of extraocular extension and to determine the apical height and diameter. The dosage of the plaque is reviewed based on the measurements. Both eyes are dilated. The radiation oncology consult is reviewed. Metastatic work up is reviewed. A long discussion is held with the patient and the family is counseled prior to the completion of the initial evaluation. The risk of metastatic disease and death are discussed in detail, as are the results of major studies regarding the outcome of melanoma.

The metastatic melanoma work group is performed and the results are obtained and reviewed prior to the planned surgery. Further testing, **such as a liver biopsy in the surgeon, when indicated.** A second conference with the family members and the patient is held wherein the results of the metastatic work up, the risks and benefits of surgery, and the risks of metastatic disease and untimely death reviewed.

Description of Intra-Service Work: The patient is brought to the operating room. Both eyes are dilated with mydriatic solution and binocular indirect ophthalmoscopy is used to examine the fundus to correctly identify the eye with the tumor. The eye is prepped and draped in the usual sterile manner. A partial limbal pertomy is performed. The eye is examined for extrascleral extension of the tumor. Transillumination is performed to identify the silhouette of the tumor this area is marked with diathermy and/or a marking pen. Depending on the location of the tumor, one or two extracapsular muscles are removed to accommodate the plaque. These muscles are isolated on a double-arm suture in a standard fashion for strabismus surgery. A cold (no seeds) plaque is then taken from a lead container. Visual inspection of the hot plaque is made before placement and a radioactive survey with Geiger counter is performed by a member of the radiation oncology staff. The hot plaque is then sewn into sutures against the muscles are placed through the original insertion of the muscle and left to hang back to accommodate the plaque. A lead shield is then placed over the eye and the patient is taken to the recovery area.

Once fully recovered from surgery, the patient is admitted to the hospital where a lead shield is kept in place over the eye at all times. The patient is seen on a daily basis by the operating surgeon, who removes the lead shield and underlying patch, inspects the eye, and places antibiotic solution before reapplying the patch and shield. The patient's vital signs and general condition are monitored.

The plaque is left in place for several (4-5) days, according to the dosimetry calculated by radiation oncology. The patient is seen every day while in the hospital. On the final day the patient is brought back to the operating room where the conjunctiva is reopened, the muscle reflected back away from eye so that the sutures can be cut and the plaque removed. The plaque is visually inspected to insure that all seeds are in place and then placed in a lead container. A radioactive survey of the patient's face, orbit, and the surrounding surgical drape and shield is then performed by radiation oncology. The muscles that were hung back by suture are now re-placed at their origin. The conjunctiva is reapproximated and closed with suture and the patient is given subconjunctival antibiotics and steroids by injection.

Operative notes for each procedure, as well as admission report and discharge summary are dictated and placed in the patient's permanent record. When the patient is fully recovered, he/she is discharged from the hospital.

Description of Post-Service Work: The patient is seen in the office or clinic on the day following discharge. The patch is removed and the patient is begun on a topical antibiotic/steroid solution and other medications as indicated. The patient is seen again one week, three weeks, and six weeks after the initial surgery and followed periodically thereafter.

Three months after surgery a baseline ultrasound measurement and photography of the melanoma is obtained for the purpose of monitoring it for reoccurrence. The patient is then seen every three months for 1-2 years followed by 2-3 exams yearly thereafter until the tumor shows no signs of growth. Periodic metastatic surveys are coordinated with the internists/oncologist. Other complications from the growth of the tumor and/or the radiation such as retinal detachment, glaucoma, cataract, strabismus, and dry eyes, are addressed as needed.

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	90	70
Median Intra-Time	60	90
Median Immediate Post-service Time	30	25
Median of Aggregate Critical Care Times		0
Median of Aggregate Other Hospital Visit Times	139	25
Median Discharge Day Management Time	36	0
Median of Aggregate Office Visit Times	68	15

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	5	4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	4
Urgency of medical decision making	3	3

Technical Skill/Physical Effort (Mean)

Technical skill required	4	4
Physical effort required	5	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4	5
Outcome depends on the skill and judgement of physician	4	5
Estimated risk of malpractice suit with poor outcome	4	4

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	5	4
Intra-Service intensity/complexity	5	5
Post-Service intensity/complexity	4	4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We recommend the median value of 18.91 RVWs for this service. This service which is rarely performed (a Medicare frequency of 391 in the 2000 RUC database) is a highly complex procedure, and involves two trips to the operating room and the use of radioactive materials requiring special precautions. We expected a low response rate to our survey for this service and find that the 11% rate is consistent with the number of ophthalmologists who perform the service. The procedure involves detaching the muscles in a process similar to codes 67311 and 67335 which have total physician work values of 9.14. This additional work was not adequately reflected in the original valuation. Hospital visits are also required with special precautions due to the radioactive nature of the plaque. The patient is then returned to the operating room for removal of the plaque and reattachment of the muscles and closure of the conjunctiva. The presence of a malignancy increases the risks and intensity of the procedure because perforation of the globe could permit extrascleral extension of the malignancy.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology _____ Commonly _____ Sometimes X Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology _____ Frequency 500 _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Ophthalmology _____ Frequency 400 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 5 No 6

- a. **This service represents new technology that has become more familiar (i.e., less work).
I agree I do not agree 11**
- b. **Patients requiring this service are now:
more complex (more work) 5 less complex (less work) no change 5**
- c. **The usual site-of-service has changed:
from outpatient to inpatient from inpatient to outpatient no change 11**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92018 Tracking Number: Global Period: XXX Recommended RVW: ~~2.95~~ 2.50 RUC

CPT Descriptor: Ophthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: “A 3 month old male is referred by his pediatrician for cloudy corneas. Epiphora has been left present for 3-4 weeks. The right cornea is enlarged and edematous with no fundus view. The left eye is mildly edematous. There are no apparent Descemet breaks. Retinoscopy cannot be accomplished. Discomfort and photophobia prevent meaningful measurement of intraocular pressure in the office.”

Description of Pre-Service Work: The family is counseled before the EUA. The history and physical exam reviewed. Office notes are reviewed. Calibration of the tonometer and keratometer are performed.

Description of Intra-Service Work: A standardized form is used to record data during the EUA. Intraocular pressure is measure immediately upon adequate anesthesia prior to intubation. Other parts are completed after intubation. Horizontal corneal diameter is measured with a caliper. The operative microscope is used with a gonioscopy lens to examine the chamber angle. Direct and indirect ophthalmoscopy are used to examine the posterior segment. If possible a careful scleral depression examination of the entire retina is performed. Refraction is performed using the retinoscope and trial lens bar if the view permits. The data obtained is analyzed and a decision made to awaken the patient of to proceed with other procedures based on the EUA data and the desires of the family obtained preoperatively.

Description of Post-Service Work: This work usually begins immediately after surgery. The surgeon will commonly speak with the Patient and the patients’ family. Instructions are given and explained, questions are addressed and a prognosis is given. It is the surgeon’s responsibility to ascertain the patient’s ability to leave the surgical facility. The patient is seen the next dya in the ophthalmic office. All follow up examination include a history of the postoperative course, an examination of the operative eye including vision, intraocular pressure, and ophthalmic evaluation of the anterior and posterior segment, and further instructions are given for medical use, patient activity and future follow up. An operative note is dictated.

SURVEY DATA:

Presenter(s) Steven Kamenetzky, MD

Specialty(s): Ophthalmology

Sample Size: 100 Response Rate: (%): 20 Median RVW: 3.5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: The survey sample was random, then reviewed by an expert panel. In addition, the data was compared with data and rationales that we had conducted five years ago.

25th Percentile RVW: 2.57 75th Percentile RVW: 7.00 Low: 1.00 High: 20.00

Median Pre-Service Time: 35 Median Intra-Service Time: 25

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99243	Office consultation, new or estab. patient	1.38

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	35	40
Median Intra-Time	25	30
Median Immediate Post-service Time	15	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	3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	4
Urgency of medical decision making	4	3 4

Technical Skill/Physical Effort (Mean)

Technical skill required	4	4
Physical effort required	4	4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4
Outcome depends on the skill and judgement of physician	4	4
Estimated risk of malpractice suit with poor outcome	4	4

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. **Your rationale should also describe how the work of performing the service has changed over the past five years**

We are recommending a work relative value of 2.95. This is based on our current survey median RVW of 3.5 and the survey median of our previous five-year review survey data of 2.5. The small number of procedures done per year under this code adds to the reasonableness of combining the two median RVWs. However, our expert panel also felt that 3.0 RVWs may be too high a value for the service and we therefore decreased it to 2.95. This procedure is one that is performed on children, and in certain cases on retarded adults, thus adding to the time and intensity of working with the patients and their families. The procedure currently valued at 1.51 RVWs pays less than the corresponding office visit during which similar services would be performed. The preservice work is more extensive than a standard office procedure because of the need for general anesthesia. Each element of the examination is more difficult because the patient is under anesthesia and the eye must be manually positioned for the tests to be completed.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty_Ophthalmology _____ Commonly _____ Sometimes _____ Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ____ Yes ____ No



Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 9 No 3

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 3 I do not agree 9**

**b. Patients requiring this service are now:
more complex (more work) 10 less complex (less work) no change 2**

**c. The usual site-of-service has changed:
from outpatient to inpatient from inpatient to outpatient 8 no change 4**

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Gastroenterology

The American Society for Gastrointestinal Endoscopy (ASGE), American College of Gastroenterology (ACG) and the American Gastrointestinal Association (AGA) provided comments to the Health Care Financing Administration that 29 codes describing gastrointestinal endoscopic services were misvalued. The gastroenterologists presented comments on two specific issues for the Five-Year Review: 1) The work values for all gastroenterology procedures involving conscious sedation are substantially undervalued and need to be increased because of added requirements associated with conscious sedation (revised JCAHO requirements, additional time required for examining the patient prior to and following the procedure, and added time for the provision of anesthesia, which has changed from a single push injection to the provision of incrementally titrated agents that are adjusted throughout the course of the procedures); and 2) identification of specific services whose work values are too low in comparison with other gastroenterology services taking into account the time and intensity of these procedures.

The ASGE with the participation of the ACG and the AGA conducted a meeting for the sole purpose of completing 29 RUC surveys. A fly-in meeting was held in which members received instructions about the survey process and were given time to complete two separate surveys. The first survey utilized the full RUC survey instrument to assess the incremental work and time associated with certain endoscopic procedures as compared to the base Endoscopy code in each family. This survey was utilized to review 24 codes and identify the additional time and work required compared to the base code. In addition, a second survey was conducted to specifically address the additional physician work involved in performing conscious sedation, as societies felt there were significant changes in the way conscious sedation was provided.

The RUC raised several issues about the physician work in providing conscious sedation in conjunction with the gastroenterology codes. Specifically, the RUC was concerned about the need to breakout different levels of physician work for conscious sedation; and 2) the inclusion or exclusion of conscious sedation in codes, as some of the gastroenterology codes have been previously valued with conscious sedation included and some codes were not valued with conscious sedation included. Therefore, the RUC excluded the physician work of providing conscious sedation while reviewing recommendations for 21 codes. The RUC agreed to create a joint RUC and CPT workgroup to review and define the issues related to conscious sedation.

Summaries of the RUC's recommendations are as follows:

- The RUC did not find compelling evidence to increase the value for ten procedures and recommended that their current value be maintained. This was primarily due to survey results that did not support a recommended increase, which the presenters acknowledged.
- The RUC is recommending an increase in the work RVUs for 17 procedures to correct anomalies and to address the new survey data that confirms the procedures were undervalued in the Harvard study and the patient population has become more complex.

Pediatric Surgery

The American Pediatric Surgical Association (APSA) provided comments to the Health Care Financing Administration, that 22 of their 28 pediatric surgery procedure codes are significantly undervalued based on one or more of the following rationale: 1) change in practice and technology, 2) change in the patient population, 3) an undervaluation of the post-service work in the global period, 4) rank order anomalies, and 5) extended postoperative critical care.

The Pediatric Surgery codes were reviewed in 1992 by the Harvard APSA study and subsequently incorporated into the fee schedule in 1993. Although this study provided relatively accurate data for the intra service work, it neglected to value the postoperative critical care services, a major component of work for these codes as these infants are critically ill in the postoperative period. The APSA submitted recommendations for 22 codes using RUC survey methodology. It is the provision of very intensive, prolonged services with long critical care and hospital stays that account for very high RVUs. The RUC received compelling evidence that these services, intensities and RVU's are appropriate for these clinical situations.

The RUC valued the codes and services presented, in what it believes to be fair and conservative valuations, but recognizes that the resulting values are some of the highest proposed RVUs in the Medicare RBRVS. Nonetheless, the RUC believes these are fair values for the services when provided by the performing neonatal surgeon.

The RUC supports the following recommendations:

- The RUC recommended increased work relative values for 12 codes to correct the undervalued physician work in the intra-and post service periods, extended Critical Care services, and a shift in patient population
- The RUC supported maintaining the current relative values of four codes because of the lack of compelling evidence for a recommended increase in the RVUs
- The RUC referred five codes to CPT for clarification of the code descriptors in pediatric versus adult populations

Pediatrics

The American Academy of Pediatrics (AAP) provided comments to the Health Care Financing Administration that five codes are believed to be significantly undervalued in comparison to other codes within one family and in comparison to evaluation and management procedures. The AAP conducted a survey using RUC survey methodology in which they solicited a panel of physicians who submitted their responses through the AAP web site. The RUC suggested that the Research Subcommittee review the survey method and provide specialty society's guidance on this method of surveying.

The RUC supported increasing the values for two of the five codes presented. The RUC recognized that the physician work component had become more difficult due to the fact that many of the patients who require venipuncture are now much younger and smaller, and due to advances in neonatology that have resulted in greater viability of pre-term infants. The RUC recommended that the other three codes presented should be forwarded to CPT for clarification, because it was unclear in the code descriptor what the exact nature of the physician services are associated with these codes.

Pulmonary Medicine/Critical Care

The societies for pulmonary medicine and critical care provided comments to the Health Care Financing Administration on four codes that the societies' identified as being undervalued. These codes were surveyed using the RUC survey via a web site. The RUC suggested that the Research Subcommittee review this survey method and provide specialty society's guidance for this method of surveying.

The RUC supported increasing the value for one code to correct an existing rank order anomaly. The RUC also recommended that one code be referred to CPT to clarify the nomenclature for this service. The RUC also recommended maintaining the value for the critical care services due to the lack of compelling evidence to recommend an increase in the work RVU above the 1999 restored proposed values of 4.00 and 2.00.

Cardiology

The American College of Cardiology (ACC) provided comments to the Health Care Financing Administration on one code that the society believed to be undervalued. This code was last reviewed in 1994 and was excluded from the first Five-Year Review when other echocardiographic imaging codes were increased. Since this code's original review, there has been a shift of patients from the inpatient to outpatient setting, and the patients receiving stress echocardiography procedures are sicker and more complex. The ACC surveyed this code using RUC survey methodology, which had a response rate of 29.5%.

The RUC supported an increase in the work RVUs for this code to account for the increased work and for the more complex patient population and the shift from the inpatient to outpatient setting.

Radiology

The American College of Radiology (ACR) identified six codes in their comment to the Health Care Financing Administration. The ACR believed that these codes were undervalued due to an increase in the amount of physician work required, increased risk factors and increased complexity in the oncologic patient population.

Specifically, the ACR believed that CPT codes *76065 Radiologic examination, osseous survey, infant* and *76090 Mammography, unilateral* and CPT Code *76091 Mammography, bilateral* were undervalued due to the following reasons. The radiological examination of an infant, CPT 76065, is most commonly performed in the setting of alleged child abuse and requires a significant amount of physician work to meet the ACR's Standard for Skeletal Surveys in Children. Additionally, the ACR believes that the two Mammography procedure codes (76090 and 76091) are still not reflective of the amount of physician work necessary to perform all the requirements for the Government regulated procedures and the ACR standard. Also, with the increase in Federal regulations on Mammography there has been a tremendous increase in physician oversight of quality control procedures required by the Mammography Quality Standards Act (MQSA) guidelines. This process requires physicians to code outcomes of the studies using the ACR's BI-RADS system, as well as sending follow-up letters to both the referring physician and patient. The intensity of mammography has also increased due to in part to potential litigation.

The Society surveyed over 280 of its members and had a response rate of 18.9%, using the RUC survey methodology. Based on the survey results, the RUC supports the following recommendations:

- Increasing the value for five codes as a result of increased physician time, mental effort and judgement
- The RUC referred three codes to CPT to clarify the code descriptors to describe the revision of implantable venous access devices and reservoirs, and the revision of implantable venous access devices or subcutaneous reservoirs, as the current code descriptors contain the term “and/or subcutaneous reservoir”

Plastic Surgery

The American Society of Plastic and Reconstructive Surgery (ASPS) submitted two codes for the Five-Year Review of the RBRVS. CPT code 42205 is being submitted before the RUC for the first time to correct a rank order anomaly created during the last Five-Year Review. Two other codes in the palatoplasty family were reviewed and increased which are now being used as the primary reference procedures for CPT 42205. The second code 49905 was created in 1991 at the request of ASPS to report the use of omental flaps in sternal wound and chest wall reconstruction. CPT designated this procedure as an add-on, which was not the original intent of ASPS. HCFA subsequently valued this procedure and reduced the pre and post op care, which ASPS believed was not valued in the recommendation submitted in 1991 by the RUC.

ASPS felt it was unnecessary to conduct a survey for either code and provided the RUC with a letter that was sent to HCFA in February 2000. The RUC reviewed CPT 42205 and recommended an increase in the value, which corrects the current rank order anomaly that exists within this family of codes. The RUC noted that code 49905 should be designated as a primary procedure and not an add-on code and should have a 90-day global. Therefore, the RUC recommended that code 49905 be referred to CPT for their review.

Spine Injection Procedures

Seven spine injection procedure codes were presented to the RUC by a group of concerned medical specialty societies. These codes were previously presented at the May 1999 RUC meeting and forwarded to the Health Care Financing Administration (HCFA), with what the RUC felt were appropriate values. HCFA agreed with the relativity of the four injection codes (62310,62311,62318,62319) forwarded from the RUC; however, HCFA applied a budget neutrality factor that went beyond what the specialties felt was appropriate. This resulted in misvalued work RVWs. HCFA also decreased the work relative values for codes 72275,62263 & 76005, because HCFA felt the RVU's were excessive.

The RUC reviewed the original surveys and subsequent recommendations and felt that they were indeed appropriate. The RUC did not agree with the adjustments that HCFA made to a portion of the codes, which destroyed the relativity that was presented to and accepted by the RUC. The RUC agreed that its original actions were appropriate and is forwarding their original recommendations submitted in May 1999.

Biofeedback

The RUC reviewed the original survey and noted that the original RUC recommendation was 2.15 RVUs; however, HCFA decreased the work value to 0.89 RVUs. The RUC noted that no further information was provided to indicate that the HCFA rationale for decreasing the RVU was inappropriate, and the specialty societies that perform this service did not present any new information to respond to HCFA's action in decreasing the work value. Therefore, the RUC recommends that 0.89 RVUs be maintained, as no compelling evidence was provided to recommend an increase in the RVUs.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE FIVE-YEAR REVIEW RECOMMENDATIONS

Conscious Sedation

HCFA did not initially submit the comment from the gastroenterology societies that specific gastrointestinal endoscopy services should be increased to account for increased physician work in providing conscious sedation. The specialty society collected data in July 2000 and petitioned HCFA to ask the RUC to review this information. Due to this delayed request to review the comment, and a RUC workgroup concern that the issue of conscious sedation should be addressed as a global issue, the RUC recommendation on this issue was not completed in time for our earlier October 2000 submission.

The RUC discussed this issue briefly in October 2000 and also at our most recent February 2001 meeting. The RUC heard arguments presented by gastroenterology representatives that the physician work in the provision of conscious sedation has changed over the past five years due to changes in specialty guidelines and JCAHO requirements. The specialty argued that physicians typically spend 20-25 minutes of additional time (10 minutes pre-, 7.5 minutes intra-, and 5 minutes post-time) performing this service than was required five years ago.

The specialty presented the following list of physician tasks that are either new or have changed in the past-five years:

Pre-Service:

- Informed consent dealing with spectrum of sedation (conscious or moderate to deep sedation) and documentation thereof.
- Obtaining a history pertinent to the risks and co-morbid conditions that may influence administration of sedation (eg, underlying pulmonary, vascular, cardiac, kidney, and/or liver disease). The specialty argued that a separate E/M service is not reported on the same date as the patient has been seen by the performing physician a week or two prior to the endoscopy, or the service is performed via open access endoscopy, where an E/M service would not be reported by the performing physician.
- Physical examination of the heart and lung systems with an anesthesia risk score and airway assessment with documentation thereof.
- Advanced directive discussion including that pertaining to a living will and patient desires in the setting of an arrest with documentation thereof. The specialty argued that the physician is required to query the patient on these issues.

Intra-Service:

- Diminished rate and quantity of administration of midazolam and meperidine. For example, conscious sedation policy at Myo Clinic dictates 0.5-1.0 mg of midazolam to be given over 2 minutes with 2 minutes of observation in healthy patients under 60 years old. For debilitated or patients more than 60 years old, the dose and increment should be reduced by 25%. In the same policy, meperidine is titrated in 10 mg aliquots each over 1-2 minutes. Importantly, the administration and monitoring of sedating effect is done independently. That is, midazolam and meperidine should not be administered simultaneously but rather sequentially.
- Ascertainment of minimum discharge criteria prior to release to the recovery room.

Post-Service:

- Documentation (including written and dictated) of adverse events and response to these during the procedure. This would include desaturation, hypotension, and administration of reversal agents.
- Provision of detailed patient instructions as it relates to sedation and explanation thereof to the family members.
- Attainment of measured discharge criteria prior to release of the patient from the endoscopy suite. Requirements for discharge criteria now result in physician interventions to deal with patients not meeting these criteria or experiencing prolonged recovery periods.

The specialty testified that JCAHO requires a RN level nursing staff for the recovery period only. The typical staff type to assist the physician in the pre- and intra- period is a LPN, which adds to the evidence that the physician performs most of these activities.

The RUC reviewed the above list and agreed that the elements of physician work related to conscious sedation has changed over the past five-years. However, the RUC was not able to quantify this increase in physician work.

The RUC had reviewed CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation* (work RVU = 0.80) and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal* (work RVU = 0.60) and provided recommendations to HCFA on these codes. The typical patient described for these codes was a child receiving services where conscious sedation would not typically be utilized (eg, laceration repair). **The RUC recommended then, and urges HCFA now to allow separate reporting and payment of conscious sedation codes 99141 and 99142 when conscious sedation is not inherently included as a component of the physician work of the procedure code.**

The representatives of gastroenterology argued that the RUC should recommend specific increases to their services to account for the increased work in providing conscious sedation. **The RUC is unable to recommend any specific conscious sedation increase to these existing gastrointestinal endoscopy codes** for the following reasons:

- The amount of time or physician work related to conscious sedation currently captured in the gastroenterology codes is unknown. There appears to be no written documentation of this issue in the Harvard/Hsaio studies, although the gastroenterologists provided verbal testimony that it was considered in the Harvard panels. The RUC reviewed the time data and current work relative values for stand-alone codes 99141 and 99142 and suggested that today's physician work for conscious sedation may already be captured appropriately in the gastrointestinal codes.
- The issue of conscious sedation extends beyond gastroenterology. Many specialties, including colon and rectal surgery, dentistry, interventional radiology, cardiology, pulmonary medicine, and others are also affected by any changes in requirements and regulations related to conscious sedation. Any increases in work related to conscious sedation should be applied fairly to all procedure codes where it is considered an inherent component. It is difficult to determine which codes inherently include conscious sedation (i.e., the services where conscious sedation is typically performed and the physician work relative values were determined based on the assumption that conscious sedation would be performed).
- RUC members expressed concern that much of the work described relating to conscious sedation relates to activities performed by nursing staff. There appears to be overlapping issues related to the direct practice expense inputs and these issues need to be resolved.

AMA/Specialty Society RVS Update Committee

RBRVS Five-Year Review

RUC Recommendations - Workgroup 6

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
11402	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	1.61	1.61	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase of the RVU. The RUC recommends that the current RVU be maintained.	2
11642	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 1.1 to 2.0 cm	2.93	2.93	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase of the RVU. The RUC recommends that the current RVU be maintained	2
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.76	1.76	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	3.92	3.92	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	3.79	3.79	The AAO-HNS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	5.95	5.95	The AAO-HNS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
19000	Puncture aspiration of cyst of breast;	0.84	0.84	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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Key (1= Adopt the recommended increase in RVUs, 2 = Maintain the current RVU; 3 = Adopt the recommended decrease in RVUs; 4 = Suggest a new RVU; 5 = Refer the code to CPT, 6 = No consensus)

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
19100	Biopsy of breast; needle core (separate procedure)	1.27	1.27	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
19125	Excision of breast lesion identified by preoperative placement of radiological marker; single lesion	6.06	6.06	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
19160	Mastectomy, partial;	5.99	5.99	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
19162	Mastectomy, partial; with axillary lymphadenectomy	13.53	13.53	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
19240	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	16.00	16.00	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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Key (1= Adopt the recommended increase in RVUs; 2 = Maintain the current RVU; 3 = Adopt the recommended decrease in RVUs, 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus)

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
21740	Reconstructive repair of pectus excavatum or carinatum	16.50	16.50	The work intensity and technical advances have greatly changed in recent years. A new approach is used for half of the patients. This adds tremendously to the stress and risk factors, the number of ICU and hospital follow-up days. Pain control has become a major factor requiring more intense and frequent in-hospital and post-hospital care. The APSA believes the reference codes 15946 (Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure) (RVW = 21.57 and code 44310 (Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula) (RVW = 25.00) has similar associated intra- and post-service work and intensity. Code 21740 signifies a misalignment of relativity across the MFS.	The RUC recommends that this code be referred to the CPT Editorial Panel to clarify the different approaches used.	5
36400	Venipuncture, under age 3 years; femoral, jugular or sagittal sinus	0.18	0.38	Reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture (RVW = 0.18)) does not require as much work as these codes, yet still has the same physician work RVUs assigned. This work is slightly greater than the work of the office/outpatient visit of a new patient. In addition, caring for young children requires both special skill and greater cognitive work.	The RUC compared code 36400 to the reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture) (0.18 RVW) and noted that 36410 had greater total time than 36400. The RUC compared code 36400 to a level 99212 Evaluation and Management service (0.43) as the work is slightly greater than the E/M service and agreed that the services were comparable. But given that the survey was not supportive of increasing the work value to the survey median RVU (0.71), the RUC agreed that an average value between the 25th percentile (0.30) and a level 99212 (0.43) would be more appropriate. The RUC agreed that an RVU of 0.38 was appropriate for this service.	4

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36405	Venipuncture, under age 3 years; scalp vein	0.18	0.32	Reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture (RVW = 0.18)) does not require as much work as these codes, yet still has the same physician work RVUs assigned. The work is slightly greater than the work of the office/outpatient visit of a new patient. In addition, caring for young children requires both special skill and greater cognitive work.	The RUC compared this code to the reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture) (0.18 RVW) and noted that code 36405 has less total time than 36410, however the preservice time is greater because obtaining consent is required, as the specimen is obtained from the scalp. The RUC agreed that code 36405 was comparable to a value between the survey 25th percentile (0.20) and a level 99212 Evaluation and Management service (0.43 RVU). The RUC agreed that 0.32 RVU would be an appropriate value for 36405. Therefore, the RUC recommends an RVU of 0.32.	4
36406	Venipuncture, under age 3 years; other vein	0.18	0.18	Reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture (RVW = 0.18)) does not require as much work as these codes, yet still has the same physician work RVUs assigned. This work is slightly greater than the work of the office/outpatient visit of a new patient. In addition, caring for young children requires both special skill and greater cognitive work.	The RUC compared code 36406 to the reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture) (0.18 RVW) which requires physician's skill and noted that code 36406 had less total time than the reference code. The RUC agreed to refer this code to the CPT Editorial Panel as it was unclear what physician work was included in code 36406, as well as to ask for clarification if CPT needs to add a code for venipuncture for children under age 3 years necessitating a physicians skill.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
				cannulization of the artery while the reference service code 36410 can be used for introduction of a needle or an intracatheter. Obviously, the insertion of a needle into an artery is less labor-intensive. Currently, the reference service code has a higher physician work value and contains disparate amounts of work (i.e., introduction of a needle versus an intracatheter). Based upon all of the reasons outlined above, ACCP recommends that the physician work for 36620 be in excess of the work values assigned to 36410.		
36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown	2.11	2.11	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)	5.42	5.42	This procedure is performed in the NICU or ICU on critically ill neonates on the ventilator with severe hypoxia and on multiple pharmacologic support. Cannulation of very friable and small vessels under stressful conditions. The APSA survey identified 150 minutes of pre-time and 132 minutes intra-service time. Code 33960 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours) (RVW = 19.36) is for the same service, but with no global period and includes the same 2 hour procedure time of this code which includes decannulation.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	1.15	1.15	<p>Code 36620 describes the insertion of a foreign body into a peripheral extremity artery; and in the case of the reference code 36140 (Introduction of needle or intracatheter, extremity artery (RVW = 2.01)), this is done for the purpose of a one-time injection of material prior to the performance of a diagnostic procedure. In placing an arterial catheter into a patient, greater technical skill is required as well as increased pre-procedure preparation of the injection site and increased post-procedure care to secure and continuously maintain the arterial catheter. Intra-service time would be substantially increased because of the acuteness of the patient's condition as well as the agitation. Another important variable adding to the complexity of the intra-service work is the difficulty in localizing the arterial vessel due to hypotension and hypovolemia. In an acutely ill patient, there are also greater risks for bleeding, thrombosis and infection, all of which increase the stress factors associated with increased risk of iatrogenic complications.</p> <p>Conversely, these factors most often are not present in the patient receiving the injection prior to a procedure. The data indicate that roughly one-third of the patients for whom the reference code is billed are outpatients, who certainly do not have the same signs, symptoms, or risk factors as the acutely ill patient. Also, when a needle or intracatheter is inserted for purposes of injection prior to a procedure, the image analysis and interpretation are billed separately.</p> <p>Additionally, code 36620 requires</p>	<p>The RUC compared code 36620 to the reference service code 36140 (Introduction of needle or intracatheter; extremity artery) (RVU = 2.01) and noted that code 36620 (1.15) has greater intra and postoperative time than the code 36140 reference service code, but was valued less creating a rank order anomaly. To correct the rank order anomaly, the RUC agreed to increase the RVU of code 36620 to the 25th percentile (2.50). However, the RUC was concerned that anesthesiologists who perform this procedure over 80% of the time did not comment or participate in the survey. As such, the RUC concluded that CPT code 36620 should be referred to CPT to clarify the appropriate use of this code.</p>	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	2.80	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36534 and noted that the descriptor contains "and/or reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code to CPT to create specific codes to describe the revision of implantable venous access devices and reservoirs, and the revision of implantable venous access devices or subcutaneous reservoirs.	5
36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2.27	2.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36535 and noted the descriptor states, "and/or subcutaneous reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code back to CPT to create specific codes for removal of implantable venous access devices and subcutaneous reservoirs, and for removal of implantable venous access devices or subcutaneous reservoirs.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	1.22	2.50	Code 36489 describes the insertion of a central venous catheter into the vena cava. Minor complications can be accompanied by increased overall risk because of the acuteness of the patient's condition. For example, the risk of tension pneumothorax may be markedly increased because of the mechanical ventilation. There is also increased pre-procedure preparation of the entry site so that long-term sterility is not compromised. Additionally, there is increased post-procedure time and effort to secure the catheter as well as maintenance of the sterility of the entrance site. Since the central venous catheter remains in place, there is an increased risk of sepsis and venous thrombosis. It should also be noted that in the case of the reference service code, the contrast materials and the interpretation of the contrast studies may be billed separately. For these reasons, the work for CPT code 36489 should be more work than the reference service code 36010 (Introduction of a catheter, superior/inferior vena cava).	The RUC noted that there is additional work and postoperative time in maintaining an indwelling catheter than compared to the reference service code 36010 (Introduction of catheter, superior or inferior vena cava) (2.43 RVW). Additionally, the RUC noted that Harvard intraservice time and pre- and postservice time was greater than the reference service code. However, as the reference service code 36010 has a higher RVU (2.43) than code 36489 (1.22), this creates a rank order anomaly. The RUC also noted that this code was reviewed in the first five-year review and the RUC did not recommend an increase in the work RVU. However, at this time the RUC agreed that it received compelling evidence that the work is misvalued in comparison to code 36010 (Introduction of catheter, superior or inferior vena cava). Therefore, the RUC agreed that the 25th percentile RVU of 2.50 would be an appropriate value, as code 36489 has greater work and postoperative time than 36010. By recommending an RVU of 2.50 which is higher than the reference service code 36010 (2.43), this corrects the rank order anomaly.	4
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	5.32	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36533 and noted that the descriptor contains "with or without subcutaneous reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code back to CPT to create separate codes to specifically describe insertion of implantable venous access devices with subcutaneous reservoirs, and insertion of implantable venous access devices without subcutaneous reservoirs.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	34.85	95.00	This is a prime example of a group of codes that are performed on critically ill neonates which need realignment and very significant reevaluation. This procedure is performed on critically ill neonates often on ECMO in the periop period. This requires meticulous hemostasis. Minimal intraoperative manipulation results in severe hypoxia. A patch or ventral hernia is frequently required. This operation requires a prolonged post-operative NICU stay on the ventilator and vasodilators and intense work to achieve survival, which still is in the 60% range. Those infants who survive have prolonged hypoxia, need for ventilation and vasodilatio, respiratory and hemodynamic instability, feeding problems. Using the building block approach the code is significantly undervalued. APSA data on the typical patient includes a total of 15 neonatology days plus 10 hospital work days and 4 office days. APSA compared the intraservice work to that between a donor nephrectomy (50300 RVW = 9.06) and hepatectomy (47133 RVW = 19.4) believing the intrawork to be similar IWPUT more than a nephrectomy, less than a hepatectomy and then added the pre and post-service work using the building block method.	The RUC agreed that all postoperative critical care services are provided by the performing pediatric surgeon. These severely ill neonates also receive critical care services by a neonatologist during the post-operative period. The joint efforts of neonatologists and pediatric surgeons are critical in the management of these children. It is the provision of these very intensive prolonged services with long Critical Care services and hospital stays that account for the very high RVUs. The RUC received compelling evidence that these indicated services and RVUs are appropriate for these critically ill neonates. The RUC noted that the survey results reflected a difference of 1550 minutes between HCFA's pre and postservice time totals and the surveyed code 39503. The RUC also noted that there was a 76 minute difference in the intraoperative time between HCFA's data and the survey code 43324 (Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures) data which calculated to 4.33 (76 minutes multiplied by an IWPUT of .057). The RUC took the current RVU 37.54 for 39503 and subtracted the 4.33 work RVUs which resulted in 33.21 RVUs as a starting point of value. The RUC then added the number and levels of visits that made up the survey postoperative time of 1550 and converted them into RVUs and added this to the base 33.21 RVU which resulted in RVUs greater than the survey median. After much discussion of the values of the post time and the legitimacy of those critical care visits, the RUC agreed that the median RVU of 95.00 was appropriate.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	9.59	13.29	CPT code 42205 (Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only) is currently assigned 9.59 RVW's and has a 90 day global. This code has never been reviewed by the AMA/Specialty Society Relative Value Update Committee. During the 1995 Five-Year review, the work values for two other codes in the palatoplasty family were reviewed and increased, causing a rank-order anomaly in the valuation of 42205. ASPS offers these two codes as their primary reference codes for demonstrating this anomaly. The first reference code, CPT code 42200 (Palatoplasty for cleft palate, soft and/or hard palate only) is currently assigned a work value of 12.00 and has a 90 day global period. The second reference code, CPT 42210 (Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft), is currently assigned a work value of 14.50 and has a 90 day global.	During the first five-year review, the work values for the other two codes in the palatoplasty were reviewed and increased which caused a rank order anomaly with code 42205. CPT code 42200 (Palatoplasty for cleft palate, soft and/or hard palate only) has an RVU of 12.00 and code 42210 (Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft) has an RVU of 14.50, but 42205 has an RVU of 9.59. The ASPS felt that this five-year review could resolve the rank order anomaly, therefore ASPS did not conduct a survey. The RUC compared code 42205 to code 42200 and noted the difference between the two is the work performed on the alveolar ridge, which is similar to code 41872 (RVU 2.59). The RUC extracted the pre and post time from the RVU of 41872 to obtain a value of 1.29 which was added to the base code 42200 (12.00) to obtain a value of 13.29. The RUC agreed that this value was appropriate, as it reflects the work performed by code 42205 and corrects the rank order anomaly.	4
43215	Esophagoscopy, rigid or flexible; with removal of foreign body	2.60	2.60	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to recommend an increase in the RVU of this service. The RUC noted that there were 2 situations in which the procedure was performed for: removal of solid objects and removal of friable objects (such as meat). Because the work involved in removing an impacted foreign body is much more difficult, it was suggested that the procedure be broken into two separate CPT codes. At the request of the presenters, it was recognized that there was not enough information to support the recommended increase in RVUs. Therefore, the RUC recommends that code 43215 be referred back to CPT.	5

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43217	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.90	2.90	Specifically, 43217 has at least twice the intra-operative time of the base diagnostic esophagoscopy code 43200 (1.59 RVU's) and requires great skill and concentration because of the possibility of perforating the wall of the esophagus.	At the request of STS, it was recognized that there was not enough compelling evidence to support the recommended increase in RVUs. Therefore, the RUC recommends that the current RVU's be maintained.	2
43219	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent	2.80	3.18	Specifically, 43219 has at least twice the intra-operative time of the base diagnostic esophagoscopy code 43200 (1.59 RVU's) and requires great skill and concentration because of the possibility of perforating the wall of the esophagus.	Since this code was last reviewed during the Harvard study, the technology has changed dramatically in that new stents have been developed for use in this procedure. This new technology has decreased the time it takes to place the stent yet increased the complexity as these stents are being placed in very complex patients that in the past would not have been able to be treated with this procedure. Since the original Harvard study, the total time for this procedure was 115 minutes as compared to the recent survey results of 135 minutes. In addition, the increased intensity of this procedure is illustrated by comparing it to CPT code 43200 (Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing) (separate procedure)) (work RVW 1.59). Based upon the survey results, the median surveyed RVU of 3.18 was felt to be an appropriate work value. Therefore, the RUC recommends an RVU of 3.18.	1
43228	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3.77	3.77	Specifically, 43228 has at least twice the intra-operative time of the base diagnostic esophagoscopy code 43200 (1.59 RVU's) and requires great skill and concentration because of the possibility of perforating the wall of the esophagus.	At the request of STS, it was recognized that there was not enough compelling evidence to support an increase in. Therefore, the workgroup recommends that the current RVU's be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	2.69	2.87	Specifically, there has been a substantial increase in the number of biopsies obtained. This is primarily due to greater efforts to detect Barrett's Esophagus and H. Pylori as a result of literature published since 1995.	The RUC noted that there has been an increase in the number of biopsies performed due in part to greater efforts to detect Barrett's Esophagus and H. Pylori. There has also been increases in the technological advances which has allowed for greater precision and detail in finding abnormalities in patients which increases the need for this service. These technological advances have also allowed for more immediacy of results which increases the post-service work in conveying the biopsy information and treatment guidance to the patient and/or care-giver following the procedure. The RUC agreed that the survey median of 2.87 was an appropriate value. The RUC recommends an RVU of 2.87.	4
43244	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices	4.59	5.05	This service has become much more complex and time consuming over the years. When the value for the code was first established, the service involved usually the application of two bands. Now eight bands are the usual standard. This adds time and complexity to this service.	The RUC noted that the work for this procedure has changed dramatically in complexity in that 8 bands are now typically applied to obliterate varices rather than 2 bands. This has resulted in an increase in the overall intra-service work, as well as an increase in the pre-and post-service work. In addition, the RUC compared code 43244 to code 43255 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method) (4.40 RVW) which the RUC felt was similar in work. However, 43244 had greater total time and more physician work, therefore the RUC agreed that the recommended work RVU of 5.05 was an appropriate value. The RUC recommends a RVU of 5.05 for code 43244.	1
43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube	4.33	4.33	Due to the time, risk and skill associated with this procedure in relationship to the base diagnostic code, the ASGS/AGA/ACG believes that this code is undervalued.	At the request of the presenters, it was recognized that there was not enough compelling evidence to support a recommended increase in RVUs. The RUC decided not to pursue changes in the value for this code, an recommends that the current RVU of 4.33 be maintained for code 43246.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body	3.39	3.59	This service is almost always performed in emergency settings. It can involve prolonged sedation and multiple passes of a scope are usually required to remove the object. Relative to the base code (43235) for a diagnostic upper GI Endoscopy, it is much more time consuming and complex, but is currently assigned only 3.39 RVU's relative to 2.29 for the base procedure.	The survey results indicated an increase in the intensity and time as a result of this procedure being performed in older patient populations with an increase in the risk of complications and morbidity. The RUC agreed that there should be an increase in the RVU, however, that it should not be the recommended RVU of 5.3. To arrive at a more appropriate work value, the RUC subtracted the RVU of the base code 43200 (Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (1.59) from 43235 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (2.39) which resulted in an increment of .8. The RUC added .8 to the work RVU of 2.6 of code 43215 which calculated to 3.40, which the RUC agreed was reflective of the work performed. The RUC noted that this value was close to the survey median RVU of 3.59 and noted that as the survey data had tight statistics, the survey median RVU of 3.59 was appropriate.	4
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	2.90	3.35	This code is valued at 2.9 RVU's. Relative to other codes in this series, the AGA/ACG believes this code is misvalued regarding the time and complexity and it should be valued at least as high as code 43258 (Upper GI endoscopy with insertion of guide wire (4.55 RVU's)).	When reviewing the survey results, the RUC noted that the complexity of the patient has changed over the last five years. Specifically, the typical patient has chronic dysphagia with recurrent or malignant strictures. Compared to the reference procedure, CPT 43235 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (work RVW=2.39), this procedure has much greater time and intensity warranting an increase in RVW to the median value of 3.35. Therefore, the RUC recommends an RVU of 3.35.	4

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43251	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.70	3.70	Due to the time, risk and skill associated with this procedure in relationship to the base diagnostic code, AGA/ACG believes that an increase in the relative value of the procedure is in order.	At the request of the presenters, it was recognized that there was not enough compelling evidence to support a recommended increase in RVUs. The RUC decided not to pursue changes in these values, allowing the current RVU's to be maintained.	2
43255	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method	4.40	4.82	This code is dramatically undervalued at 4.4 RVUs. It is always performed in emergency, life-threatening situations and usually involves at least 90 minutes of time for the intra-operative portion of the procedure. The AGA/ACG believes the work of this service is equivalent to 1.5 hours of critical care (codes 99291 and 99292) which would be assigned 5.4 RVU's.	The RUC reviewed the survey results and noted that the methods for controlling bleeding (e.g., laser) has expanded in the recent years. The complexity of this new technology increases physician work as there is greater intensity in controlling the patient's actively bleeding stomach. The RUC compared this code to 43244 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices (RVU = to 4.59) (total time of 70 minutes) which the RUC agreed was similar both in time and physician work. Therefore, the RUC recommends an RVU of 4.82 for CPT code 43255.	4
43258	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	4.55	4.55	Due to the time, risk and skill associated with this procedure in relationship to the base diagnostic code, the AGA/ACG believes that an increase in the relative value of this procedure is in order.	At the request of the presenters, it was recognized that there was not enough compelling evidence to support a recommended increase in the RVU. Therefore, the RUC decided not to pursue changes in these values recommending that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43259	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination	4.89	8.59	This code is substantially undervalued. This code requires up to two hours to perform, not including the pre and post time. This service requires a great deal of technical expertise and judgement, involving an evaluation of several different regions of the GI tract (pancreas, bile duct, gall bladder, etc). The AGA/ACG believes that doubling the current value (3.79 RVU's) can be justified. However, a series of six new endoscopic ultrasound codes has been approved by CPT and is scheduled to be reviewed by the RUC at the April 2000 meeting. The RVU's for the existing code should not be used by the RUC to serve as the baseline for the valuation of the new codes, since this code itself is substantially undervalued.	The RUC noted that this code was reviewed in the first five-year review of the RBRVS. The RUC recommended an RVU of 6.11 which HCFA decreased, as HCFA determined that the ultrasound code comparison was inappropriate and the comparison to the ERCP code was partially inappropriate. The survey results support that this service is more difficult than an ERCP and the equipment now has doppler capabilities which is an integral component of this procedure. To calculate an RVU reflective of the work included in this service, the RUC took 75% of 2.11, which is the difference between the HCFA 1994 value of 4.00 and the RUC recommended RVU of 6.11 resulting in 1.5 work RVUs. The RUC added this value to 4.89 which is the current RVU of 43259 to arrive at a starting point RVU of 6.39. The RUC then added the work value of 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report (2.20 RVW) noting the similarities in physician work of 93312 to arrive at a value of 8.59, which the RUC agreed was appropriate.	4
43263	Endoscopic retrograde cholangio-pancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	6.19	7.29	There is substantial amount of time, complexity and risk associated with this ERCP procedure that is not reflected in the current work values. The AGA/ACG believes the values within the overall scale for ERCP procedures requires some adjustment. For example, code 43263 (ERCP with pressure measurement of sphincter of Oddi) is a very lengthy procedure involving the use of two catheters and presents a very high risk of pancreatitis.	When reviewing the survey results, the RUC noted that the physician time, effort, and risk increased for this procedure from the last RUC review, due to the importance of measuring pressures in both the biliary and pancreatic sphincters. The RUC also noted an increase in the pre and postoperative time for monitoring the patient, as measuring both pressures presents a high risk of pancreatitis. To arrive at a work value the RUC felt was appropriate, 1.10 RVUs, which is a level 99214 E/M service was added to the existing RVU of 43263 (6.19) to reflect the increase in the postoperative time. This resulted in a RVU of 7.29 which the RUC agreed was an appropriate work value.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43265	Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of stone(s), any method	8.90	10.02	There is a substantial amount of time, complexity and risk associated with ERCP that is not reflected in the current work values. Code 43265 involves the removal of stones increasing the time and work above that assigned to code 43264, which is assigned the same work value. A five percent increase in the RVU for this code over code 43268 is appropriate.	The RUC agreed that this service is currently undervalued; however, in relation to similar codes with similar work, the RUC could not accept the survey median RVU of 10.55 presented by the specialty. The RUC developed a building block approach based on the difference in survey data and existing Harvard physician time data. The RUC took the current RVU of code 43265 (8.90) and added the increased intraservice time component plus the increased pre and postservice time component to substantiate a modest increase in the RVU to 10.02, which the RUC agreed was an appropriate work value.	4
43269	Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent	6.04	8.21	Code 43269 corresponds to ERCP with removal of foreign body or change of tube or stent. This is a lengthier and more complex procedure than code 43268 which currently has a higher value than 43269. The AGA/ACG believes that this code should be valued at 7.5 RVU's or slightly higher than the 7.39 RVU's assigned to code 43268.	The RUC noted that a rank order anomaly exists between codes 43268 (Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct) (7.39 RVU) and 43269. When reviewing the survey results, the RUC noted there were 6 extra minutes of intraservice time for code 43269 for removing the stent and placing a new one. To account for the increased intraservice work, the RUC multiplied 6 minutes by .045 IWP/PUT, which the RUC agreed was an appropriate IWP/PUT, to arrive at .27 work value. The RUC added this value to 1/2 the value of a level 99214 (.55) to arrive at a total of .82. The RUC added .82 to 7.39 the current RVU of 43268, which resulted in a final work RVU of 8.21. The RUC agreed that this RVU was appropriate, as it was reflected the increased work and corrected the rank order anomaly between codes 43268 and 43269.	4

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43310	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	25.39	25.39	This family of codes is performed on critically ill neonates and in need of realignment and significant reevaluation. The newborn has one chance to have a good outcome. The long-term consequences from poor results follow the child into adult life including need for esophageal replacement. The typical patient is premature and has other associated anomalies (VACTERYL). The follow-up care far outweighs what is actually reflected in the surgical package. Using the building block approach, the code is significantly undervalued. APSA data on the typical patient includes a total of 32.24 neonatology work units plus 1.75 hospital work units and 2.01 office work units.	The RUC noted that this code was surveyed for services performed on critically ill neonates as the typical patient. However, the RUC noted that this service may also be performed on adults. The RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates, however, the RUC agreed to refer code 43310 to CPT to create new codes to accurately describe services performed on pediatric and adult populations.	5
43312	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	28.42	28.42	For code 43312, APSA compared the intraservice work to that of a donor hepatectomy (47133, RVW = 19.40), believing the intrawork to have similar IWPUT and then added the pre and post-service work using building block method.	The RUC noted that this code was surveyed for services performed on critically ill neonates as the typical patient. However, the RUC noted that this service may also be performed on adults. The RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates, however, the RUC agreed to refer code 43312 to CPT to create new codes to accurately describe services performed on pediatric and adult populations.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44055	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)	13.14	22.00	This code is not in alignment with reference codes of similar work, intensity and time. The intraservice procedure is quite complex and involves dividing bands effacing the mesentery and proper positioning of the intestine. Determination of bowel viability is difficult and often requires prolonged intraoperative observation after detorsing. The presence of ischemic bowel requires close attention in the NICU or ICU for several days. These infants frequently require TPN management in the hospital and at home while the bowel is recovering during the global period. The APSA believes the global work including IWPUT and pre- and post-service is slightly less than 61312 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural (RVW = 24.57), but significantly more than 43331, Esophagomyotomy (Heller type); thoracic approach (RVW = 16.23). Code 44055 represents a code for which there is rank order misalignment across the fee schedule.	The RUC reviewed the survey results and felt that the survey and building block methodology appropriately reflected the RVUs for postoperative care which was not previously addressed by the RUC. The RUC also noted that the intraservice intensity for 44055 is much greater due to the urgency in decision making for determining the need for immediate surgery. The RUC agreed that the postoperative care which was not captured previously and the increased intraservice intensity clearly validates the increase in RVU's. A consensus panel reviewed the survey and made a recommendation of 22.00 RVUs, which was the 25th percentile because the pre and post visit data were more accurate for the typical patient. The RUC, however, noted the intraservice time is the 50th percentile, of 90 minutes. The RUC acknowledged that the intraservice intensity of 44055 is much greater, as is the urgency of decision-making in determining the need for immediate surgery and viability of the intestine. Therefore, the RUC agreed that the 25th percentile of 22.00 RVUs was appropriate.	1
44147	Colectomy, partial; abdominal and transanal approach	18.17	18.17	The ASCRS comment that this code is currently undervalued in the family of codes.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.82	3.70	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC recognized a rank order anomaly existed between codes 44388 through 44393. To correct this anomaly, the RUC compared reference code 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)) (3.70 RVU) and decided to use the value as an anchor RVU for the other codes. Code 45378 was chosen because it had comparable intra-service and total time as code 44388. The survey results of 44388 had similar time and physician work intensity as 45378 and the RUC agreed that the survey median work RVU of 3.70 was appropriate.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44389	Colonoscopy through stoma; with biopsy, single or multiple	3.13	4.26	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC reviewed the survey and noted that Harvard intraservice time was 33 minutes and the survey time was 49 minutes which accounted for the increase in work for multiple biopsies removed from multiple sites. The RUC used code 44388 (Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)) (3.70 RVU) as the anchor code and added a .74 biopsy increment to calculate a total work value of 4.44. Based upon this calculation, the RUC agreed that the median RVU of 4.26 was an appropriate work value.	4
44390	Colonoscopy through stoma; with removal of foreign body	3.83	4.81	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC reviewed the survey and noted the increased physician work in inserting and manipulating the scope and inserting the snare to remove the foreign body. There is also increased risk in perforating the patient. The RUC calculated the difference between codes 45379 and 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)) which resulted in a 1.02 increment. The 1.02 incremented was added to the base code 44388 (Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)) (3.70 RVU) to obtain a value of 4.72. The RUC compared this value to the median RVU of 4.81 and agreed that the median value was an appropriate work value.	4
44391	Colonoscopy through stoma; with control of bleeding, any method	4.32	5.18	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC reviewed the survey results and noted that the times accurately reflected the amount of physician work. The RUC used the anchor code 44388 (Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)) (3.70 RVU) and added a 1.48 increment for the control of bleeding, to obtain a 5.18 work value which equaled the survey median RVU. The RUC agreed that 5.18 was an appropriate work RVU.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.82	4.81	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC reviewed the survey and compared this service to code 44389 (Colonoscopy through stoma; with biopsy, single or multiple) and noted there was an intraservice time difference of 5 minutes, which the RUC calculated into a .69 difference. The RUC added .69 to the RVU of code 44389 (4.26) to obtain a value of 4.95. The RUC compared this value to the survey median RVU of 4.81 and agreed that 4.81 was an appropriate value.	4
44393	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	4.84	5.00	Relative to the equivalent codes in the upper GI Endoscopy series, ACG, AGA, and ASGE believes these codes are undervalued because of the much greater time, skill, complexity and risk associated with them. ACG, AGA and ASGE recommends a 10 percent increase in the work RVUs value for these codes.	The RUC reviewed the survey and noted there were 59 minutes of intra-service time, which was 5 minutes more than the intraservice time for code 44392 (Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery) (4.81 RVU). The RUC agreed that an RVU of 5.00 was appropriate based upon the increase in the intraservice time.	4
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.43	4.43	The ASCRS commented that this service was "out of order in family value."	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45111	Proctectomy; partial resection of rectum, transabdominal approach	16.48	16.48	The ASCRS commented that this codes was undervalued, less than segmental colectomy	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	24.60	24.60	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The APSA agrees with the ACS as to the misvaluing of this family of codes.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in RVUs. Therefore, the RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	27.04	27.04	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach. The APSA agrees with the ACS as to the misvaluing of this family of codes.	The RUC supports maintaining the current RVU for this code noting that no compelling evidence for a change was presented by the specialty.	2
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.01	1.01	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	2.01	2.01	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.96	0.96	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45337	Sigmoidoscopy, flexible; with decompression of volvulus, any method	2.36	2.36	The ASCRS commented that this service is undervalued in family and is less than rigid scope decompression.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3.14	3.14	The ASCRS commented that this service is undervalued and is less than snare technique.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70	3.70	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	4.01	4.44	The physician work for performing a colonoscopy with biopsy or with polyp removal has increased over the years as a result of improved imaging. There has been a substantial increase in the average number of biopsies obtained because more lesions can be visualized, leading to a greater number of biopsies. In addition, there has been a substantial increase in the complexity of polyps/lesions removed. This is due in part to the fact that "flatter" polyps can now be detected which formerly were not even seen and which are difficult to remove. Moreover, more polyps are now being removed from the right side of the colon where the mucosa is much thinner, presenting a danger of perforation.	When reviewing the survey results, the RUC noted there was an increase in the number of biopsies being performed due to improved imaging. The improved imaging now allows for flatter polyps to be removed which were previously unable to be detected. When comparing the total times, the RUC noted that the total time for code 45380 (119) was 27 minutes greater than the HCFA total time (92 minutes). As a result of the increased time and physician work, the RUC agreed that the survey median RVU of 4.44 was appropriate.	4
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	5.87	5.87	The physician work for performing a colonoscopy with biopsy or with polyp removal has increased over the years as a result of improved imaging. There has been a substantial increase in the average number of biopsies obtained because more lesions can be visualized, leading to a greater number of biopsies. In addition, there has been a substantial increase in the complexity of polyps/lesions removed. This is due in part to the fact that "flatter" polyps can now be detected which formerly were not even seen and which are difficult to remove. Moreover, more polyps are now being removed from the right side of the colon where the mucosa is much thinner, presenting a danger of perforation.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase of the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	4.70	4.70	The physician work for performing a colonoscopy with biopsy or with polyp removal has increased over the years as a result of improved imaging. There has been a substantial increase in the average number of biopsies obtained because more lesions can be visualized, leading to a greater number of biopsies. In addition, there has been a substantial increase in the complexity of polyps/lesions removed. This is due in part to the fact that "flatter" polyps can now be detected which formerly were not even seen and which are difficult to remove. Moreover, more polyps are now being removed from the right side of the colon where the mucosa is much thinner, presenting a danger of perforation.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	5.31	5.31	The physician work for performing a colonoscopy with biopsy or with polyp removal has increased over the years as a result of improved imaging. There has been a substantial increase in the average number of biopsies obtained because more lesions can be visualized, leading to a greater number of biopsies. In addition, there has been a substantial increase in the complexity of polyps/lesions removed. This is due in part to the fact that "flatter" polyps can now be detected which formerly were not even seen and which are difficult to remove. Moreover, more polyps are now being removed from the right side of the colon where the mucosa is much thinner, presenting a danger of perforation.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46716	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula	12.15	15.07	The family of codes from 46705 to 46740 which includes babies with imperforate anus with and without fistulas to the genitourinary tract is in need of reevaluation and realignment. These are newborns with significant combinations of anomalies involving the development of the hindgut and its separation from the genitourinary tract. The procedures require intraoperative identification and preservation of the muscles of control, no small task in tiny patients with underdeveloped structures. The anorectal structure must then be separated from the genitourinary structures, both of which are then reconstructed. Then these structures must be carefully placed at the proper perineal location within the appropriate muscles which themselves are reconstructed. Practice has changed in the past few years so that these operations are performed on smaller and younger patients often in newborns and sometimes without protective ostomies. This has increased the intra difficulty stress and complexity of te post-operative care. The APSA believes code 46740 Repair of anus for congenital absence; perineal or sacroperineal approach (RVW = 23.11) compares to the intraservice IWPUT, time and intensity of 15756 and has even more post-service work. The dissection is more difficult, the meticulous detail and the fine suture technique and magnification need are similar.	The RUC agreed that the codes for imperforated anus repair are one of the most difficult/intense procedures performed by physicians. The previous RUC review of these codes were valued with the lowest level inpatient & outpatient codes, however, the specialty provided clear evidence based on survey data, that the higher level and number of E/M codes were appropriate. Further, these procedures are performed on children at an earlier age due to evidence of better functional outcome. The RUC agreed that this is 1/2 of the anchor code 46740 (Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach) (23.11 RVW). The RUC noted that there was a difference in intraoperative time of 48 minutes. The RUC multiplied an IWPUT of .046, which the RUC agreed was appropriate, to the 48 minutes which calculated to 2.20 which was subtracted from the current RVU of 12.15 which calculated to 9.95. The RUC then added 6.85 work RVUs from the postoperative time (3 99212 visits and 4 99214 visits) to 9.95 which calculates to 16.80. All prior 3 postoperative visits were valued at 99212 and the inpatient visits also valued minimally (99231 and 99238). Recalculating for decreased intraoperative time but adjusted for 5 postoperative 99241 visits, which does appear appropriate would add on an increment of 3.25, which is greater than the 15.07 requested, providing compelling evidence to the RUC that the value is appropriate. The workgroup supports a recommended RVU of 15.07.	1

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46730	Repair of high imperforate anus without fistula; perineal or sacroperineal approach	21.57	26.75	The family of codes from 46705 to 46740 which includes babies with imperforate anus with and without fistulas to the genitourinary tract is in need of reevaluation and realignment. These are newborns with significant combinations of anomalies involving the development of the hindgut and its separation from the genitourinary tract. The procedures require intraoperative identification and preservation of the muscles of control, no small task in tiny patients with underdeveloped structures. The anorectal structure must then be separated from the genitourinary structures, both of which are then reconstructed. Then these structures must be carefully placed at the proper perineal location within the appropriate muscles which themselves are reconstructed. Practice has changed in the past few years so that these operations are performed on smaller and younger patients often in newborns and sometimes without protective ostomies. This has increased the intra difficulty stress and complexity of te post-operative care. The APSA believes code 46740 Repair of anus for congenital absence; perineal or sacroperineal approach (RVW = 23.11) compares to the intraservice IWPUT, time and intensity of 15756 and has even more post-service work. The dissection is more difficult, the meticulous detail and the fine suture technique and magnification need are similar.	The RUC agreed that the codes for imperforated anus repair are one of the most difficult/intense procedures performed by physicians. The previous RUC review of these codes were valued with the lowest level inpatient & outpatient codes, however, the specially provided clear evidence based on survey data, that the higher level and number of E/M codes were appropriate. Further, these procedures are performed on children at an earlier age due to evidence of better functional outcome. Code 46730 is the same procedure as 46740 (Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach) (23.11 RVW) the anchor code, but without the fistula. The RUC noted that as this code is performed without a fistula, there is less intraoperative intensity than 46740. To maintain relativity between the codes, the RUC recommended an RVW of 26.75. The RUC agreed this was appropriate based on the identical post-operative care between codes 46730 and 46740. The RUC recommends a RVU of 26.75 for code 46730.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46735	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches	25.94	32.17	The family of codes from 46705 to 46740 which includes babies with imperforate anus with and without fistulas to the genitourinary tract is in need of reevaluation and realignment. These are newborns with significant combinations of anomalies involving the development of the hindgut and its separation from the genitourinary tract. The procedures require intraoperative identification and preservation of the muscles of control, no small task in tiny patients with underdeveloped structures. The anorectal structure must then be separated from the genitourinary structures, both of which are then reconstructed. Then these structures must be carefully placed at the proper perineal location within the appropriate muscles which themselves are reconstructed. Practice has changed in the past few years so that these operations are performed on smaller and younger patients often in newborns and sometimes without protective ostomies. This has increased the intra difficulty stress and complexity of the post-operative care. The APSA believes code 46740 Repair of anus for congenital absence; perineal or sacroperineal approach (RVW = 23.11) compares to the intraservice IWPUT, time and intensity of 15756 and has even more post-service work. The dissection is more difficult, the meticulous detail and the fine suture technique and magnification need are similar.	The RUC agreed that the codes for imperforated anus repair are one of the most difficult/intense procedures performed by physicians. The previous RUC review of these codes were valued with the lowest level inpatient & outpatient codes, however, the specialty provided clear evidence based on survey data, that the higher level and number of E/M codes were appropriate. Further, these procedures are performed on children at an earlier age due to evidence of better functional outcome. The RUC compared code 46735 to CPT code 46740 (Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach) (23.11 RVW), which is the anchor code, and noted that the intraoperative time (230 minutes) and hospital visits (7) are higher for code 46735, while the office visits (6) are the same. The RUC noted that the intraoperative intensity for code 46735 is similar to 46740. This RUC noted that code 46735 is the same as 46730, however, with an additional abdominal approach is performed. The additional intraoperative and hospital visit times required by performing a separate transabdominal approach, appeared consistent with the additional 2.17 RVUs from 46740. The RUC used multiple procedure building blocks to value this code, which resulted in higher values serving to further support the specialty's recommendation. Therefore, the RUC agreed that the recommended RVU of 32.17 for 46735 is appropriate, as it maintains the relativity between 46730 and 46735. The RUC recommends a RVU of 32.17 for code 46735.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	23.11	30.00	The family of codes from 46705 to 46740 which includes babies with imperforate anus with and without fistulas to the genitourinary tract is in need of reevaluation and realignment. These are newborns with significant combinations of anomalies involving the development of the hindgut and its separation from the genitourinary tract. The procedures require intraoperative identification and preservation of the muscles of control, no small task in tiny patients with underdeveloped structures. The anorectal structure must then be separated from the genitourinary structures, both of which are then reconstructed. Then these structures must be carefully placed at the proper perineal location within the appropriate muscles which themselves are reconstructed. Practice has changed in the past few years so that these operations are performed on smaller and younger patients often in newborns and sometimes without protective ostomies. This has increased the intra difficulty stress and complexity of te post-operative care. The APSA believes code 46740 Repair of anus for congenital absence; perineal or sacroperineal approach (RVW = 23.11) compares to the intraservice IWPUT, time and intensity of 15756 and has even more post-service work. The dissection is more difficult, the meticulous detail and the fine suture technique and magnification need are similar.	The RUC agreed that the codes for imperforated anus repair are one of the most difficult/intense procedures performed by physicians. The previous RUC review of these codes were valued with the lowest level inpatient & outpatient codes, however, the specialty provided clear evidence based on survey data, that the higher level and number of E/M codes were appropriate. Further, these procedures are performed on children at an earlier age due to evidence of better functional outcome. The RUC used several building block methods to value the code agreeing that the prior IWPUT did appear quite low at 0.29. The RUC used a building block approach to justify the increase in RVUs. The RUC noted that there was 180 minutes from the society's median intraservice time and multiplied this by an IWPUT of .09, to obtain an RVU of 16.50. The RUC took the Harvard pre and postservice time of 322 minutes and multiplied this by an IWPUT of .042 which resulted in an RVU of 13.56. The RUC added this RVU to 16.50 to obtain a total work RVU of 30.06. The RUC noted that this total was higher than the specialty society survey (25th percentile which equaled the median RVU)-with sample of 31 [57%]. Therefore, the RUC agreed that the requested 25th percentile and median of 30.00 was appropriate. The RUC recommends a RVU of 30.00 for code 46740.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46742	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches	29.67	35.80	The family of codes from 46705 to 46740 which includes babies with imperforate anus with and without fistulas to the genitourinary tract is in need of reevaluation and realignment. These are newborns with significant combinations of anomalies involving the development of the hindgut and its separation from the genitourinary tract. The procedures require intraoperative identification and preservation of the muscles of control, no small task in tiny patients with underdeveloped structures. The anorectal structure must then be separated from the genitourinary structures, both of which are then reconstructed. Then these structures must be carefully placed at the proper perineal location within the appropriate muscles which themselves are reconstructed. Practice has changed in the past few years so that these operations are performed on smaller and younger patients often in newborns and sometimes without protective ostomies. This has increased the intra difficulty stress and complexity of te post-operative care. The APSA believes code 46740 Repair of anus for congenital absence; perineal or sacroperineal approach (RVW = 23.11) compares to the intraservice IWPUP, time and intensity of 15756 and has even more post-service work. The dissection is more difficult, the meticulous detail and the fine suture technique and magnification need are similar.	The RUC agreed that the codes for imperforated anus repair are one of the most difficult/intense procedures performed by physicians. The previous RUC review of these codes were valued with the lowest level inpatient & outpatient codes, however, the specialty provided clear evidence based on survey data, that the higher level and number of E/M codes were appropriate. Further, these procedures are performed on children at an earlier age due to evidence of better functional outcome. The RUC compared this code to code 49000 (Exploratory laparotomy) (RVU = 11.68) because of the similarity in work in performing the combined transabdominal and sacroperineal approaches. The RUC took half of the exploratory laparotomy value, (5.80 RVW) and added this to the new RVU of 30.00 for code 46740 (Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach) to obtain an RVU of 35.80. The RUC agreed that a RVU of 35.80 was appropriate, as it maintains the relativity within this family of codes.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach	33.21	52.63	This family which includes codes 46744-46748 is the most complex type of congenital anomaly. In these children, there is a single connection (cloacal) representing the urinary, genital and rectal structures. The procedures require separation of these three structures while preserving neurovascular and muscle function. Extensive reconstruction is required in order to achieve satisfactory urinary, fecal and sexual function. There are frequently associated anomalies of the internal genitalia and GU and spinal structures. These procedures are performed in a limited number of centers due to their complexity and need for experience and skill in order to achieve good outcome. These operations typically take 6-10 hours and may actually take as many as 20 hours to complete. The post operative care is complex, requires intense attention in the hospital and office setting during the global period. There is really only one chance for satisfactory outcome and that requires the experience, skill and attention of an expert surgeon. The complexity of these procedures is second to none in the fee schedule.	The RUC noted that code 46744 was identified as one of the most intense procedures performed by pediatric surgeons via an internal survey. The RUC agreed that the original IWPUR was undervalued and the survey RVU is supported by the magnitude of the postoperative service. The postoperative service was reviewed and the RUC agreed that it substantiated the increase of 19.42 RVUs, which is the difference between the current RVU (33.21) and the recommended RVU (52.63). A building block approach was also used, which substantiated the increase in the RVU. The RUC agreed that the recommended RVU of 52.63, which was also the survey median, is an appropriate value. The RUC recommends a RVU of 52.63 for code 46744.	1

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;	36.74	58.22	<p>This family which includes codes 46744-46748 is the most complex type of congenital anomaly. In these children, there is a single connection (cloacal) representing the urinary, genital and rectal structures. The procedures require separation of these three structures while preserving neurovascular and muscle function. Extensive reconstruction is required in order to achieve satisfactory urinary, fecal and sexual function. There are frequently associated anomalies of the internal genitalia and GU and spinal structures. These procedures are performed in a limited number of centers due to their complexity and need for experience and skill in order to achieve good outcome. These operations typically take 6-10 hours and may actually take as many as 20 hours to complete. The post operative care is complex, requires intense attention in the hospital and office setting during the global period. There is really only one chance for satisfactory outcome and that requires the experience, skill and attention of an expert surgeon. The complexity of these procedures is second to none in the fee schedule.</p>	<p>The RUC used the survey results from code 46744 (Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach (32.21 RVW) to justify the increase in the RVU for code 46746. The value for code 46746 was extrapolated from the 46744 survey by adding the work of the "combined abdominal and sacroperineal approach."</p> <p>Based on the survey results, the RUC agreed that the other two CPT codes within this family should maintain their original relativity. As such, the RUC agrees that a work relative value of 58.22 for CPT 46746 is appropriate.</p>	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps	40.52	64.21	This family which includes codes 46744-46748 is the most complex type of congenital anomaly. In these children, there is a single connection (cloacal) representing the urinary, genital and rectal structures. The procedures require separation of these three structures while preserving neurovascular and muscle function. Extensive reconstruction is required in order to achieve satisfactory urinary, fecal and sexual function. There are frequently associated anomalies of the internal genitalia and GU and spinal structures. These procedures are performed in a limited number of centers due to their complexity and need for experience and skill in order to achieve good outcome. These operations typically take 6-10 hours and may actually take as many as 20 hours to complete. The post operative care is complex, requires intense attention in the hospital and office setting during the global period. There is really only one chance for satisfactory outcome and that requires the experience, skill and attention of an expert surgeon. The complexity of these procedures is second to none in the fee schedule.	The RUC used the survey results from code 46744 (Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach (32.21 RVW) to justify the increase in the RVU for code 46748. The value for code 46748 was extrapolated from the 46744 survey by adding the work of the "combined abdominal and sacroperineal approach." The RUC noted that this procedure requires separation of the three structures (urinary, genital and rectal) while still preserving neurovascular and muscle function. Extensive reconstruction is required to assure the satisfactory function of these three structures. Based on the survey results, the RUC agreed that the other two CPT codes within this family, 46744 and 46746, should maintain their original relativity. As such, the RUC agreed that a work relative value of 64.21 for 46748 is appropriate, as this is an extremely complex procedure. The RUC recommends an RVU of 64.21 for code 46748.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47701	Portoenterostomy (eg, Kasai procedure)	27.81	27.81	These are performed in infants with atresia of the extrahepatic bile ducts. Failures of this procedure result in the alternative of liver transplantation. The intraservice work has at least the same intensity and time as a right hepatic lobectomy (47130 RVW = 34.25) and also includes two anastomosis as in the Whipple procedure (48150 Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancratojejunostomy (RVW = 43.48)). The dissection is difficult. The post-service work is greater with similar lengths of hospital stay but more frequent office visits to monitor and avoid cholangitis, ascites, and deal with metabolic and nutritional issues.	The RUC reviewed the survey results and agreed that no compelling evidence was provided to recommend an increase in the work RVU. Therefore, the RUC agreed to maintain the current RVU for this code.	2
49215	Excision of presacral or sacrococcygeal tumor	22.36	33.50	These usually present in the newborn period with a large mass that equals the size of the infant. Its resultant blood flow can cause the needs for emergent operation and results in significant blood loss. Incomplete removal leads to recurrence and malignant change. The tumor typically extends into the pelvis and may require laparotomy for removal. The coccyx must be removed at the operation. This requires extensive prep and drape and positioning in the pre-service time. The intraservice time is more than 200 minutes. They spend a median of 5 days in the NICU and 4 more days in the hospital. They typically require 3 office visits in the global. The work is comparable to a right hepatic lobectomy (47130 Hepatectomy, resection of liver; total right lobectomy (RVW = 34.25)).	When reviewing this code, the RUC noted that the original Harvard estimates of time and intensity were questionable due to the extremely low sample size and that the patient population requiring this procedure has changed. When originally valued, there were no prenatal diagnoses for this condition while now the patient includes more preterm infants and hemodynamically unstable infants. Compared to the reference procedure, CPT code 45116 (Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type) (work RVW 20.89), CPT code 49215 has much more intense intraservice time due to the size, vascularity and anatomic sites of these tumors. Additionally, the survey results showed that these critically ill neonates require five additional critical care visits and 4 more postoperative visits. Based upon the physician work required to perform the service and the increase in postoperative care, the RUC agreed that the recommended RVU of 33.50 was appropriate.	1

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49495	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; reducible	5.89	5.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	At the time this code was originally reviewed in 1993, the "typical" patient requiring this procedure was based on a mix of infant/premature infants. However, in current practice the patient population and ratio of premature to term babies has changed, as repair is now recommended prior to discharge from the NICU. The "typical" patient is now a premature neonate with very difficult anatomy, repair and postoperative care. As the typical patient has changed in that this service is typically performed on premature neonates, the RUC agreed to refer this code to CPT to create a new code that accurately describes this service performed on premature infants.	5
49496	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; incarcerated or strangulated	8.79	8.79	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC noted that the "typical" patient requiring this procedure was based on a mix of infant/premature infants. However, in current practice the patient population and ratio of premature to term babies has changed, as repair is now recommended prior to discharge from the NICU. The "typical" patient is now a premature neonate with very difficult anatomy, repair and postoperative care. As the typical patient has changed in that this service is typically performed on premature neonates, the RUC agreed to refer this code to CPT to create a new code that accurately describes this service performed on premature infants.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	22.66	76.00	The issue here is the same as code 39503, this procedure is performed on critically ill neonates and is in need of realignment and very significant reevaluation. This operation is performed on critically ill neonates on the ventilator, frequently premature, and with large fluid shifts. While a larger number of these patients previous were omphaloceles, today most are gastroschisis. A patch or ventral hernia is frequently required. This operation requires a prolonged post-operative NICU stay on the ventilator and hemodynamic instability, nutritional and feeding problems. They are on prolonged TPN, frequently still at the time of discharge. Using the building block approach, the code is significantly undervalued. APSA compared the intraservice work to 19325 (Mammoplasty, augmentation; with prosthetic implant (RVW = 8.45)) believing the intrawork of 49605 to be somewhat greater IWPUR and then added the pre- and post-service work using the building block method.	The RUC recognized that the survey results for this code represent an intense and complex procedure, as this is typically performed on premature babies. It was understood that this procedure would require considerable critical care postoperative time. The RUC recommends that this code be valued at the survey median of 76.00 RVUs, as the RUC recognized that these services are very unusual and very intense. The RUC justified the survey results by developing a building block approach. The RUC recommends the survey median RVU of 76.00 for code 49605.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49606	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	18.60	18.60	The issue here is the same as code 39503, this procedure is performed on critically ill neonates and is in need of realignment and very significant reevaluation. This operation is performed on critically ill neonates on the ventilator, frequently premature, and with large fluid shifts. While a larger number of these patients previous were omphaloceles, today most are gastroschisis. A patch or ventral hernia is frequently required. This operation requires a prolonged post-operative NICU stay on the ventilator and hemodynamic instability, nutritional and feeding problems. They are on prolonged TPN, frequently still at the time of discharge. Using the building block approach, the code is significantly undervalued. APSA compared the intraservice work to 19325 (Mammoplasty, augmentation; with prosthetic implant (RVW = 8.45)) believing the intrawork of 49605 to be somewhat greater IWP/UT and then added the pre- and post-service work using the building block method.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. Therefore, the RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49905	Omental flap (eg, for reconstruction of sternal and chest wall defects) (List separately in addition to code for primary procedure)	6.55	6.55	<p>ASPS maintains that, for this code to be used as it was originally intended for reconstruction of sternal and chest wall defects, code 49905 should be designated as a primary procedure code (not an add-on code) with a 90 day global period. Accordingly, the work value of the code should be adjusted to reflect the true physician work involved in transferring an omental flap from one body cavity to another. Using 49000 (Exploratory laparotomy) and 49255 together as a basis to value the work of 49905 understates the additional pre-, intra- and post-operative work involved in transferring the omental flap from one body cavity to another.</p> <p>To appropriately estimate the value of 49905 with a 90 day global period, ASPS has chosen as a primary reference service, code 15734 (Muscle, myocutaneous or fasciocutaneous flap; trunk) which is currently valued at 17.79 and a 90 day global period. Clearly the work of 15734 is significantly higher than that of the current omental flap. Considering that a separate body cavity must be entered in order to harvest the flap, the current value for the work involved in this procedure (omental flap) does not reflect the time and effort involved in reconstruction of the sternum.</p>	The RUC noted that code 49905 should be designated as a primary procedure and not an add-on code and should have a 90 day global. The ASPS asked the RUC to disregard the STS survey, as it did not provide compelling evidence for recommending an increase in RVU's. Based upon this information presented, the RUC agreed to maintain the current RVU and to refer this issue to the CPT Editorial Panel to address whether the code should be a stand-alone code or an add-on code.	5
60100	Biopsy thyroid, percutaneous core needle	0.97	1.56	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	The RUC agreed that the specialty society recommended RVU of 1.56, which was the 25th percentile RVU, fit well in the range of the biopsy codes and appropriately reflected the work performed. The RUC recommends an RVU of 1.56 for code 60100.	1

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)	6.02	7.20	<p>This code refers to a percutaneous method of treating scarring and/or inflammation in and around the spinal nerves and roots. The RUC recommended a value of 7.20. HCFA reduced the value to 6.02 RVU's based on two decisions: 1) that the RUC, in adding the component services of epidurolysis, had erroneously counted insertion of a catheter into the epidural space (62279) twice, and 2) that the appropriate building block method for the fluoroscopic guidance component was code 76003, not 76005.</p> <p>The reference service code used by the RUC survey respondents is revealing. They believed that the appropriate reference service was 63650 (percutaneous implantation of neurostimulator electrode array, epidural) with 6.74 work RVU's. Given the additional 15 minutes of intra-service time and 65 minutes of post-operative time for the fluoroscopic guidance code, the 7.20 RVU's recommended by the RUC for 62263 represent the correct valuation.</p>	<p>This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 7.20. HCFA reviewed the RUC's actions and decreased the value to 6.02 RVUs based on the conclusion that the RUC had erroneously counted the insertion of the catheter into the epidural space (62279) twice and that the appropriate building block method for the fluoroscopic guidance component was code 76003, not 76005. The RUC agreed with the original RUC survey results and noted that the work for the catheter placement is twice the work of code 62279. Therefore, the RUC reaffirms its original action and agrees that the RUC recommended value of 7.20 is appropriate.</p>	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	1.91	2.20	HCFA accepted the relativity established by the RUC for the new codes, but reduced their work values in order to maintain budget neutrality. We would point out that the aggregate work values for the new codes should be higher, because some of the services included in the descriptors are of greater intensity. Even if budget neutrality must be maintained; however, the new values are slightly lower than necessary. We refer you to the analysis described in the comment letter that we signed jointly with the AANS, NASS and CNS, showing that the true budget neutrality target for this family of codes should be \$47,356,574.	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 2.20, however, HCFA reduced the work value in order to maintain budget neutrality. The RUC agreed that its original recommendation was appropriate, therefore the RUC reaffirms its original action and agrees that the original RUC recommended RVU of 2.20 be maintained.	1
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	1.54	1.78	HCFA accepted the relativity established by the RUC for the new codes, but reduced their work values in order to maintain budget neutrality. We would point out that the aggregate work values for the new codes should be higher, because some of the services included in the descriptors are of greater intensity. Even if budget neutrality must be maintained; however, the new values are slightly lower than necessary. We refer you to the analysis described in the comment letter that we signed jointly with the AANS, NASS and CNS, showing that the true budget neutrality target for this family of codes should be \$47,356,574.	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 1.78, however, HCFA reduced the work value in order to maintain budget neutrality. The RUC agreed with its original RUC recommendation, therefore the RUC reaffirms its original action and agrees that the original RUC recommended RVU of 1.78 be maintained for code 62311.	1

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	2.04	2.35	HCFA accepted the relativity established by the RUC for the new codes, but reduced their work values in order to maintain budget neutrality. We would point out that the aggregate work values for the new codes should be higher, because some of the services included in the descriptors are of greater intensity. Even if budget neutrality must be maintained; however, the new values are slightly lower than necessary. We refer you to the analysis described in the comment letter that we signed jointly with the AANS, NASS and CNS, showing that the true budget neutrality target for this family of codes should be \$47,356,574.	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 2.35, however, HCFA reduced the work value in order to maintain budget neutrality. The RUC agreed that its original RUC recommendation was appropriate, therefore the RUC reaffirms its original action and agrees that the original RUC recommended RVU of 2.35 should be maintained.	1
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	1.87	2.15	HCFA accepted the relativity established by the RUC for the new codes, but reduced their work values in order to maintain budget neutrality. We would point out that the aggregate work values for the new codes should be higher, because some of the services included in the descriptors are of greater intensity. Even if budget neutrality must be maintained; however, the new values are slightly lower than necessary. We refer you to the analysis described in the comment letter that we signed jointly with the AANS, NASS and CNS, showing that the true budget neutrality target for this family of codes should be \$47,356,574.	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 2.15, however, HCFA reduced the work value in order to maintain budget neutrality. The RUC agreed that its original RUC recommendation was appropriate, therefore the RUC reaffirms its original action and agrees that the original RUC recommended RVU of 2.15 should be maintained.	1
69990	Use of operating microscope (List separately in addition to code for primary procedure)	3.47	3.47	The AAO-HNS believes that this code is undervalued.	Compelling evidence was not provided to recommend an increase in the RVU. Therefore, the RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
72275	Epidurography, radiological supervision and interpretation	0.54	0.83	<p>HCFA reduced the work RVU's for this new code by approximately one-third, from the 0.83 recommended by the RUC to 0.54. In doing so, HCFA rejected the RUC's comparison of the new service (a technique involving the injection of small amounts of contrast material through a catheter or needle placed in the epidural or subarachnoid space to confirm radiologically the depth of insertion) to myelography 72665. Part of the reason for this rejection was the fact that in the absence of any epidurography code, physicians had frequently coded epidurography as 72265-52 (lumbar myelography) with reduced service. That usage of 72265-52 in no way reflects a belief that epidurography is a less demanding procedure. Rather, it reflects the advent of new technology with which the CPT system is only now catching up and the inadequacies of the CPT system and HCFA 1500 forms with respect to reporting new services. If HCFA were correct in its assumption that physicians' use of existing codes for new technologies endorses a broad interpretation or the ambiguities of those codes, there would be no need for annual revisions to the CPT system.</p> <p>The RUC survey of these codes showed that there were 6 minutes more in pre- and post-time for 72275 than for the reference code as well as a consistently higher estimation of intensity and complexity. The other factor overlooked by HCFA is that a direct comparison with lumbar myelography reveals that epidurography will be done as much as 10% of the time via an epidural catheter rather than a needle. This will automatically increase the work above that</p>	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 0.83, however, HCFA decreased the work value as it was felt to be excessive. The RUC agreed with its original RUC recommendation and recommends that a value of 0.83 be maintained.	1

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
				of a standard needle puncture myelogram and when this is averaged into the other 90% of the cases, the work involved in epidurography will clearly match or exceed the work RVU's of the lumbar myelogram.		
76005	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	0.60	0.60	New code 76005 involves significantly greater work intensity than the code to which HCFA has equated it, 76003 (0.54 work RVU's) which is why the RUC recommended a value of 0.60 RVU's. The fact that physicians used 76003 to report the fluoroscopic guidance service before there was a specific code does not imply any acceptance of the work RVUs for 76003 as applied to 76005. Physicians also used 76001 to report fluoroscopic guidance, and that code has a work RVU of 0.67.	This code was reviewed by the RUC in May of 1999 and the RUC recommended a work relative value of 0.60, however, HCFA reduced the work value as HCFA agreed that the increase of 10 minutes of extra work was insignificant compared to the reference service code 76003. The RUC reviewed the original survey and noted that the survey results confirmed greater time and intensity. Therefore, the RUC agrees that its original RUC recommendation was appropriate and recommends that the RVU of 0.60 be maintained.	1
				Fluoroscopic guidance of a needle or catheter tip for a spine injection requires much more precision than fluoroscopic guidance for a needle biopsy; the needle tip must be accurately placed in a much smaller space. RUC survey results revealed a consistent higher estimation of work and intensity as well as an additional 10 minutes of pre- and post-time.		

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
76065	Radiologic examination, osseous survey, infant	0.28	0.70	The ACR believes CPT code 76065 (Radiographic examination, osseous survey, infant) is grossly undervalued. After a thorough analysis of all the components of CPT code 76065 and 76062 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton); pre, intra, and post-time, mental effort and judgement, technical skill and physical effort, psychological stress and intensity, the ACR's consensus panel recommendation is to increase the physician work RVU for CPT code 76065 from 0.28 to 0.60.	When reviewing the survey results, the RUC noted that the intensity is higher for the code 76065 for infants than the reference service code 76062 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton) (0.54 RVW) for adults. The RUC noted that for the intraservice work, the physician typically reviews 17 films, whereas in the reference service code 76062, 10 films are typically reviewed. As a result of the increased physician work in reviewing 17 films as compared to 10 films, the RUC agreed that an RVU of 0.70 was appropriate. The RUC recommends an RVU of 0.70 for code 76065.	1
76090	Mammography; unilateral	0.58	0.70	The ACR believes that the current RVU's for codes 76090 Mammography, unilateral and code 76091 Mammography, bilateral are still not reflective of the level of physician work necessary to perform all the requirements for these government regulated procedures and should be increased to more accurately reflect the physician work. After a thorough analysis of all the components of CPT codes 76090 and 76091; pre, intra, post time, mental effort and judgement, technical skill and physical effort, psychological stress and intensity, the ACR's consensus panel recommendation is to increase the physician work RVU's for CPT code 76090 from 0.58 to 0.64 and CPT code 76091 from 0.69 to 0.76.	The RUC noted there was increased physician work as a result of the revision of the Mammography Quality Standards Act which requires physicians to code the radiological results using BIRADS terminology and that a separate report be dictated and sent to the patient, in addition to a separate report sent to the referring physician. As a result, there is increased physician time, mental effort and judgement. The RUC agreed that the surveyed 25th percentile of 0.70 was more appropriate than the survey median (0.93 RVW). Therefore, the RUC recommends an RVU of 0.70 for code 76090.	4

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
76091	Mammography; bilateral	0.69	0.87	The ACR believes that the current RVU's for codes 76090 Mammography, unilateral and code 76091 Mammography, bilateral are still not reflective of the level of physician work necessary to perform all the requirements for these government regulated procedures and should be increased to more accurately reflect the physician work. After a thorough analysis of all the components of CPT codes 76090 and 76091; pre, intra, post time, mental effort and judgement, technical skill and physical effort, psychological stress and intensity, the ACR's consensus panel recommendation is to increase the physician work RVU's for CPT code 76090 from 0.58 to 0.64 and CPT code 76091 from 0.69 to 0.76.	The RUC noted there was increased physician work as a result of the revision of the Mammography Quality Standards Act which requires physicians to code the radiological results using BIRADS terminology and that a separate report be dictated and sent to the patient, in addition to separate report sent to the referring physician. The RUC also noted that, as this code is a bilateral mammography, two separate studies are performed as compared to a unilateral mammography. There is a 3.5 minute difference between the total time for 76090 (Mammography; unilateral) (19.5 minutes) and for the bilateral mammography code 76091 (23 minutes). The RUC agreed that the surveyed 25th percentile of 0.87 was more appropriate than the survey median (1.10 RVW). Therefore, the RUC recommends an RVU of 0.87 for code 76091.	4
76095	Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation	1.59	1.59	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
88170	Fine needle aspiration with or without preparation of smears; superficial tissue (eg, thyroid, breast, prostate)	1.27	1.27	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
88171	Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance	1.27	1.27	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	0.89	0.89	MEDPAC believes that this code is undervalued.	The RUC reviewed the original survey and noted that the original RUC recommendation was 2.15 RVUs; however, HCFA decreased the work value to 0.89. The RUC noted that no further information was provided to indicate that the HCFA rationale for decreasing the RVU was inappropriate, and the specialty societies that perform this service did not present any new information to respond to HCFA's action in decreasing the work value. Therefore, as no compelling evidence was provided to recommend an increase in the work RVUs, the RUC recommends that the current 0.89 RVU be an maintained.	2
93350	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	0.78	1.48	Code 93350 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report) is undervalued and should be reconsidered. The work value for this code was not increased during the first five-year review because 93350 was not an admissible code in 1995-1996.	Prior to 1994, code 93350 included the exercise stress portion of the stress imaging procedure. In 1994, the code was revised to exclude the stress component, which is now separately reportable using the series of codes 93015-93018. When reviewing the survey results, the RUC noted that the major work of this service involves reviewing and interpreting the images. The RUC compared this code to code 78465 (Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification) (1.46 RVW) and noted there was 41 minutes of Harvard intraservice time. As the intraservice time is similar to 78465, the RUC agreed that the 25th percentile of 1.48 was appropriate. Therefore, the RUC recommends an RVU of 1.48.	4
94640	Nonpressurized inhalation treatment for acute airway obstruction	0.00	0.00	Many times, the nebulizer treatment is provided by the physician. There is also cognitive physician work done in deciding to provide these treatments. Will require sedation or general anesthesia in a child.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	0.00	0.00	Many times, the nebulizer treatment is provided by the physician. There is also cognitive physician work done in deciding to provide these treatments. Will require sedation or general anesthesia in a child.	The RUC noted that this code is used to report services for teaching patients how to use an inhaler and that for the typical patient, the physician does not provide this service as the code is not presently valued. Based upon the information contained in the survey, the RUC was unclear as to what physician services were included in the code. As this information was unclear, the RUC agreed that this code should be sent to CPT for clarification.	5

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CPT						
Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
94665	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	0.00	0.00	Many times, the nebulizer treatment is provided by the physician. There is also cognitive physician work done in deciding to provide these treatments. Will require sedation or general anesthesia in a child.	The RUC noted that this code is used to report services for teaching patients how to use an inhaler and that for the typical patient, the physician does not provide this service as the code is not presently valued. Based upon the information contained in the survey, the RUC was unclear what physician services are included in this code. As this information was unclear, the RUC agreed that this code should be sent to CPT for clarification.	5
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.	1.51	1.51	The AAP believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99273	Confirmatory consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	1.19	1.19	The AAP believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2
99274	Confirmatory consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.	1.73	1.73	The AAP believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	3.60	4.00	These codes are undervalued for both adults and children.	The RUC noted that HCFA decreased the value to 3.60 in 2000. The presenters noted that there was an increase in physician work due to increased monitoring of the patient which increases the amount of data to be reviewed, ventilators are more complex, there is more technology available, and data demonstrates that the patients are sicker and more complex. However, noting that HCFA recently proposed to restore the value back to 4.00, the RUC agreed that this was an appropriate work RVU. The RUC recommends an RVU of 4.00 for code 99291.	4
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)	1.80	2.00	These codes are undervalued for both adults and children.	Based upon the action of 99291 to maintain the current value of 4.00 RVUs, the RUC recommended taking half of the RVU for code 99291. Therefore, the RUC recommends that the RVU for code 99292 be maintained at 2.00.	4
99440	Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	2.93	2.93	Reference service code is 92950, Cardiopulmonary resuscitation (eg, in cardiac arrest) (RVW = 3.80).	Compelling evidence was not provided to the RUC to suggest a recommendation in the increase in the RVU. The RUC recommends that the current RVU be maintained.	2

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36400 Tracking Number: Global Period: XXX Recommended RVW: 0.71
0.38 RUC

CPT Descriptor:

Venipuncture, under age 3 years; femoral, jugular, or sagittal sinus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A physician is called to the critical care unit to perform a technically difficult phlebotomy on a 2-year-old child who is recovering from an overdose of an unknown medication. Laboratory tests of the blood have been ordered on a four-hour basis. The child has already had numerous phlebotomies of the arms and legs. Because of the exceptional need for the laboratory evaluation and the condition of the old phlebotomy sites in the arms and legs, the physician elects to draw blood from the femoral vein, jugular vein, or sagittal sinus. The area is prepped for sterile entry, necessary lighting and additional staff aid are summoned. After the physician obtains informed consent from the parent/legal guardian, he/she obtains the specimen and prepares it for delivery to the laboratory. Special attention is given to the site of the phlebotomy to ensure hemostasis and preserve the site for future use.

Description of Pre-Service Work:

Review patient chart; review laboratory results

Description of Intra-Service Work:

Inspect condition of old phlebotomy sites; prep draw area for sterile entry; prepare necessary lighting; summon for assistance; obtain informed consent from parent/legal guardian; obtain specimen for delivery to laboratory

Description of Post-Service Work:

Attend to phlebotomy site to ensure hemostasis and preserve the site for future use

SURVEY DATA:

Presenter(s) American Academy of Pediatrics

Specialty(ies) Pediatric Emergency Medicine, Pediatric Pulmonology, Pediatric Allergy/Immunology, Pediatric Critical Care, Neonatology, General Pediatrics

Sample Size: 164 Response Rate: (%): 16 Median RVW: 0.71

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: We sent surveys out to those groups within the Academy that are the most knowledgeable about the codes being surveyed. We included the Executive Committees of the Section on Allergy and Immunology, the Section on Perinatal Pediatrics, the Section on Pediatric Pulmonology, the Section on Emergency Medicine, and the Section on Critical Care. We also sent surveys out to members of the Committee on Coding and Reimbursement and the Task Force on Reimbursement since the members of these National Committees are most knowledgeable about how to complete RUC surveys.

25th Percentile RVW: 0.30 75th Percentile RVW: 0.90 Low: 0.15 High: 3.50

Median Pre-Service Time: 5.00 Median Intra-Service Time: 10.00

CPT Code: 36400

25th Percentile Intra-Svc Time: 10.00 75th Percentile Intra-Svc Time: 20.00 Low: 5.00 High: 45.00

Median Post-Service Time:

	Level of Service by CPT Code	
	<u>Total Time</u>	<u>(List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>5.00 minutes</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>N/A</u>	
Discharge Day Mgmt.:	<u>N/A</u>	
Office Visits:	<u>N/A</u>	

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
36410	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture.	0.18

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> <u>36400</u>	<u>Reference</u> <u>Service 1 CPT:</u> <u>36410</u>
Median Pre-Time	5.00	6.00
Median Intra-Time	10.00	11.50
Median Immediate Post-service Time	5.00	6.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	1.88
Urgency of medical decision making	2.00	1.94

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.60
Physical effort required	3.00	2.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	1.58
Outcome depends on the skill and judgement of physician	3.00	2.31
Estimated risk of malpractice suit with poor outcome	2.00	1.58

INTENSITY/COMPLEXITY MEASURES

<u>CPT Code</u>	<u>Reference</u>
36400	<u>Service 1</u> 36410

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	2.00	2.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

The American Academy of Pediatrics convened a conference call to develop the final recommendations for the Five-Year survey codes. The call took place on July 27, 2000 at 4:00-6:00 pm (CDT). The call attendees had the data before them during the call and came to consensus on all the final recommendations. The following demographic information will give you an idea how diverse the call attendees were throughout the nation.

Types of Physicians: 13 Total Pediatricians
 1 Gastroenterology Pediatrician
 1 Orthopedic Pediatrician
 2 Emergency Medicine Pediatricians
 1 State Dept of Public Health Physician Administrator
 1 Neonatology Pediatrician
 7 General Pediatricians

Locations: 6 from South TN, TX (4), GA
 2 from Midwest, IL, OH
 3 from East, DC, MA, DE
 2 from the West, CO, WA

Types of Practices: 0 from Solo Practice
 6 from Single Specialty
 2 from Multispecialty
 4 from Medical Centers (1 Chief of Staff, 1 Medical Director, 2 ED Directors)

Experience of panel: 1 CPT Advisor
 1 CPT Editorial panel member
 1 ICD-9-CM Editorial Advisory Board Member
 1 AAP RUC Representative
 1 AAP PEAC Representative
 1 AAP RUC Advisor

Although the setting and technology have not changed over the past five years, the physician work component has become more difficult due to the fact that many of the patients who require venipuncture are now much younger/smaller than they were previously. This is due in part to advances in neonatology that have resulted in greater viability of pre-term infants.

CPT Code: 36400

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics _____ Commonly Sometimes _____ Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics _____ Frequency: **It is very difficult to get this information, as Medicare does not track pediatric patients.**

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Pediatrics _____ Frequency 0 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes _____ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 1 No 19

**a. This service represents new technology that has become more familiar (ie, less work).
I agree I do not agree 1**

**b. Patients requiring this service are now:
more complex (more work) 1 less complex (less work) no change**

**c. The usual site-of-service has changed:
from outpatient to inpatient from inpatient to outpatient no change 1**

10/24/00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36405 Tracking Number: Global Period: XXX Recommended RVW: 0.40
0.32 RUC

CPT Descriptor:
Venipuncture, under age 3 years; scalp vein

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A physician is called to the NICU for a technically difficult phlebotomy on a 1-kilogram infant who is recovering from respiratory distress syndrome. Laboratory tests of the blood have been ordered on a four-hour basis. The umbilical arterial catheter had been removed due to vascular spasm in the foot. The child has already had numerous phlebotomies of the arms and legs. Because of the exceptional need for the laboratory evaluation and unavailable phlebotomy sites in the arms and legs, the physician elects to draw blood from the scalp vein. The area is prepped for sterile entry and necessary lighting and additional staff are summoned. After the physician obtains informed consent from the parent/legal guardian, he/she obtains the specimen and prepares it for delivery to the laboratory. Special attention is given to the site of the phlebotomy to ensure hemostasis and preserve the site for future use.

Description of Pre-Service Work:

Review patient chart; review laboratory results

Description of Intra-Service Work:

Inspect condition of old phlebotomy sites; prep draw area for sterile entry; prepare necessary lighting; summon staff for assistance; obtain informed consent from parent/legal guardian; obtain specimen for delivery to laboratory

Description of Post-Service Work:

Attend to phlebotomy site to ensure hemostasis and preserve the site for future use

SURVEY DATA:

Presenter(s) American Academy of Pediatrics

Specialty(ies) Pediatric Emergency Medicine, Pediatric Pulmonology, Pediatric Allergy/Immunology, Pediatric Critical Care, Neonatology, General Pediatrics

Sample Size: 164 Response Rate: (%) 16 Median RVW: 0.40

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: We sent surveys out to those groups within the Academy that are the most knowledgeable about the codes being surveyed. We included the Executive Committees of the Section on Allergy and Immunology, the Section on Perinatal Pediatrics, the Section on Pediatric Pulmonology, the Section on Emergency Medicine, and the Section on Critical Care. We also sent surveys out to members of the Committee on Coding and Reimbursement and the Task Force on Reimbursement since the members of these National Committees are most knowledgeable about how to complete RUC surveys.

25th Percentile RVW: 0.20 75th Percentile RVW: 2.91 Low: 0.10 High: 3.90

Median Pre-Service Time: 4.00 Median Intra-Service Time: 10.00

CPT Code: 36405

25th Percentile Intra-Svc Time: 10.00 75th Percentile Intra-Svc Time: 20.00 Low: 5.00 High: 45.00

Median Post-Service Time:

	Level of Service by CPT Code	
	<u>Total Time</u>	<u>(List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>4.00 minutes</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>N/A</u>	
Discharge Day Mgmt.:	<u>N/A</u>	
Office Visits:	<u>N/A</u>	

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
36410	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture.	0.18

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u> <u>36405</u>	<u>Reference</u> <u>Service 1 CPT:</u> <u>36410</u>
Median Pre-Time	4.00	5.00
Median Intra-Time	10.00	15.00
Median Immediate Post-service Time	4.00	5.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	3.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.00
Physical effort required	4.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.00
Outcome depends on the skill and judgement of physician	4.00	2.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	4.00	2.00
Post-Service intensity/complexity	2.00	2.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

The American Academy of Pediatrics convened a conference call to develop the final recommendations for the Five Year survey codes. The call took place on July 27, 2000 at 4:00-6:00 pm (CDT). The call attendees had the data before them during the call and came to consensus on all the final recommendations. The following demographic information will give you an idea how diverse the call attendees were throughout the nation.

Types of Physicians:**13 Total Pediatricians**

- 1 Gastroenterology Pediatrician
- 1 Orthopedic Pediatrician
- 2 Emergency Medicine Pediatricians
- 1 State Dept of Public Health Physician Administrator
- 1 Neonatology Pediatrician
- 7 General Pediatricians

Locations:

- 6 from South TN, TX (4), GA
- 2 from Midwest, IL, OH
- 3 from East, DC, MA, DE
- 2 from the West, CO, WA

Types of Practices:

- 0 from Solo Practice
- 6 from Single Specialty
- 2 from Multispecialty
- 4 from Medical Centers (1 Chief of Staff, 1 Medical Director, 2 ED Directors)

Experience of panel:

- 1 CPT Advisor
- 1 CPT Editorial panel member
- 1 ICD-9-CM Editorial Advisory Board Member
- 1 AAP RUC Representative
- 1 AAP PEAC Representative
- 1 AAP RUC Advisor

Although the setting and technology have not changed over the past five years, the physician work component has become more difficult due to the fact that many of the patients who require venipuncture are now much younger/smaller than they were previously. This is due in part to advances in neonatology that have resulted in greater viability of pre-term infants.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics _____ Commonly Sometimes _____ Rarely _____

Specialty _____ Commonly _____ Sometimes _____ Rarely _____

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics _____ Frequency: **It is very difficult to get this information, as Medicare does not track pediatric patients.**

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Pediatrics _____ Frequency 0 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes _____ No _____

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 5 No 18

a. This service represents new technology that has become more familiar (ie, less work).

I agree I do not agree 1

b. Patients requiring this service are now:

more complex (more work) 2 less complex (less work) no change 3

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient no change 1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 36489

Current RVW: 1.22
Recommended RVW: ~~3.10~~
2.50 RUC

CPT Descriptor: Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2

Global Period: 000

Typical Patient (*Survey Vignette*):

A 65 year-old man is admitted to the hospital following a motor vehicle accident with multiple trauma. He is hypotensive, and mechanical ventilation is begun. He has an ileus and is unable to tolerate enteral feedings. A central venous catheter is inserted for fluid and nutritional management.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work :

Review of patient chart. Explanation of procedure to patient /family members, risks and benefits outlined, and consent obtained.

Intra-service work - Skin to skin:

Landmarks of the chest are mapped out where the catheter is to be inserted, skin is antiseptically prepped, and local anesthesia is administered. A long needle with an intracatheter is directed toward the superior vena cava and, upon puncture, the catheter is inserted into the superior vena cava. The needle is then removed, while threading the catheter farther into the vena cava, avoiding puncture of the venous wall. Once the catheter is in place, a sample is withdrawn, and the line is flushed with a saline solution to ascertain that the catheter is patent and that the integrity of the vascular wall has not been compromised. Since the catheter must remain in place for some time, care is taken to secure the line (absolutely necessary in a restless, acutely ill patient) and to maintain a sterile environment.

Post-service work:

Chest is examined for any complications. Note is written describing procedure. A chest x-ray is ordered and reviewed by the physician for evaluation of catheter position and possible complications. (The formal interpretation of the full chest radiograph is separately billable). Instructions are given to staff about maintaining patency of catheter and sterility of insertion site, as well as keeping the catheter secure so that it will not be dislodged.

SURVEY DATA

Presenter(s): George Sample, MD
 Scott Manaker, MD
 Charles Shoemaker, MD
 Robert Vogelzang, MD

Specialty(s): American College of Chest Physicians (ACCP)
 Society of Critical Care Medicine (SCCM)
 American Thoracic Society (ATS)
 American Society of General Surgeons (ASGS)
 American College of Radiology (ACR)
 Society of Cardiovascular & Interventional Radiology (SCVIR)

Type of Sample: Random (web/mail/fax) Convenience (committee meeting)

Sample Size: 6,600 email/website (ACCP, SCCM, ATS) **Response:** 174 (2.5%)
 350 mail (ASGS, ACR)
 80 committee (SCVIR)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.40	2.50	3.10	4.00	10.00
Pre-Service			15		
Intra-Service	2	20	20	30	60

Post-Service:	Total Time	CPT code / # of visits
Immed. Post-Service	15	
Critical Care	0	
Other Hospital	0	
Discharge Day Mgmt	0	
Office Visits	0	

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rw</u>	<u>GLOB</u>
36010	Introduction of catheter, superior or inferior vena cava	2.43	XXX

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

	<u>Svy CPT</u>	<u>Ref CPT</u>
TIME ESTIMATES (MEDIAN)	36489	36010
Pre-service time	15	15
Intra-service time	20	25
Immediate Post-service time	15	10
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	0	0
Total office visit time	0	0
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	2.41	1.45
Intra-service	3.23	3.20
Post-service	2.05	2.18
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.39	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.40	2.53
Urgency of medical decision making	3.01	2.91
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.46	3.38
Physical effort required	2.81	2.85
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.21	3.13
Outcome depends on the skill and judgment of physician	3.63	3.35
Estimated risk of malpractice suit with poor outcome	2.96	2.83

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

The consensus committee representing all participating organizations note that the vignette used in the survey is the simplest of the multiple methods for inserting a catheter into the vena cava. More complex, more intensive variations include using a wire through a needle technique, multiple lumen catheters, and dilators for large bore catheters. In additions, clots, scars, and intravascular webs from previous catheters make the procedure complex and difficult. The total work for this procedure is greater than the reference service. The survey median RVW of 3.10 is recommended for CPT 36489. This RVW correctly ranks CPT 36489 relative to 36010.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Pulmonary Medicine: Commonly
 Critical Care Medicine: Commonly
 Radiology: Commonly
 General Surgery: Commonly

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.

Cannot estimate national 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.

239,307	anesthesiology	218	gastroenterology
135,434	general surgery	204	pediatric medicine
54,559	diagnostic radiology	180	obstetrics/gynecology
32,440	internal medicine	125	radiation oncology
28,913	pulmonary disease	118	osteopathic manipulative therapy
21,432	clinic or group practice (not gppp)	95	endocrinology
20,592	cardiology	71	otolaryngology
17,974	nephrology	69	gynecology/oncology
17,354	interventional radiology	62	nuclear medicine
14,829	emergency medicine	60	pathology
12,544	thoracic surgery	49	geriatric medicine
11,045	vascular surgery	47	maxillofacial surgery
9,950	critical care (intensivists)	43	ophthalmology
8,872	cma, anesthesia assistant	38	allergy/immunology
5,017	general practice	27	psychiatry
4,245	cardiac surgery	23	certified clinical nurse specialist
2,862	family practice	21	hematology
1,277	colorectal surgery	13	hand surgery
975	infectious disease	13	rheumatology
892	surgical oncology	7	unknown supplier/provider specialty
864	physician assistant	6	dermatology
822	hematology/oncology	5	optometrist
521	neurology	4	physical medicine and rehabilitation
509	peripheral vascular disease	3	oral surgery (dentists only)
489	plastic & reconstructive surgery	3	unknown physician specialty
349	urology	2	ASC
294	neurosurgery	1	independently-billing clinical lab
271	nurse practitioner	1	independently-billing psychologist
260	medical oncology	1	neuropsychiatry
227	orthopaedic surgery		

Do many physicians perform this service across the United States? Yes

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

- 89 Yes
- 84 No
- 1 No response

b. This service represents new technology that has become more familiar (i.e., less work).

- 15 I agree
- 72 I do not agree
- 87 no response

c. Patients requiring this service are now:

- 85 more complex (more work)
- 0 less complex (less work)
- 2 no change
- 87 no response

d. The usual site-of-service has changed:

- 9 from outpatient to inpatient
- 9 from inpatient to outpatient
- 66 no change
- 90 no response

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 39503

Global: 090

Current RVW: 37.54
Recommended RVW: 95.00

CPT Descriptor: Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia

Typical Patient (Survey Vignette): A 2.8-kg infant presents with severe respiratory distress in the delivery room and is transported (intubated) with x-ray evidence of a left-sided diaphragmatic hernia. Preoperative stabilization (separately billable) is attempted for several days. The patient improves marginally and undergoes repair of a left-side posterior diaphragmatic hernia. Immediate postoperative management includes ventilator support, nitric oxide and cardiovascular pharmacologic support. Intermediate and longer-term management includes parenteral nutrition, enteral nutrition, and treatment of sepsis and metabolic issues. Long-term management includes discharge and home care arrangements for follow-up for nutritional issues, oxygen therapy, diuretics, etc.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- Write preoperative orders for perioperative medications.
- Review preoperative work-up with particular attention to pathology reports.
- Review preoperative work-up with particular attention to films.
- Review planned incisions and procedure.
- Confirm OR start time – notify patient and family.
- Arrange for surgical assistant.

Pre-service work - Day of surgery:

- Check with lab – make certain blood and/or x match is available.
- Change into scrub clothes.
- Review the surgical procedure, postop recovery in and out of the hospital, and expected outcome(s) with patient and family.
- Answer patient and family questions and obtain informed consent, arrange where to meet postop.
- Review length and type of anesthesia with anesthesiologist and aid in positioning endotracheal tube.
- Review planned procedure and positioning and draping of patient.
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite.
- Monitor patient positioning and draping, and assist with positioning as needed.
- Accompany patient with nurses from NICU to operating room.
- Adjust NO therapy and or Oscillator
- Assist with intubation as necessary, watching for patient decompensation with positive pressure ventilation.
- Adjust headlight and surgical telescopic loupes.
- Scrub and gown

Intra-service work - Skin to skin:

- Hemostasis is critical at every stage due to potential for ECMO.
- Skin incision is made and anterior abdominal wall is carefully divided.
- The peritoneal cavity is entered and the bowel is protected.
- Assessment made for position of hernia.
- Identification of herniated viscera.
- Herniated viscera reduced into abdomen.
- Size of lung bud evaluated.
- Chest tube placed into thorax through separate incision and sutured.
- Reduced viscera examined for injuries or abnormalities.
- Hernia defect repaired by suture or placement of prosthetic patch.

- The abdomen cavity is irrigated and checked meticulously for bleeding.
- Wound closed, depending on tension, either in multiple layers or skin only, depending on torsion.
- The skin is closed.

Post-op Same day work

- Apply dressings.
- Write an OP note in the patient's record.
- Sign OR forms, indicating pre- and postop diagnosis and operation performed, and any pathology forms.
- Write orders for postop labs, films, medications, diet, and patient activity.
- Review care and medications with neonatal nursing staff.
- Discuss procedure outcome with family.
- Dictate postop report.
- Discuss procedure outcome with referring physician.
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company.
- Write and summarize orders.
- Obtain and review postop x-ray.
- Review ventilator management and write ventilator orders.
- Determine need for NO therapy.
- Determine need for ECMO.
- Evaluate hemodynamic status.
- Examine patient, check wounds and patient progress.
- Check function of NG tube, fluid and electrolyte status and urine output.
- Review nursing/other staff patient chart notes.
- Answer patient/family questions.
- Answer nursing/other staff questions.
- Write orders for following day's labs, films, medications, diet, and patient activity.
- Chart patient progress notes.

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Frequent evaluation of hemodynamic and ventilatory status.
- Frequent review of blood gases and chest x-rays.
- Write ventilation orders.
- Determine need for NO and ECMO.
- Write NO orders if needed.
- Examine and talk with family.
- Check wounds and patient progress.
- Write TPN orders and evaluate nutrition status.
- Review lab data.
- Determine when NG tube can be removed and oral intake started.
- Carefully evaluate return of bowel function, any temperature elevation, and any wound drainage.
- Discuss patient progress with referring physician (verbal and written).
- Review nursing/other staff patient chart notes.
- Answer patient/family questions.
- Answer nursing/other staff questions (verbal and written).
- Answer insurance staff questions.
- Write orders for postop labs, films, medications, diet, and patient activity.
- Chart patient progress notes.

Discharge day work –

- Carefully explain to family dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Discuss oxygen therapy and apnea monitoring and write orders for same.

- Assure CPR training.
- Arrange visiting nurse.
- Check wounds and patient progress.
- Review nursing/other staff patient chart notes.
- Review post-discharge wound care and activity limitations with patient.
- Answer patient/family questions.
- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for post-discharge labs, films, and medications.
- Chart patient discharge notes.

Post-op Office work - After discharge from hospital

- Examine patient.
- Check wounds and patient progress.
- Evaluate need for oxygen therapy and continue apnea monitoring.
- Discuss at this time any additional or adjuvant treatment that may be required and referrals.
- Answer patient/family questions.
- Answer insurance staff questions.
- Discuss patient progress with referring physician (verbal and written).
- Write orders for medications.
- Review post-discharge labs/films.
- Discuss progress with patient/family.
- Remove sutures/drains.
- Dictate patient progress notes for medical chart.

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 31 (57%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	40.00	53.00	95.00	120.00	283.00

Pre-Service			150		
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Intra-Service	60	106	120	120	180
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Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	60	
Critical Care	1890	99291x14 99292x6
Other Hospital	355	99233x5 99232x5
Discharge Day Mgmt	45	99239
Office Visits	114	99214x1 99213x2 99212x2

KEY REFERENCE SERVICE(S):

<u>'00 RWV</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.58	90	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<u>TIME ESTIMATES (MEDIAN)</u>	Survey CPT 39503 (n=31)	Ref CPT 43324 (n=13)
Pre-service time	150	80
Intra-service time	120	120
Immediate Post-service time	60	25
Total critical care time	1890	0
Total other hospital visit time	355	117
Discharge management time	45	35
Total office visit time	114	38

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.84	2.92
Intra-service	4.45	3.25
Post-service	4.84	2.83

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.29	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.55	3.17
Urgency of medical decision making	4.87	2.83

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.39	3.58
Physical effort required	3.97	3.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.97	2.92
Outcome depends on the skill and judgment of physician	4.84	3.17
Estimated risk of malpractice suit with poor outcome	4.00	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI-2). A consensus panel (see Attachment I) reviewed the survey and made final recommendation. Prenatal diagnosis has led to delivery at perinatal centers. Babies who would have previously died at birth are now undergoing treatment. CPT 39503 intraop time is the same as 43324, but the intensity is higher. Postop work for 39503 is significantly greater than for 43324. Neonates requiring this procedure are typically in the hospital 25 days (survey 25th pctl LOS was 22 days and 75th pctl LOS was 31 days), with 14 days of that in NICU. See (Attachment III) single institution data with median post op time on ventilator 14 days and median LOS 35 days). Daily hospital and office visit care is significant – as described in the service description. We note that the survey median RVW of 95.00 does not fully compensate for the post-op work of this code but represents the survey median. We also note that the neonatal codes were not valued when this code was last reviewed and the post service work for them alone exceed the recommended RVW's. Malpractice suits for bad outcomes for these babies have typically been in the \$20 million range.

Since the survey median RVW of 95.00 does not fully compensate for even the post-op work of this code, the consensus panel debated recommending the 75th pctl RVW, in consideration of RUC convention agreed to retain the survey median. We would like *consideration* given to changing the global period from 90 days to 0 days to deal with the unique post service work. **We recommend an RVW of 95.00.**

Building block comparison:

95.00 Recommended RVW
101.84 Subtract postop HV & OV RVWs
(6.84) Negative balance RVWs for pre-op and intra-op work

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatric Surgery 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: Pediatric Surgery Frequency: 200

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Pediatric Surgery Frequency: 0

Do many physicians perform this service across the United States? No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

11 Yes
9 No

b. This service represents new technology that has become more familiar (i.e., less work).

- 1 I agree
- 8 I do not agree

c. Patients requiring this service are now:

- 11 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 11 no change

CPT 42205: PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; SOFT TISSUE ONLY

ASPS CPT/RUC Committee members believe it is not necessary to conduct a survey to determine an appropriate work value for CPT 42205. This decision is based on the rationale and recommendation we provided in our February 22, 2000 letter to HCFA, which is summarized here.

CPT 42205 (*Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only*) is currently assigned 9.59 work relative value units (RVWs) and has a 90 day global period. During the 1995 Five-Year Review, the work values for two other codes in the palatoplasty family, 42200 and 42210, were reviewed and increased, causing a rank order anomaly in the valuation of 42205. CPT 42200 (*Palatoplasty for cleft palate, soft and/or hard palate only*), is currently assigned a work value of 12.00 and has a 90 day global period. CPT 42210 (*Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)*) is currently assigned a work value of 14.50 and has a 90 day global period.

To correct the rank order anomaly of CPT 42205 relative to codes 42200 and 42210, we offer the following recommendation in lieu of conducting a survey. In 1995, the revised value of 42210 was created by adding 50% of CPT 20900 (*Bone graft, any donor area; minor or small (eg, dowel or button)*) to the recommended value of 42200. Code 42205 differs from 42210 only with the absence of bone grafting. We therefore submit that correction of the anomaly for 42205 can be done in part by subtracting 50% of 20900 (currently 5.58 RVWs) from 42210 (currently 14.5 RVWs) to derive a recommended value. Calculations for this value based on the 2000 RVWs is 11.71 RVWs, for which a rank order anomaly still persists (i.e., 42200 is currently 12.0 RVWs). We therefore recommend a slight increase to 12.0 RVWs for 42205 to reestablish rank order in the cleft family of codes. This would also take into account the differences in work relative value units between 1995 and 2000.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43219 Tracking Number: Global Period: 000 Recommended RVW: 3.18

CPT Descriptor: Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An elderly patient with progressive dysphagia and weight loss was found to have an obstructing, concentric squamous cell carcinoma in the mid-esophagus. Esophagoscopy was performed with placement of an expandable wire mesh esophageal stent to relieve obstruction. Fluoroscopy is employed during the procedure to insure proper positioning of the stent. Post placement, contrast is injected through the endoscope to assess placement and patency. Detailed instructions are reviewed with the patient upon awakening with respect to complications (hemorrhage, migration, tracheo-esophageal fistula, aspiration) and precautions (diet modification, upright position after eating, proton pump inhibitors).

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: 84(%) Median RVW: 3.18

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 2.58 75th Percentile RVW: 4.61 Low: 1.59 High: 11.13

Median Pre-Service Time: 57 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 40 75th Percentile Intra-Svc Time: 55 Low: 19 High: 105

Median Post-Service Time:

Total Time

Immediate Post Service Time: 33

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	1.59

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	57	
Median Intra-Time	45	
Median Immediate Post-service Time	33	

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	3.88	2.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	2.16
Urgency of medical decision making	3.80	2.06

Technical Skill/Physical Effort (Mean)

Technical skill required	4.51	2.24
Physical effort required	4.24	2.16

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.39	2.14
Outcome depends on the skill and judgement of physician	4.45	2.38
Estimated risk of malpractice suit with poor outcome	3.82	2.24

INTENSITY/COMPLEXITY MEASURES**CPT Code** **Reference**
Service 1**Time Segments (Mean)**

Pre-Service intensity/complexity	3.74	2.10
Intra-Service intensity/complexity	4.44	2.18
Post-Service intensity/complexity	3.8	2.18

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 1,124

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 38 No 5

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 13 I do not agree 25**

**b. Patients requiring this service are now:
more complex (more work) 28 less complex (less work) 1 no change 9**

**c. The usual site-of-service has changed:
from outpatient to inpatient 22 from inpatient to outpatient 14 no change 1**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43239 Tracking Number: Global Period: 000 Recommended RVW: 3.76
2.87 RUC

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A middle-aged man with persistent dyspepsia and mild anemia undergoes esophagogastroduodenoscopy with the finding of a 1cm antral ulcer. Multiple biopsies are taken for histology and H. pylori urease screen test.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 95% Median RVW: 2.87

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 2.75 75th Percentile RVW: 2.99 Low: 2.39 High: 4.18

Median Pre-Service Time: 27 Median Intra-Service Time: 34

25th Percentile Intra-Svc Time: 29 75th Percentile Intra-Svc Time: 34 Low: 26 High: 44

Median Post-Service Time:

Total Time

Immediate Post Service Time: 23.5

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	27	
Median Intra-Time	34	
Median Immediate Post-service Time	23.5	

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	2.33
Urgency of medical decision making	2.95	2.26

Technical Skill/Physical Effort (Mean)

Technical skill required	2.93	2.31
Physical effort required	2.84	2.26

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.69	2.24
Outcome depends on the skill and judgement of physician	2.93	2.31
Estimated risk of malpractice suit with poor outcome	3.50	2.46

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.44	2.17
Intra-Service intensity/complexity	3.07	2.34
Post-Service intensity/complexity	2.85	2.26

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Substantial increase in number of biopsies due in part to greater efforts to detect Barrett's Esophagus and H.Pylori

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 650

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 29 No 27

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 3 I do not agree 30

b. Patients requiring this service are now:

more complex (more work) 21 less complex (less work) 0 no change 12

c. The usual site-of-service has changed:

from outpatient to inpatient 0 from inpatient to outpatient 10 no change 23

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43244 Tracking Number: _____ Global Period: 000 Recommended RVW: 5.05

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man with chronic hepatitis C presents to the Emergency Room with massive hematemesis and anemia. Esophagogastroduodenoscopy reveals bleeding esophageal varices. After confirmation of the bleeding site, the endoscope is removed, and a multibanding variceal ligator is attached with reinsertion of the endoscope. Multiple bands are deployed ligating the bleeding variceal column and other adjacent variceal columns. Hemostasis is achieved.

Description of Pre-Service Work:

Please see survey instructions and background

Description of Intra-Service Work:

information distributed by the AMA.

Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 90% Median RVW: 4.78

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 3.82 75th Percentile RVW: 5.92 Low: 2.75 High: 11.95

Median Pre-Service Time: 57 Median Intra-Service Time: 54

25th Percentile Intra-Svc Time: 49 75th Percentile Intra-Svc Time: 64 Low: 39 High: 84

Median Post-Service Time:

Total Time

Immediate Post Service Time: 36

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	57	
Median Intra-Time	54	
Median Immediate Post-service Time	36	

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	4.19	2.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.02	2.41
Urgency of medical decision making	4.69	2.43

Technical Skill/Physical Effort (Mean)

Technical skill required	4.41	2.41
Physical effort required	4.31	2.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	2.38
Outcome depends on the skill and judgement of physician	4.54	2.51
Estimated risk of malpractice suit with poor outcome	4.06	2.60

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.02	2.31
Intra-Service intensity/complexity	4.47	2.4
Post-Service intensity/complexity	3.8	2.35

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Has become much more complex since service now usually involves application of 8 bands as compared with 2 when the service was established.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 50,033

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 44 No 7

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 24 I do not agree 21**

**b. Patients requiring this service are now:
more complex (more work) 30 less complex (less work) 1 no change 14**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 1 no change 44**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43247 Tracking Number: _____ Global Period: 000 Recommended RVW: 5.3
3.59 RUC

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An elderly patient with a history of chronic dysphagia presents to the Emergency Room with inability to swallow solid or liquids which occurred during a meal. The endoscope is inserted to a level of the distal esophagus where a meat bolus obstructs further advancement. A snare/retrieval device is used to dislodge the bolus, either removing the bolus intact or fragmenting the bolus and displacing it into the stomach. The scope is then reinserted or advanced into the stomach and duodenum to complete the evaluation with particular attention to the gastroesophageal junction.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 95 Median RVW: 3.59

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 3.35 75th Percentile RVW: 4.78 Low: 2.63 High: 10.76

Median Pre-Service Time: 42 Median Intra-Service Time: 54

25th Percentile Intra-Svc Time: 44 75th Percentile Intra-Svc Time: 54 Low: 24 High: 84

Median Post-Service Time:

Total Time

Immediate Post Service Time: 26

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code**

Median Pre-Time	42
Median Intra-Time	54
Median Immediate Post-service Time	26

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.45	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	2.40
Urgency of medical decision making	3.97	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	4.02	2.33
Physical effort required	4	2.32

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	2.30
Outcome depends on the skill and judgement of physician	4.03	2.36
Estimated risk of malpractice suit with poor outcome	3.93	2.57

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.19	2.21
Intra-Service intensity/complexity	4.11	2.33
Post-Service intensity/complexity	2.96	2.24

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology X Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 17,452

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 20 No 36

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 6 I do not agree 14

b. Patients requiring this service are now:

more complex (more work) 9 less complex (less work) 1 no change 10

c. The usual site-of-service has changed:

from outpatient to inpatient 1 from inpatient to outpatient 4 no change 15

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43249 Tracking Number: Global Period: 000 Recommended RVW: 5.1
3.35 RUC

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old woman with chronic dysphagia and recurrent esophageal stricture undergoes endoscopic evaluation. A tight stricture of the distal esophagus is observed. A balloon is advanced through the scope and into the strictured area to dilate the stricture. The balloon is removed, and the scope advanced into the stomach and duodenum to complete the evaluation with particular attention to the gastroesophageal junction.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 95% Median RVW: 3.346

Type of Sample (Circle One): random, panel, convenience Explanation of sample size:

25th Percentile RVW: 3.107 75th Percentile RVW: 4.153 Low: 2.629 High: 5.975

Median Pre-Service Time: 42 Median Intra-Service Time: 39

25th Percentile Intra-Svc Time: 34 75th Percentile Intra-Svc Time: 44 Low: 29 High: 74

Median Post-Service Time:

Total Time

Immediate Post Service Time: 26

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	42	
Median Intra-Time	39	
Median Immediate Post-service Time	26	

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	3.40	2.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	2.28
Urgency of medical decision making	3.28	2.26

Technical Skill/Physical Effort (Mean)

Technical skill required	3.62	2.30
Physical effort required	3.33	2.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	2.30
Outcome depends on the skill and judgement of physician	3.66	2.36
Estimated risk of malpractice suit with poor outcome	3.95	2.5

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.93	2.26
Intra-Service intensity/complexity	3.60	2.31
Post-Service intensity/complexity	3.02	2.28

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology ___ Commonly ___ Sometimes X Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 31,815

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes ___ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 28 No 23

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 8 I do not agree 20

b. Patients requiring this service are now:

more complex (more work) 19 less complex (less work) 0 no change 10

c. The usual site-of-service has changed:

from outpatient to inpatient from inpatient to outpatient 9 no change 19

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43255 Tracking Number: Global Period: 000 Recommended RVW: 6
4.82 RUC

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old woman on Ibuprofen for arthritic symptoms presents to the Emergency Room with melena and hematemesis. Esophagogastroduodenoscopy reveals an adherent clot in the duodenal bulb. After aggressive irrigation a 1cm ulcer in the duodenal bulb with active pulsatile bleeding in the ulcer base is identified. Epinephrine at 1:10,000 dilution is injected into the base of the ulcer with hemostasis. Bicap cautery is applied around the bleeding site. There is no further active bleeding.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%) 95 Median RVW: 4.6

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 3.59 75th Percentile RVW: 5.975 Low: 2.63 High: 11.95

Median Pre-Service Time: 47 Median Intra-Service Time: 54

25th Percentile Intra-Svc Time: 44 75th Percentile Intra-Svc Time: 54 Low: 34 High: 84

Median Post-Service Time:

Total Time

Immediate Post Service Time: 31

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	47	
Median Intra-Time	54	
Median Immediate Post-service Time	31	

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	3.95	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.66	2.39
Urgency of medical decision making	4.42	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.45	2.45
Physical effort required	4.24	2.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.35	2.32
Outcome depends on the skill and judgement of physician	4.34	2.46
Estimated risk of malpractice suit with poor outcome	3.98	2.48

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.82	2.26
Intra-Service intensity/complexity	4.51	2.37
Post-Service intensity/complexity	3.70	2.28

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology X Commonly ___ Sometimes ___ Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 35,609

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes ___ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 35 No 19

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 9 I do not agree 26**

**b. Patients requiring this service are now:
more complex (more work) 30 less complex (less work) 1 no change 4**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 33**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43259 Tracking Number: Global Period: 000 Recommended RVW: 10.8
8.59 RUC

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) with endoscopic ultrasound examination

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman who develops painless jaundice is identified to have dilation of her bile duct and pancreatic duct on CT scan. A discrete mass lesion is not identified. The patient is referred for an endoscopic ultrasound to identify if a mass lesion is present and if so then stage the tumor and determine operability.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 62 Response Rate: (%): 53 Median RVW: 10.76

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 9.56 75th Percentile RVW: 13.74 Low: 4.78 High: 16.73

Median Pre-Service Time: 57 Median Intra-Service Time: 69

25th Percentile Intra-Svc Time: 64 75th Percentile Intra-Svc Time: 74 Low: 29 High: 114

Median Post-Service Time:

Total Time

Immediate Post Service Time: 36

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code**

Median Pre-Time	57
Median Intra-Time	69
Median Immediate Post-service Time	36

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.44	2.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.75	2.50
Urgency of medical decision making	4.13	2.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	2.38
Physical effort required	4.25	2.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	2.38
Outcome depends on the skill and judgement of physician	4.93	2.63
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.24	2.24
Intra-Service intensity/complexity	4.82	2.47
Post-Service intensity/complexity	4.24	2.24

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 4,579

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 13 No 3

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 2 I do not agree 13**

**b. Patients requiring this service are now:
more complex (more work) 15 less complex (less work) 0 no change 1**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 12**

AMA/SPECIALTY SOCIETY RVS-UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43263 Tracking Number: Global Period: 000 Recommended RVW: 10.8
7.29 RUC

CPT Descriptor: Endoscopic retrograde cholangio-pancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old woman with chronic recurrent right upper quadrant pain and abnormal liver tests undergoes ERCP with findings of normal pancreatic and biliary anatomy. A manometric catheter is advanced into the common bile duct with careful incremental withdrawal. Manometric tracings of the biliary sphincter tone are recorded. The catheter is then redirected and manometry is performed of the pancreatic sphincter in a similar fashion. Aspiration is performed to minimize the risk of pancreatitis. The serial tracings are then reviewed.

Description of Pre-Service Work:

Please see survey instructions and background

Description of Intra-Service Work:

information distributed by the AMA.

Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 59 Median RVW: 9.54

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 8.34 75th Percentile RVW: 11.92 Low: 7.15 High: 20.86

Median Pre-Service Time: 47.5 Median Intra-Service Time: 76

25th Percentile Intra-Svc Time: 76 75th Percentile Intra-Svc Time: 91 Low: 56 High: 111

Median Post-Service Time:

	<u>Total Time</u>
Immediate Post Service Time:	<u>40</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	47.5	
Median Intra-Time	76	
Median Immediate Post-service Time	40	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.39
Urgency of medical decision making	3.72	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	3.67
Physical effort required	4.83	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	3.81
Outcome depends on the skill and judgement of physician	4.69	4.69
Estimated risk of malpractice suit with poor outcome	4.72	3.92

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 16 No 20

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 3 I do not agree 114**

**b. Patients requiring this service are now:
more complex (more work) 14 less complex (less work) 1 no change 2**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 7 no change 10**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43265 Tracking Number: Global Period: 000 Recommended RVW: ~~11.3~~
10.02 RUC

CPT Descriptor: Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of stone(s), any method

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 80 year old woman with recurrent right upper quadrant pain and jaundice undergoes ERCP with the findings of a dilated common bile duct and large common bile duct stones. Because the stones are too large to retrieve through the sphincterotomy site, mechanical lithotripsy is required. The lithotripter basket is passed into the common bile duct multiple times crushing stones and removing fragments before the common bile duct is cleared.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 79 Median RVW: 10.55

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 8.94 75th Percentile RVW: 11.92 Low: 6.85 High: 28.31

Median Pre-Service Time: 40 Median Intra-Service Time: 83.5

25th Percentile Intra-Svc Time: 76 75th Percentile Intra-Svc Time: 102.25 Low: 49 High: 166

Median Post-Service Time:

Immediate Post Service Time: Total Time
35

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	40	
Median Intra-Time	83.5	
Median Immediate Post-service Time	35	

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	4.07	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.25
Urgency of medical decision making	4.15	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	3.77
Physical effort required	4.69	3.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.64	3.69
Outcome depends on the skill and judgement of physician	4.72	3.79
Estimated risk of malpractice suit with poor outcome	4.40	3.77

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.79	3.25
Intra-Service intensity/complexity	4.75	3.58
Post-Service intensity/complexity	3.75	3.27

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology _____ Commonly _____ Sometimes X Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology _____ Frequency 1,058 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 27 No 21

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 6 I do not agree 22

b. Patients requiring this service are now:

more complex (more work) 22 less complex (less work) 0 no change 6

c. The usual site-of-service has changed:

from outpatient to inpatient 0 from inpatient to outpatient 7 no change 21

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43269 Tracking Number: Global Period: 000 Recommended RVW: 10.3
8.21 RUC

CPT Descriptor: Endoscopic retrograde cholangio-pancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old woman with malignant biliary obstruction due to pancreatic carcinoma presents with recurrent jaundice 3 months after undergoing ERCP with biliary stent placement. ERCP is now performed for the removal of the biliary stent using a snare or retrieval device and repeat cholangiography with insertion of a new biliary endoprosthesis. An expandable metallic stent is placed to allow for longer patency.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 79% Median RVW: 9.54

Type of Sample (Circle One): random, panel, convenience Explanation of sample size:

25th Percentile RVW: 8.34 75th Percentile RVW: 10.73 Low: 6.08 High: 23.84

Median Pre-Service Time: 40 Median Intra-Service Time: 71

25th Percentile Intra-Svc Time: 66 75th Percentile Intra-Svc Time: 81 Low: 46 High: 106

Median Post-Service Time:

	<u>Total Time</u>
Immediate Post Service Time:	<u>30</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

CPT Code

Reference Service 1 CPT:

Median Pre-Time	40
Median Intra-Time	71
Median Immediate Post-service Time	30

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	3.81	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.27
Urgency of medical decision making	3.66	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	3.60
Physical effort required	4.28	3.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	3.65
Outcome depends on the skill and judgement of physician	4.51	3.69
Estimated risk of malpractice suit with poor outcome	3.96	3.60

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference**
Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.66	3.17
Intra-Service intensity/complexity	4.47	3.48
Post-Service intensity/complexity	3.57	3.15

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology X Commonly ___ Sometimes ___ Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 5,989

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes ___ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 27 No 16

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 9 I do not agree 18**

**b. Patients requiring this service are now:
more complex (more work) 19 less complex (less work) 0 no change 8**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 10 no change 17**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 44055

Global: 090

Current RVW: 13.14
Recommended RVW: 22.00

CPT Descriptor: Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)

Typical Patient (Survey Vignette): A five-day old infant presents with bilious vomiting and abdominal distention. X-ray reveals high intestinal obstruction. At operation, there is mid-gut volvulus with dusky, possible ischemic bowel. A Ladd's procedure is performed. Postoperative management includes ventilatory management, attentive observation for a need for a second-look operation, parenteral and ultimately enteral feeding management, discharge management, and postoperative office management through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- Start and complete preoperative work-up with thorough physical examination with particular attention to abdominal findings.
- Review work-up with pediatric and radiological colleagues paying particular attention to the UGI.
- Review planned incisions, procedure and possible additional procedures with the family and referring physician.
- Write preoperative orders for perioperative medications, consent, preop lab evaluations, and type and crossmatch.
- Confirm OR start time and necessary equipment with OR staff.
- Review preoperative work-up with anesthesiology and collaborate for other preop evaluations.
- Arrange for surgical assist.

Pre-service work - Day of surgery:

- Reevaluate patient for any changes in the overall condition paying particular attention to the abdominal examination.
- Check with lab—make certain blood is available.
- Secure that needed loupes, headlight, and other necessary equipment is available to complete operation.
- Answer family questions and arrange where to meet postoperatively.
- Verify that all necessary surgical instruments, supplies, and support personnel are available in the operative suite.
- Monitor and assist patient positioning and draping.
- Scrub and gown.

Intra-service work - Skin to skin:

- Assist anesthesiologist for awake or rapid induction intubation including preoxygenation.
- Make skin incision and divide appropriate abdominal wall musculature to enter the abdomen safely.
- Once the peritoneal cavity is entered, the presence and degree of volvulus is determined by examination of the intestines.
- If volvulus is present, the volvulus is derotated if possible and without resection.
- If intestinal compromise is present, the decision is made to either resect or return the involved intestines back into the abdomen.
- The correction of malrotation is performed as follows: the right colon is mobilized by dividing the lateral peritoneal reflection and extending this line of division to include Ladd's bands as they course over the duodenum. The colon is mobilized medially to the middle colic vessels so it can be reflected into the left side of the abdomen. The duodenum is mobilized and derotated so that the ligament of trietz is divided on top of the mesenteric vessels protecting them from injury. The base of the

mesentery is opened by dividing adhesions between the layers of the mesentery as though "opening an Aldermen's apron".

- The duodenum should now lie as a straight line along the right paravertebral gutter. The appendix is routinely removed.
- The abdominal cavity is irrigated and checked meticulously for bleeding.
- The abdominal wall is closed in layers by suture approximation.
- The skin is approximated with the appropriate technique.
- The dressing is applied.
- The decision to extubate or not extubate is shared with the anesthesiologist and this decision will determine whether the patient will go to recovery or directly to a critical care area.

Post-op Same day work from operating room to NICU

- Dress wound with sterile dressings.
- Secure NG tube
- Transfer patient to transport isolette with appropriate monitoring.
- Sign OR forms, indicating pre and post-op diagnosis and operation performed.
- Accompany patient back to the NICU with anesthesiologists and nurses.
- Transfer patient to neonatal heating bed with appropriate monitoring equipment.
- Write orders for post-op labs, x-rays, initial ventilator settings, monitors, drains, medications, diet, and nursing care.
- Adjust ventilator.
- Review postoperative chest x-ray.
- Review postoperative blood studies.
- Write an op note in the patient's record.
- Discuss procedure outcome with family.
- Dictate post-op report.
- Discuss procedure outcome with referring physician.
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company.
- Examine patient for postoperative stability.
- Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings.
- Write and summarize orders for NICU nurse.

Post-op Same day work after transfer to NICU

- Examine patient, check wounds and patient progress.
- Wean ventilator as able.
- Check function of OG tube, fluid and electrolyte status and urine output.
- Review nursing/other staff patient chart notes.
- Answer patient family questions.
- Answer nursing/other staff questions.
- Write orders for following day's labs, x-rays, medications, diet, and nursing care.
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1/Discharge Day

- Examine patient and talk with family.
- Check wounds and patient progress.
- Extubate patient when appropriate and use supplemental oxygen as needed
- Evaluate and treat hemodynamic cardiac and renal function
- Treat fluid shifts
- Evaluate blood gases lactate level and abdomen for signs of bowel ischemia
- Carefully evaluate return of bowel function, any temperature elevation, and any wound drainage.
- Determine when the NG tube can be removed and oral intake started.
- Discuss patient progress with referring physician (written and oral).
- Review nursing/other staff patient chart notes.
- Answer patient /family questions.

- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for postop labs, radiographs, medications, diet, and patient activity.
- Chart patient progress notes.

Discharge day work –

- Examine patient and talk with family.
- Check final report and discuss with family.
- Carefully explain to parents dietary management, activities, bathing and care of any wounds or drains, return appointment to the office, etc.
- Check wounds and patient progress.
- Review nursing/other staff patient chart notes.
- Review post discharge wound care and activity limitations with family.
- Answer family questions.
- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for post-discharge labs, films, and medications.
- Chart patient discharge notes.

Post-op Office work - After discharge from hospital

- Examine patient and speak with family.
- Check wounds and patient progress.
- Discuss any additional or adjuvant therapy that may be required and make referrals.
- Answer family questions.
- Answer insurance staff questions.
- Discuss patient progress with referring physician (written and verbal)
- Write orders for medications.
- Review post discharge labs and films.
- Remove sutures where applicable.
- Dictate patient progress notes for medical chart.
- Discuss risk of post op adhesive obstruction
- Discuss need for long-term follow-up.
- Refer to high-risk follow-up clinic.

SURVEY DATA**Presenter(s):** Eugene Wiener, MD**Specialty(s):** American Pediatric Surgical Association**Sample Size:** 54 **Response Rate:** 30 (56%)**Type of Sample:** Random

	<u>Low</u>	<u>**25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.25	22.00	25.00	27.95	45.00
Pre-Service		65	84		
Intra-Service		79	90		

<u>** 25th pctl**</u>	<u>** 25th pctl**</u>	<u>** 25th pctl**</u>
Post-Service :	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	30	
Critical Care	270	99291x1 99292x1
Other Hospital	210	99233x1 99232x5 99231x1
Discharge Day Mgmt	36	99238
Office Visits	46	99213x2

****APSA consensus committee recommends the 25th percentile data, which has slightly lower pre-service and post-service time and one less hospital visit than the survey median data. The committee recommends the median intraservice time. Please see "Additional Rationale" section for discussion.**

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.58	90	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (25th pctl for pre- and post- survey CPT; median for ref CPT)

	Survey CPT 44055 (n=30)	Ref CPT 43324 (n=8)
Pre-service time	65	60
Intra-service time	90	120
Immediate Post-service time	30	30
Total critical care time	270	0
Total other hospital visit time	210	117
Discharge management time	36	30
Total office visit time	46	35

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.57	3.29
Intra-service	4.13	3.29
Post-service	4.27	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.30	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.43
Urgency of medical decision making	4.90	3.14

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.93	3.57
Physical effort required	3.40	3.14

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.77	3.29
Outcome depends on the skill and judgment of physician	4.33	3.29
Estimated risk of malpractice suit with poor outcome	4.13	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI-4). A consensus panel (see Attachment I) reviewed the survey and made final recommendation. Because the consensus panel believes that the 25th percentile pre and post service time and visit data were more accurate for the typical patient requiring this procedure, the 25th percentile RVW is also recommended. (The panel believes the intraservice time is the 50th pctl 90 mins.) The panel notes that the intraservice intensity of 44055 is much greater as is the urgency of decision making in determining the need for immediate surgery and the viability of the intestine. The consequences of poor outcome are loss of the entire small bowel and right colon. We note that the **recommended RVW 22.00** does not fully compensate for even the post-op work of this code. We also note that the neonatal codes were not valued when this code was last reviewed

Simplified building block comparison:

22.00 Recommended RVW

22.03 Subtract postop HV & OV RVWs

(0.03) negative balance RVWs for pre-op and intra-op work

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatric Surgery Sometimes

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: Pediatric Surgery Frequency: 600

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: Pediatric Surgery Frequency: 200

Do many physicians perform this service across the United States? Yes

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

1 Yes

19 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

1 I do not agree

c. Patients requiring this service are now:

0 more complex (more work)

- 0 less complex (less work)
- 1 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 1 no change

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 44388 Tracking Number: Global Period: 000 Recommended RVW: 4.5
3.70 RUC

CPT Descriptor: Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman had low anterior resection of a rectal cancer. Follow-up colonoscopy through a colostomy is performed for surveillance one year following colon resection.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 93% Median RVW: 3.70

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 3.70 75th Percentile RVW: 4.07 Low: 3.70 High: 5.18

Median Pre-Service Time: 35 Median Intra-Service Time: 39

25th Percentile Intra-Svc Time: 39 75th Percentile Intra-Svc Time: 44 Low: 39 High: 69

Median Post-Service Time:

	<u>Total Time</u>
Immediate Post Service Time:	<u>17</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	35	
Median Intra-Time	39	
Median Immediate Post-service Time	17	

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.63	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.58
Urgency of medical decision making	2.49	2.51

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.84
Physical effort required	2.84	2.84

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.82	2.77
Outcome depends on the skill and judgement of physician	2.89	2.84
Estimated risk of malpractice suit with poor outcome	3.02	3.02

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference**
Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.54	2.53
Intra-Service intensity/complexity	2.91	2.82
Post-Service intensity/complexity	2.56	2.58

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology ___ Commonly X Sometimes ___ Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 235

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes ___ No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 12 No 40

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 12**

**b. Patients requiring this service are now:
more complex (more work) 7 less complex (less work) 0 no change 6**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 3 no change 10**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44389 Tracking Number: Global Period: 000 Recommended RVW: 5
4.26 RUC

CPT Descriptor: Colonoscopy through stoma; with biopsy, single or multiple

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman had low anterior resection of a rectal cancer. Diminutive polyp was found with cold biopsy removal of the polyp.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%) 93 Median RVW: 4.26

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.07 75th Percentile RVW: 4.44 Low: 3.79 High: 8.14

Median Pre-Service Time: 35 Median Intra-Service Time: 49

25th Percentile Intra-Svc Time: 44 75th Percentile Intra-Svc Time: 49 Low: 39 High: 79

Median Post-Service Time:

Immediate Post Service Time: Total Time
20

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	35	
Median Intra-Time	49	
Median Immediate Post-service Time	20	

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	3.11	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.54
Urgency of medical decision making	2.72	2.45

Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	2.84
Physical effort required	3.07	2.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.05	2.75
Outcome depends on the skill and judgement of physician	3.16	2.84
Estimated risk of malpractice suit with poor outcome	3.14	2.98

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 14 No 37

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 1 I do not agree 13**

**b. Patients requiring this service are now:
more complex (more work) 6 less complex (less work) 0 no change 8**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 3 no change 11**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 44390 Tracking Number: Global Period: 000 Recommended RVW: 5.6
4.81 RUC

CPT Descriptor: Colonoscopy through stoma; with removal of foreign body.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man with a prior history of left colon resection swallowed a coin which became lodged at the ileocecal valve. Colonoscopy through a stoma was performed to retrieve the foreign body.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%) 66 Median RVW: 4.81

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.44 75th Percentile RVW: 5.92 Low: 3.70 High: 10.18

Median Pre-Service Time: 50 Median Intra-Service Time: 54

25th Percentile Intra-Svc Time: 54 75th Percentile Intra-Svc Time: 59 Low: 39 High: 99

Median Post-Service Time:

	<u>Total Time</u>
Immediate Post Service Time:	<u>22</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	50	
Median Intra-Time	54	
Median Immediate Post-service Time	22	

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	3.43	2.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	2.60
Urgency of medical decision making	3.38	2.58

Technical Skill/Physical Effort (Mean)

Technical skill required	4.03	3.64
Physical effort required	3.72	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	2.78
Outcome depends on the skill and judgement of physician	3.88	2.85
Estimated risk of malpractice suit with poor outcome	3.38	2.90

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.21	2.53
Intra-Service intensity/complexity	3.95	2.85
Post-Service intensity/complexity	2.95	2.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes X Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 4

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 10 No 25

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 0 I do not agree 10

b. Patients requiring this service are now:

more complex (more work) 6 less complex (less work) 0 no change 4

c. The usual site-of-service has changed:

from outpatient to inpatient 0 from inpatient to outpatient 0 no change 9

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44391 Tracking Number: Global Period: 000 Recommended RVW: 5.6
5.18 RUC

CPT Descriptor: Colonoscopy through stoma; with control of bleeding, any method.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman had low anterior resection of a rectal cancer. A bleeding angiodysplasia was found in the right colon requiring application of bicap cautery for obliteration of the angiodysplasia.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 86 Median RVW: 5.18

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.76 75th Percentile RVW: 6.48 Low: 4.07 High: 11.0

Median Pre-Service Time: 55 Median Intra-Service Time: 59

25th Percentile Intra-Svc Time: 54 75th Percentile Intra-Svc Time: 64 Low: 41 High: 84

Median Post-Service Time:

Immediate Post Service Time: Total Time
27

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference Service 1 CPT:**

Median Pre-Time	55	
Median Intra-Time	59	
Median Immediate Post-service Time	27	

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	3.57	2.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	2.63
Urgency of medical decision making	3.70	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.98	2.83
Physical effort required	3.83	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.91	2.85
Outcome depends on the skill and judgement of physician	3.98	2.91
Estimated risk of malpractice suit with poor outcome	3.67	2.96

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.39	2.59
Intra-Service intensity/complexity	4.00	2.83
Post-Service intensity/complexity	3.20	2.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes X Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 82

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 16 No 31

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 4 I do not agree 12**

**b. Patients requiring this service are now:
more complex (more work) 11 less complex (less work) 0 no change 5**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 13**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44392 Tracking Number: Global Period: 000 Recommended RVW: 5.2
4.81 RUC

CPT Descriptor: Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman had low anterior resection of a rectal cancer. Multiple diminutive polyps were found in the right colon. These were removed by hot biopsy forceps technique.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 90 Median RVW: 4.81

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.44 75th Percentile RVW: 5.37 Low: 3.89 High: 9.25

Median Pre-Service Time: 35 Median Intra-Service Time: 54

25th Percentile Intra-Svc Time: 54 75th Percentile Intra-Svc Time: 59 Low: 39 High: 79

Median Post-Service Time:

Immediate Post Service Time:
 Total Time
 22

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	35	
Median Intra-Time	54	
Median Immediate Post-service Time	22	

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	3.29	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	2.51
Urgency of medical decision making	2.93	2.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.36
Physical effort required	3.54	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	2.78
Outcome depends on the skill and judgement of physician	3.60	2.84
Estimated risk of malpractice suit with poor outcome	3.56	2.93

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.65	2.47
Intra-Service intensity/complexity	3.69	2.78
Post-Service intensity/complexity	3.09	2.55

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes X Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 575

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No



Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 15 No 35

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 2 I do not agree 13**

**b. Patients requiring this service are now:
more complex (more work) 10 less complex (less work) 0 no change 5**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 2 no change 12**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44393 Tracking Number: Global Period: 000 Recommended RVW: 5.8
5.00 RUC

CPT Descriptor: Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman had low anterior resection of a rectal cancer. A flat villous adenoma was found in the transverse colon. The polyp site is injected with saline to create a cushion and minimize the risk for transmural thermal injury. The lesion is then ablated with argon plasma coagulation.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 72 Median RVW: 5.55

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.81 75th Percentile RVW: 6.85 Low: 3.96 High: 12.95

Median Pre-Service Time: 45 Median Intra-Service Time: 59

25th Percentile Intra-Svc Time: 54 75th Percentile Intra-Svc Time: 69 Low: 39 High: 99

Median Post-Service Time:

Immediate Post Service Time: Total Time
27

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RWV</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	45	
Median Intra-Time	59	
Median Immediate Post-service Time	27	

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	3.58	2.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.55
Urgency of medical decision making	3.45	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.14	2.84
Physical effort required	3.93	2.84

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.21	2.77
Outcome depends on the skill and judgement of physician	4.19	2.89
Estimated risk of malpractice suit with poor outcome	4.02	3.07

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.02	2.50
Intra-Service intensity/complexity	4.16	2.86
Post-Service intensity/complexity	4.05	2.64

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Great majority of survey respondents indicate that patients receiving this service are much more complex.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes X Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 158

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 24 No 13

**a. This service represents new technology that has become more familiar (i.e., less work).
I agree 8 I do not agree 16**

**b. Patients requiring this service are now:
more complex (more work) 14 less complex (less work) 0 no change 10**

**c. The usual site-of-service has changed:
from outpatient to inpatient 0 from inpatient to outpatient 5 no change 19**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45380 Tracking Number: Global Period: 000 Recommended RVW: 5.2
4.44 RUC

CPT Descriptor: Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old man with diarrhea, anemia, and intermittent rectal bleeding is evaluated with colonoscopy. Diffuse inflammation is found, and multiple biopsies are taken in several regions of the colon for diagnosis.

Description of Pre-Service Work: Please see survey instructions and background
Description of Intra-Service Work: information distributed by the AMA.
Description of Post-Service Work:

SURVEY DATA (exclusive of anesthesia data):

Presenter(s) Maurits Wiersema, MD; Joel Brill, MD

Specialty(s): Gastroenterology

Sample Size: 61 Response Rate: (%): 95 Median RVW: 4.44

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 4.26 75th Percentile RVW: 4.81 Low: 3.70 High: 9.25

Median Pre-Service Time: 45 Median Intra-Service Time: 51.5

25th Percentile Intra-Svc Time: 49 75th Percentile Intra-Svc Time: 57.75 Low: 39 High: 69

Median Post-Service Time:

	<u>Total Time</u>
Immediate Post Service Time:	<u>22</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	45	
Median Intra-Time	51.5	
Median Immediate Post-service Time	22	

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	3.65	2.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.57
Urgency of medical decision making	3.25	2.52

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	2.86
Physical effort required	3.47	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	2.76
Outcome depends on the skill and judgement of physician	3.44	2.81
Estimated risk of malpractice suit with poor outcome	3.40	2.98

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service I

Time Segments (Mean)

Pre-Service intensity/complexity	2.90	2.52
Intra-Service intensity/complexity	3.62	2.79
Post-Service intensity/complexity	3.09	2.52

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Substantial increase in number of biopsies obtained because more lesions can now be visualized. This includes "flatter" polyps being detected which formerly were not seen and are difficult to remove.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Commonly Sometimes Rarely

Specialty _____ Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ 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 Gastroenterology Frequency 260,314

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 17 No 39

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 0 I do not agree 18

b. Patients requiring this service are now:

more complex (more work) 13 less complex (less work) 0 no change 4

c. The usual site-of-service has changed:

from outpatient to inpatient 0 from inpatient to outpatient 5 no change 12

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

Survey CPT Code: 46740 **Global:** 090 **Current RVW:** 24.19
Recommended RVW: 30.00
CPT Descriptor: Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach

Family CPT Code: 46716 **Global:** 090 **Current RVW:** 12.15
Recommended RVW: 15.07
CPT Descriptor: Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula

Family CPT Code: 46730 **Global:** 090 **Current RVW:** 21.57
Recommended RVW: 26.75
CPT Descriptor: Repair of high imperforate anus without fistula; perineal or sacroperineal approach

Family CPT Code: 46735 **Global:** 090 **Current RVW:** 25.94
Recommended RVW: 32.17
CPT Descriptor: Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches

Family CPT Code: 46742 **Global:** 090 **Current RVW:** 29.67
Recommended RVW: 36.80
35.80 RUC
CPT Descriptor: Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches

Typical Patient (Survey Vignette): At six weeks of age, after neonatal colostomy, a sacroperineal repair is performed that includes repair of the urethral fistula, reconstruction of the muscular components, and anoplasty. After discharge, postoperative rectal dilatations are instituted in the office.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- Write preoperative orders for perioperative medications.
- Review preoperative work-up, with particular attention to previous x-rays and operative reports.
- Review planned incisions and procedure.
- Write bowel prep orders.
- Confirm OR start time – notify patient's family.
- Arrange for surgical assistant.
- Arrange for required equipment in the operating room, specifically, a nerve/muscle stimulator.

Pre-service work – Day of surgery:

- Change into scrub clothes.
- Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcomes with the family.
- Answer questions from patient's parents and family and obtain informed consent, if not previously obtained in the office, and arrange where to meet postoperatively.
- Review case with anesthesiologist with particular attention to patient positioning and avoidance of muscle relaxants.
- Review distal colostogram to determine position of anorectum.

- Review procedure positioning and draping with OR nursing staff.
- Verify that all necessary surgical instruments and supplies, especially the nerve/muscle stimulator, are available in the operative suite.
- Assure adequacy of bowel prep, irrigate stoma, if present, and fistula with sterile solutions.
- Insert Foley catheter with attention to fistula.
- Confirm that preoperative antibiotics have been given.
- Position the patient (prone for a posterior sagittal anorectoplasty).
- Total body prep if combined abdominal-sacral-perineal approach contemplated.
- Scrub and gown.

Intra-service work - Skin to skin:

- Using the nerve muscle stimulator, mark the center of the proposed new anal opening.
- Skin incision is made in a posterior sagittal fashion from the midportion of the sacrum to perineum.
- Parasagittal muscle fibers are split in the midline.
- The nerve/muscle stimulator is repeatedly used to determine absolutely and exactly the midline.
- External sphincter fibers may also be split in the midline.
- The incision is deepened, again, carefully staying in the midline down to the coccyx; in some cases, the coccyx is split in the midline.
- Hemostasis is meticulous with precise cauterization of blood vessels to maintain an absolutely dry surgical field.
- The levator muscle is divided, again, in the midline maintaining control of this with the muscle/nerve Stimulator.
- The striated muscle complex (external sphincter) is identified and either split or an intact circumference of striated muscle complex is left to tunnel the new anorectum.
- The posterior wall of the rectum is identified.
- The preoperative distal colostogram (x-ray) usually gives a hint as to where the fistula between the rectum and urethra (or vagina) is.
- Fine silk stay sutures are placed on both sides of the midline of the distal rectum, and a posterior incision into the rectum is made.
- Fine silk stay sutures are placed circumferentially around this opening.
- The rectourethral or vaginal fistula is then identified.
- Fine silk rectal mucosal stay sutures are placed just proximal to the fistula to aid in separation of the the rectum from the urethra or vagina.
- If the urinary catheter was unable to be placed into the bladder, but was placed into the fistula instead, it is relocated at this point into the bladder.
- A submucosal dissection is carried out to separate the anterior wall of the rectum from the urethra or vagina; this becomes full thickness more proximally.
- The urethral fistula or vaginal fistula is then sutured with fine absorbable suture.
- Adequate rectal length is then obtained by carefully dividing the bands on the rectal wall in a circumferential fashion applying traction to the previous stay sutures; taper the rectum when adequate length has been obtained.
- The levator has sutures placed in it where the previous midline incision had been made – these are not yet brought together.
- The mobilized rectum is pulled underneath this layer.
- The perineum is reconstructed and closed.
- The levator sutures are then tied and additional sutures placed distally in the striated muscle complex and distal levator that both close the muscle and attach and anchor the rectum.
- The anoplasty is then performed, specifically, the anorectal anastomosis suturing either the Nixon flaps or the cut edge of skin to the rectum in circumferential fashion.
- The parasagittal muscle fibers are then closed along with the subcutaneous tissue followed by skin closure.
- Hemostasis is checked for and obtained prior to each level of closure.
- Rectal mucosa is checked for viability before and after anastomosis; some surgeons do place

subcutaneous drains prior to closure.

Post-op Same day work through discharge from recovery

- Apply dressings.
- Write an op note in the patient's record.
- Sign OR forms.
- Write postoperative orders.
- Review recovery room care and medications with staff.
- Accompany patient to recovery room with anesthesiologist.
- Discuss procedure outcome with family.
- Dictate operative report.
- Discuss procedure outcome with referring physician.
- Dictate letter to referring physician and/or insurance company.
- Revisit patient to assess recovery progress.
- Write and summarize orders for floor nurse.
- Write discharge order to floor unless done by anesthesiologist.

Post-op Same day work after discharge from recovery

- Examine patient, check wounds and patient progress.
- Check fluid and electrolyte status and urine output.
- Maintain Foley catheter and review the importance of leaving the catheter intact with nursing and other staff.
- Review nursing patient chart notes.
- Answer family questions and nursing staff questions.
- Chart patient progress notes.

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine patient and talk with parents and family.
- Check wounds and patient progress.
- Determine when patient can resume oral intake.
- Write daily orders regarding activity, diet, medications, labs.
- Perform daily dressing change.
- Evaluate any temperature elevation and wound drainage.
- Discuss patient progress with referring physician.
- Review nursing and other staff patient chart notes.
- Answer family questions.
- Answer nursing staff questions.
- Answer insurance staff questions.
- Chart patient progress notes.
- Evaluate comfort level of patient and adjust pain medications appropriately.
- Remove drain (if placed) at appropriate time.

Discharge day work –

- Examine patient.
- Check wound.
- Talk with family.
- Remove Foley catheter and make sure patient is able to void without any problems prior to discharge.
- Explain to family diet, activities permitted, bathing, wound care and when to return to office.
- Review nursing and other staff patient chart notes.
- Answer family questions.
- Answer nursing and other staff questions.
- Answer insurance staff questions.
- Write discharge orders.

- Chart discharge note.

Post-op Office work - After discharge from hospital

- Examine patient and talk with parents.
- Check wounds and patient progress.
- Answer family questions.
- Answer insurance staff questions.
- Discuss patient progress with referring physician (verbal and written).
- Write prescriptions for medications as needed.
- Remove sutures as needed.
- Write or dictate patient progress note for medical chart.
- Beginning two to four weeks post-discharge, perform anorectal dilatation in the office with Hegar Dilators.
- Instruct parents on how to perform at home twice a day anorectal dilatations.
- Obtain dilators for the parents.
- Schedule colostomy closure.
- Discuss timing of colostomy closure procedure with the parents

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 31 (57%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	24.75	30.00	30.00	36.00	41.03
Pre-Service			115		
Intra-Service	90	180	180	240	360

Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	30	
Critical Care	0	
Other Hospital	120	99233x1 99232x2 99231x1
Discharge Day Mgmt	38	99239
Office Visits	228	99214x6

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
20.89	90	45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 46740 (n=31)	Ref CPT 45116 (n=16)
Pre-service time	115	98
Intra-service time	180	150
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	120	136
Discharge management time	38	35
Total office visit time	228	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.90	3.46
Intra-service	4.45	3.31
Post-service	3.83	2.92

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.69	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
Urgency of medical decision making	3.43	3.23

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.75	3.62
Physical effort required	4.00	3.46

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.34	3.38
Outcome depends on the skill and judgment of physician	4.76	3.77
Estimated risk of malpractice suit with poor outcome	3.79	3.38

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI-6). A consensus panel (see Attachment I) reviewed the survey and made final recommendation. The relationship within this family of codes to the anchor code was extensively discussed. These procedures are typically performed at an earlier age than previously due to data that suggests better functional outcome with earlier bowel continuity. The younger age presents greater technical challenges and more post work.

Building block comparison:

30.00 Recommended RVW for 46740

12.50 Subtract postop HV & OV RVWs

1.51 Subtract estimated pre and immed post RVWs for 145 minutes work (1.51= RVW for 99233)

15.39 Balance RVWs for 180 intra-op minutes (input = 0.088)

FAMILY CODE RECOMMENDATIONS (46716, 46730, 46735, and 46742)

A mini-survey of time, visits, and relative intraop intensity was conducted for four additional codes. The recommendations for these codes is based on a comparison of this data.

46716: Relative to CPT 46740 (as the anchor code), CPT 46716 data for intraop time (90) and HV (3) and OV (5) are all lower. Intraop intensity for 46716 is also less than 46740. **We recommend an RVW of 15.07** for 46716. This RVW maintains the previous relativity between 46716 and 46740. [old RVW ratio (12.15/24.19) = new RVW ratio (15.07/30.00)]

46730: Relative to CPT 46740 (as the anchor code), CPT 46730 intraop time (180) and HV (5) and OV (6) are the same. Intraop intensity for 46730 is less than 46740. **We recommend an RVW of 26.75** for 46730. This RVW maintains the previous relativity between 46730 and 46740. [old RVW ratio (21.57/24.19) = new RVW ratio (26.75/30.00)]

46735: Relative to CPT 46740 (as the anchor code), CPT 46735 intraop time (230) and HV (7) are higher and OV (6) is the same. Intraop intensity for 46735 is similar to 46740. This procedure, however, is the same as 46730, with an additional abdominal approach. **We recommend an RVW of 32.17** for 46735. This RVW maintains the previous relativity between 46730 and 46735. [old RVW ratio (21.57/25.94) = new RVW ratio (26.75/32.17)]

46742: Relative to CPT 46740 (as the anchor code), CPT 46742 intraop time (240) and HV (7) are higher and OV (6) is the same. Intraop intensity for 46742 is higher than 46740. **We recommend an RVW of 36.80** for 46742. This RVW maintains the previous relativity between 46740 and 46742. [old RVW ratio (24.19/29.67) = new RVW ratio (30.00/36.80)]

Family Code Summary:

46740 anchor

46716 ratio to 46740 maintained

46730 ratio to 46740 maintained

46735 ratio to 46730 maintained

46742 ratio to 46740 maintained

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatric Surgery 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: Pediatric Surgery	Frequency: (for 46716)	500
	Frequency: (for 46730)	300
	Frequency: (for 46735)	300
	Frequency: (for 46740)	500
	Frequency: (for 46742)	300

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: Pediatric Surgery Frequency: 0 for all codes

Do many physicians perform this service across the United States? No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

7 Yes
13 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree
7 I do not agree

c. Patients requiring this service are now:

5 more complex (more work)
0 less complex (less work)
2 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient
0 from inpatient to outpatient
7 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

Survey CPT Code: 46744

Global: 090

Current RVW: 33.21
Recommended RVW: 52.63

CPT Descriptor: Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach

Family CPT Code: 46746

Global: 090

Current RVW: 36.74
Recommended RVW: 58.22

CPT Descriptor: Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;

Family CPT Code: 46748

Global: 090

Current RVW: 40.52
Recommended RVW: 64.21

CPT Descriptor: Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps

Typical Patient (Survey Vignette): A 3-month old female with a cloaca had a newborn colostomy and is now admitted to the hospital for bowel prep and repair of the cloaca through a combined abdominal and sacroperineal approach. A shortened vagina is found and high dissection is required to obtain adequate length. Urethral reconstruction is performed. The vagina is positioned and a perineal body is created. The anus is positioned within the muscular sling that is recreated and the anoplasty performed. Anomalies of the lower GU tract are corrected, if present. Early postoperative care includes management of third space losses, infection control, and management of catheters. After discharge, postoperative rectal dilatations are instituted in the office and urinary function is monitored.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery

- Write pre-operative orders for perioperative medications
- Review pre-operative work-up, with particular attention to x-rays, ultrasounds (including spine and kidneys), MRI's, CT scans and renal scans
- Review pre-operative blood tests
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Arrange for surgical assistant
- Confirm adequacy of bowel clean-out and adjust orders as needed
- Write orders for bowel prep
- Discuss procedure and post op course with family
- Obtained informed consent and assure outcome expectations

Pre-service work – Day of surgery

- Check with laboratory – confirm that blood and/or x-match is available
- Change into scrub clothes
- Review the surgical procedure, post-operative recovery in and out of hospital, and expected outcomes with patient and family (extensive)
- Write preoperative note in patient record
- Answer patient and family questions and obtain informed consent. Arrange where to meet postoperatively and where to reach family intra-operatively, if needed.
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient with OR team
- Verify that all the necessary surgical instruments and surgical supplies are readily available

- Review preop xrays for final verification
- Irrigate colon from above and below to be sure that bowel prep is adequate and effluent is clear
- Monitor patient positioning, total body circumferential skin prep and draping
- Scrub and gown

Intra-service work - Skin to skin:

- Patient is placed in the prone position so that patient can be sterilely turned supine intraoperatively if needed, and all pressure points are padded
- Electrical stimulation of the perineal musculature is performed and center of sphincter complex is marked both with ink and sutures
- Posterior sagittal incision is created and the levator musculature is carefully divided in the midline
- Probe is placed in the UG sinus to facilitate dissection
- Dissection is carried anteriorly to the urogenital sinus and the sinus is opened longitudinally
- Dissection is carried in cranial direction until the vaginal fistula to the UG sinus is identified.
- Vagina is carefully dissected off the UG sinus and the bladder neck – this is a very difficult dissection and care must be taken not to injure the bladder neck or the bladder.
- As dissection proceeds cranially, the fistula from the rectum to the vagina is identified.
- Rectum is dissected away from the vagina and is mobilized superiorly as far as possible
- Vagina is mobilized as far superiorly as possible
- Urethral catheter is placed into the bladder via the bladder neck and secured in place with sutures
- Urogenital sinus tissue is then mobilized while protecting its blood supply carefully from the perineum to the bladder neck in order to create a urethra
- Urogenital sinus is then tubularized around the urethral catheter to create a neo-urethra with fine, running absorbable suture
- A second layer of peri-urethral tissue is sutured over the length of the closure of the neo-urethra to reinforce the closure
- Muscle stimulator is used to locate the muscle fibers of the levator sling
- Meticulous control of bleeding is performed with fine needle cautery as the reconstruction continues
- The mobilized vagina is advanced downward to the perineum and sutured to the perineal skin and the pelvic musculature to anchor it securely.
- A Hagar dilator is placed in the vagina to calibrate it
- Levator musculature is sutured behind the vagina to separate the vagina and the rectum and to create the perineal body. The muscle stimulator is used repeatedly to define the musculature, and multiple layers of sutures are used.
- The rectum is then advanced downward and sewn anteriorly to the levator muscle and the perineal body. The rectum is placed such that it is exactly in the center of the maximal contraction of the levator muscle.
- A Hagar dilator is placed in the rectum to calibrate it.
- The sides of the rectum are sewn to the levator muscle
- The anterior rectum is trimmed and sewn to the perineal skin with interrupted sutures.
- If the pulled-through colon is too dilated, a wedge of posterior colon is removed and the colon is closed in two layers longitudinally to taper it.
- The posterior levator musculature is sutured to the posterior rectum with the Hagar dilator in place to prevent excessive narrowing of the rectum
- The posterior rectum is trimmed and anastomosed to the posterior perineal skin to finish fashioning the neo-anus.
- The soft tissue behind the levator muscle is closed with interrupted suture
- The skin of the perineum is closed with interrupted suture
- The muscle stimulator is used to check that the anus and rectum have been placed in the center of maximal levator muscle contraction
- Hagar dilators are passed via the vagina and rectum to guard against excessive narrowing
- The urethral catheter is carefully and securely anchored to the skin of the perineum
- A small Vaseline gauze packing is placed partially into the vagina
- A dry dressing is applied to the suture lines.

Post-op Same day work through discharge from operating suite to ICU

- Dress wound and drainage tubes with sterile dressings.
- Transfer patient to transport bed with appropriate monitoring.
- Sign OR forms, indicating pre and post-op diagnosis and operation performed.
- Accompany patient back to the ICU with anesthesiologists and nurses.
- Transfer patient to ICU bed with appropriate monitoring equipment.
- Write orders for post-op labs, x-rays, initial ventilator settings, monitors, drains, medications, diet, and nursing care.
- Adjust ventilator.
- Place drainage tubes on appropriate suction. Secure Foley catheter drainage.
- Review postoperative chest x-ray.
- Review postoperative blood studies.
- Write an op note in the patient's record.
- Discuss procedure outcome with family.
- Dictate post-op report.
- Discuss procedure outcome with referring physician.
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company.
- Examine patient for postoperative stability.
- Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings.
- Write and summarize orders for ICU nurse.

Post-op Same day work after transfer to ICU

- Examine patient, check wounds and patient progress.
- Wean ventilator as able.
- Check function of NG tube, Foley catheter, fluid and electrolyte status and urine output.
- Review nursing/other staff patient chart notes.
- Answer patient family questions.
- Answer nursing/other staff questions.
- Write orders for following day's labs, x-rays, medications, diet, and nursing care.
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine and talk with patient family
- Check wounds, vagina and rectum and patient progress
- Check fluid and electrolyte status; correct deficits if present
- Extubate when appropriate and order supplemental oxygen therapy
- Determine when transfer from ICU is appropriate
- Determine when PO intake can begin and advance diet when appropriate
- Carefully evaluate temperature evaluation and any wound drainage
- Assure adequate urine output and urethral tube patency
- Review any laboratory tests, x-rays or images that have been obtained in the previous 24-hours.
- Discuss patient progress with referring physician (written and verbal)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff question (written and verbal)
- Answer insurance company questions
- Write orders for post-operative medications, laboratories, x-rays and other imaging tests, diet and activity
- Chart patient progress notes
- Determine when urethral catheter can be removed (usually not before 10-14 post-operative days)
- Instruct patient/family in technique of clean, intermittent catheterization if necessary after urethral catheter has been removed.

Discharge day work –

- Examine and talk with patient
- Check final pathology report and/or test results and discuss with patient
- Explain to patient/family dietary management, activity restrictions, bathing, return appointments, care of any residual tubes or drains
- Check wounds and patient progress
- Verify that patient/family is comfortable with clean, intermittent catheterization and has necessary supplies, if necessary
- Review nursing/other staff notes
- Review post-discharge wound care and activity restrictions
- Answer patient/family questions
- Answer nursing/staff questions
- Answer insurance staff questions
- Write orders for discharge, including prescriptions, x-rays or other imaging as well as follow-up appointments
- Chart patient progress notes
- Notify referring physician of discharge and post-discharge plans

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress
- Assess patient/family's ability to perform clean, intermittent catheterization and be sure they have adequate supplies
- Instruct patient/family on vaginal and rectal dilations, including providing a schedule of intervals and sizes of dilators. Be sure they have adequate supplies for dilations.
- Assure adequacy and progression of dilatations
- Answer patient/family questions
- Answer insurance staff questions (verbal and written)
- Discuss patient progress with referring physician (verbal and written)
- Write prescriptions as needed
- Review any post-discharge laboratory tests and x-rays or images
- Discuss progress with patient/family
- Remove any remaining sutures or drains
- Dictate patient progress notes for medical record
- Arrange for future follow-up or surgical interventions
- Arrange for consultations with other specialists, if needed
- Discuss timing of colostomy closure

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 28 (52%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	32.00	44.00	52.63	55.00	63.23

Pre-Service			138		
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Intra-Service	180	300	360	443	720
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Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	45	
Critical Care	120	99291x2
Other Hospital	251	99233x3 99232x3 99231x2
Discharge Day Mgmt	38	99239
Office Visits	228	99214x6

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
39.52	90	51596	Cystectomy, complete, with continent diversion, any technique, using any

segment of small and/or large bowel to construct neobladder

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (MEDIAN)	Survey CPT 46744 (n=28)	Ref CPT 51596 (n=7)
Pre-service time	138	90
Intra-service time	360	240
Immediate Post-service time	45	45
Total critical care time	120	0
Total other hospital visit time	251	199
Discharge management time	38	35
Total office visit time	228	122

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.63	4.00
Intra-service	5.00	4.43
Post-service	4.56	4.14

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.46	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.82	3.71
Urgency of medical decision making	3.75	3.71

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	4.14
Physical effort required	4.57	3.86

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.86	4.57
Outcome depends on the skill and judgment of physician	5.00	4.29
Estimated risk of malpractice suit with poor outcome	4.21	3.86

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

Congenital cloacal anomalies are rare. They require creation of the anorectal, urethral and vaginal structures. The diagnostic assessment, operative planning, execution of the procedure, and post-operative management are as complex as any developmental anomaly in pediatric surgery possibly with the exception of Siamese Twins. The entire process must occur in a single operative event of significant magnitude in order to create any hope for optimal functional outcome. When this family of codes (46744, 46746, 46748) were originally surveyed and valued, data were provided by "guestimate" because few surgeons performed or had experienced this operation during training. These children are typically managed at a limited number of centers.

A RUC survey of these codes was performed (see Attachment VI-7) for the first time. Many of the survey respondents expressed some limited experience in the past 12 months but all had had experience during training or at specialized course taught by the masters of these procedures. A consensus panel (see Attachment I), which included some of the experts in this field, reviewed the survey and made final

- 0 I agree
- 2 I do not agree

c. Patients requiring this service are now:

- 2 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 2 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 49215

Global: 090

Current RVW: 23.20

Recommended RVW: 33.50

CPT Descriptor: Excision of presacral or sacrococcygeal tumor

Typical Patient (*Survey Vignette*): A 3.0-kg infant presents with a prenatally diagnosed very large sacrococcygeal mass with superficial erosion of the skin. Urgent surgery is required because of the potential for rupture and bleeding. An ultrasound reveals presacral extension. A perineal/sacral approach is used and the entire tumor and presacral component are excised. The rectum is spared with careful dissection and a dilator to identify the rectal extent. Repair of the levator mechanism is accomplished and the wound is closed in layers with a plastic repair of the skin. Drains are placed. Postoperative ventilation is required and third space losses are managed. Patient hospital and office follow-up care through the 90-day global period also includes wound management and checks for urinary and stool function.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- None – surgery is the day of birth.

Pre-service work - Day of surgery:

- Check with lab to make certain that there is blood x-matched and available.
- Change into scrub clothes.
- Review surgical procedure with family, obtain surgical consent and review expected outcome with family, including bleeding and death. Review over phone operative procedure with mother who is still in postpartum area, usually in outside institution if baby is outborn.
- Review preoperative films in operating room including plain films and ultrasound for proposed surgical approach.
- Review length and type of anesthesia with anesthesiologist.
- Review planned procedure and positioning and draping of patient. Total body prep usually required.
- Verify that all surgical instruments and supplies are readily available in the operative suite.
- Monitor patient positioning and draping and assist as needed.
- Scrub and gown.

Intra-service work - Skin to skin:

- Packing is sterilely placed in the rectum.
- Foley is placed.
- Skin incision is made outlining the proposed skin flaps on the buttocks, depending on the size and extent of the tumor.
- Upper and lower skin flaps are made, preserving blood supply to the flaps.
- Dissection is carried inferiorly and laterally around the tumor.
- Tumor is dissected off the rectum, using dilator and possible muscle stimulator for identification of rectal wall. Remove packing if used.
- Dissection is continued up retrorectal space.
- Coccyx is freed and separated using bone instruments
- Middle sacral artery identified and ligated
- Tumor and coccyx are removed enbloc
- Presacral dissection continues for the extent of the tumor
- The patient is turned sterilely and laparotomy performed if required
- Frozen section is obtained
- Wound is irrigated.
- Wound is inspected for other abnormal areas.

- Frozen section report is given—additional biopsies may be needed if malignant.
- Posterior rectal wall and levator muscles are reapproximated in the midline.
- Insert drains.
- Deep layers of the wound are closed to reconstruct the normal buttock and buttock crease.
- Skin is closed with plastic repair.
- Rectal packing is removed.
- Secure Foley catheter

Post-op Same day work through discharge from operating suite to NICU

- Dress wound and drainage tube with sterile dressings.
- Transfer patient to transport isolette with appropriate monitoring.
- Sign OR forms, indicating pre and post-op diagnosis and operation performed.
- Accompany patient back to the NICU with anesthesiologists and nurses.
- Transfer patient to neonatal heating bed with appropriate monitoring equipment.
- Accompany infant back to NICU.
- Write post-operative orders for medications, intravenous fluids, labs, x-rays, and ventilator settings.
- Review operative findings and post-operative orders with NICU nursing staff.
- Discuss operation with parents.
- Discuss operation and outcome with referring obstetrician and pediatrician or neonatologist.
- Assess arterial blood gas (ABG) results and adjust ventilator settings.
- Assess peripheral perfusion and adjust intravenous fluids.
- Monitor urine output and acid/base status.
- Monitor blood sugars.
- Check post-operative chest x-ray for position of all tubes and lung fields.
- Re-position tubes as indicated by x-ray.
- Re-examine infant and check repeat ABG, urine output, perfusion, and post-operative labs including blood sugar.
- Treat any laboratory abnormalities.
- Place drainage tube on appropriate suction.
- Place Foley to drainage
- Review postoperative chest x-ray.
- Review postoperative blood studies.
- Write an op note in the patient's record.
- Discuss procedure outcome with family.
- Dictate post-op report.
- Discuss procedure outcome with referring physician.
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company.
- Examine patient for postoperative stability.
- Revisit patient to assess progress, pulmonary, cardiac, renal function and status of dressings.
- Write and summarize orders for NICU nurse.

Post-op Same day work after transfer to NICU

- Examine patient, check wounds and patient progress.
- Wean ventilator as able.
- Check function of NG tube, fluid and electrolyte status and urine output.
- Review nursing/other staff patient chart notes.
- Answer patient family questions.
- Answer nursing/other staff questions.
- Write orders for following day's labs, x-rays, medications, diet, and nursing care.
- Chart patient progress notes.
-
- Frequent revisit patient to assess progress, pulmonary, cardiac, renal function and status of dressings.

- Check blood gases and labs.

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Examine patient, talk with family.
- Check wounds and patient progress.
- Assure hemodynamic stability and pulmonary and renal function
- Check blood gases and labs
- Adjust ventilator settings to wean infant from ventilator.
- Monitor acid/base status and perfusion.
- Monitor labs including ABG, glucose, electrolytes, CBC, albumin at least once daily.
- Replace NG tube losses.
- Check chest x-ray daily until extubated.
- Extubate when appropriate and use supplemental oxygen as needed
- Determine if patient can start diet by mouth, assess bowel function.
- Check wound, vital signs and wound drainage. Assess need for drain.
- Assess need for Foley.
- Review nursing and other staff notes.
- Answer nursing and other staff questions (verbal and written).
- Answer insurance staff questions.
- Discuss patient progress with referring physician (verbal and written).
- Write orders for postop labs, films, medications, diet and patient activity.
- Chart patient progress notes.

Discharge day work –

- Examine patient.
- Talk with family, answer questions.
- Check final pathology-review with family.
- Carefully explain to family dietary management, wound care, drain care if still in, activity permitted, bathing, return appointments.
- Check wound, review postoperative wound care with family.
- Review nursing and other staff questions.
- Answer family questions.
- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for post-discharge labs, films, and medication.
- Arrange home nursing
- Chart patient discharge notes.

Post-op Office work - After discharge from hospital

- Examine patient. Talk with family.
- Check wounds and patient progress.
- Remove sutures and drain.
- Discuss at this time any additional or adjuvant treatments that may be required and referrals.
- Check anal and bladder function
- Answer family questions.
- Answer insurance staff questions.
- Discuss patient progress with referring physician (verbal and written).
- Write orders for medications.
- Review post discharge labs/films.
- Discuss progress with family.
- Dictate patient progress notes for medical chart.

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 30 (56%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	25.00	30.00	33.50	37.48	50.00
Pre-Service			118		
Intra-Service	120	180	180	233	260
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	35				
Critical Care	630	99291x2 99292x1			
Other Hospital	183	99233x3 99232x2			
Discharge Day Mgmt	36	99238			
Office Visits	69	99213x3			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
20.89	90	45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 49215 (n=30)	Ref CPT 45116 (n=8)
Pre-service time	118	103
Intra-service time	180	150
Immediate Post-service time	35	30
Total critical care time	630	0
Total other hospital visit time	183	177
Discharge management time	36	35
Total office visit time	69	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.14	3.25
Intra-service	4.66	3.50
Post-service	4.07	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.03	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.25
Urgency of medical decision making	4.52	3.13

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.62	3.63
Physical effort required	4.07	3.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.48	3.63
Outcome depends on the skill and judgment of physician	4.62	4.00
Estimated risk of malpractice suit with poor outcome	3.90	3.25

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI-9). A consensus panel (see Attachment I) reviewed the survey and made final recommendation. CPT 49215 has notations in the Harvard Study that indicate it took two cycles of surveys and two panels to provide intraop survey data, and still the survey sample was low. Therefore, the magnitude estimation for work/intensity from that study is suspect. Additionally, the patient population requiring this procedure has changed. When originally valued, there were no prenatal diagnoses for this condition. The patient population now includes more preterm infants and infants that are hemodynamically unstable, who would not previously survived to require this procedure. The intraservice work compared to the reference code 45116 is much more intense and longer due to the size, vascularity, and anatomic relationships of these tumors. These neonates, who are critically ill, require NICU care typically for 5 days (survey 25th pctl is 3 days and 75th pctl is 6 days). We also note that the neonatal codes were not valued when this code was last reviewed. We note that the recommended survey median RVW of 33.50 does not fully compensate for even the post-op work of this code. **We recommend an RVW of 33.50.**

Building block comparison:

33.50 Recommended RVW

37.88 Subtract postop HV & OV RVWs

(4.38) negative balance left for pre-service and intra-op work

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatric Surgery 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: Pediatric Surgery Frequency: 100

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Pediatric Surgery Frequency: 20

Do many physicians perform this service across the United States? No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

12 Yes

8 No

b. This service represents new technology that has become more familiar (i.e., less work).

1 I agree

10 I do not agree

c. Patients requiring this service are now:

- 12 more complex (more work)
- 0 less complex (less work)
- 0 no change

d. The usual site-of-service has changed:

- 0 from outpatient to inpatient
- 0 from inpatient to outpatient
- 10 no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

Survey CPT Code: 49605

Global: 090

Current RVW: 24.94

Recommended RVW: 76.00

CPT Descriptor: Repair of large omphalocele or gastroschisis; with or without prosthesis

Family CPT Code: 49606

~~Global: 090-~~
Rec. global: 000

~~Current RVW: 27.51~~

Rec. RVW: *to be discussed*
18.60

CPT Descriptor: Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room

Typical Patient (Survey Vignette): An 1800-gram preemie with the prenatal diagnosis is born with gastroschisis with a thick peel on the surface of intestine all of which is extra-abdominal. During the repair, the bladder pressure and gastric pressure, and ventilatory compliance are parameters used to determine the feasibility of primary closure. After primary repair, the baby is maintained on the ventilator postoperatively. The fluid and metabolic issues are monitored and corrected. The blood flow to the bowel is carefully monitored with blood gases and physical examination. Venous return from extremities is monitored, as well as abdominal examination. Prolonged naso-gastric suction and central nutrition are required until intestinal function has recovered. The child is carefully monitored for weight gain and intestinal function through the 90-day global period. (Please remember that although your care may continue after 90 days, only consider the work through this 90-day global period for this survey.)

CLINICAL DESCRIPTION OF SERVICE:

Pre-Service Work: All emergent

- Arrange emergency transport to hospital.
- Review with transport team proper care of infant including dressing of eviscerated abdominal organs and management of possible meconium aspiration.
- Arrange for admission to Neonatal Intensive Care Unit (NICU).
- Review perinatal history.
- Perform physical examination upon arrival to NICU.
- Evaluate viability of eviscerated abdominal organs and assess need for enlarging abdominal wall defect.
- Perform endotracheal intubation.
- Monitor arterial blood gases and adjust mechanical ventilation parameters.
- Assess intravascular volume and begin intravenous fluids.
- Order perinatal medications and infant screening tests.
- Arrange chest x-ray and interpret chest x-ray.
- Arrange for cardiac echocardiography to evaluate for cardiac anomalies.
- Arrange for abdominal ultrasonography to assess for renal anomalies.
- Monitor and treat potential hypoglycemia.
- Insert arterial line for monitoring.
- Review lesion, prognosis, and treatment options with family.
- Obtain informed consent from family.
- Arrange operating room start time.
- Discuss infant's lesion and associated anomalies with anesthesiologist.
- Review anesthesia plan with anesthesiologist.
- Arrange for intra-operative monitoring of intra-abdominal pressure.
- Confirm availability of all necessary OR equipment and adequate temperature in OR.
- Accompany infant in transport from NICU to operating room.

- Position infant on OR table.
- Perform rectal dilatation and rectal wash-out.
- Insert Foley catheter.
- Set-up intragastric pressure monitoring.
- Ligate umbilical cord and amputate stump.
- Perform sterile prep of abdominal contents and abdomen.
- Drape patient.
- Scrub and gown.

Intra-service work – Skin to skin:

- Carefully replace abdominal organs into abdominal cavity.
- Assess intra-abdominal pressure and/or ventilatory changes.
- Determine whether primary closure is safe.
- Remove omphalocele sac if present.
- Ligate and divide umbilical cord structures beneath the fascia.
- Dissect skin from fascia raising skin flaps circumferentially.
- Place multiple interrupted sutures in fascia and rectus muscle.
- Begin to close fascia primarily, monitoring intra-abdominal pressure and ventilatory parameters.
- Perform rectus muscle mobilization if primary closure is too tight.
- If still too tight, place prosthetic patch in abdominal wall.
- If primary closure not possible then construct silo
- Suture silo to fascia
- Close skin.
- Create neo-umbilicus using small skin flaps.

Post-op Same day work through discharge from operating suite to NICU

- Apply dressings.
- Write op note in patient's chart.
- Sign all OR forms, confirming pre-operative and post-operative diagnosis and operation performed, and intra-operative medications given.
- Accompany infant back to NICU.
- Write post-operative orders for medications, intravenous fluids, labs, x-rays, and ventilator settings.
- Review operative findings and post-operative orders with NICU nursing staff.
- Discuss operation with parents.
- Discuss operation and outcome with referring obstetrician and pediatrician or neonatologist.
- Assess arterial blood gas (ABG) results and adjust ventilator settings.
- Assess peripheral perfusion and adjust intravenous fluids.
- Monitor urine output and acid/base status.
- Monitor blood sugars.
- Check post-operative chest x-ray for position of all tubes and lung fields.
- Re-position tubes as indicated by x-ray.
- Dictate operative report.
- Re-examine infant and check repeat ABG, urine output, perfusion, and post-operative labs including blood sugar.
- Treat any laboratory abnormalities.
- Discuss peri-operative management with cardiologist (if associated cardiac anomaly).
- Chart patient progress note.

Post-op Other Hospital work - Beginning on post-op day 1, in NICU

- Examine patient daily.
- Adjust ventilator settings to wean infant from ventilator.
- Monitor acid/base status and perfusion to assess for abdominal compartment syndrome.
- Monitor labs including ABG, glucose, electrolytes, CBC, albumin at least once daily.

- Check wound and abdomen for tightness.
- Replace NG tube losses.
- Check chest x-ray daily until extubated.
- Insert PICC line.
- Begin total parenteral nutrition (TPN).
- Adjust composition of TPN daily based on labs.
- Answer nursing staff questions daily.
- Discuss progress and plans with family daily.
- Write progress notes daily.
- Arrange transfer to ward when extubated and stable.
- Write transfer orders.

Hospital days non-NICU

- Examine patient daily.
- Check wound and abdomen for tightness.
- Examine lungs and heart daily.
- Monitor labs several times each week.
- Replace NG tube losses if continually excessive.
- Adjust TPN composition daily as necessary.
- Withdraw NG tube when bowel function begins.
- Gradually begin enteral feeding via feeding tube.
- Discuss nutritional plans with dietician.
- Monitor oxygen saturation.
- Arrange for anti-reflux wedge and medications.
- Gradually increase enteral feeding rate and decrease TPN rate.
- Monitor carefully for tolerance of enteral feedings, including stool volume, reducing substances, fat content, and blood.
- Obtain abdominal x-rays to exclude necrotizing enterocolitis if feeding is poorly tolerated.
- Chart daily progress notes.
- Discuss progress and plans with parents.
- Update community pediatrician.
- Discuss plans and questions with nursing staff daily.

Discharge day work

- Examine patient and discuss with family.
- Carefully explain to parents the feeding plan and warning signs of feeding intolerance.
- Discuss status and plans with community pediatrician.
- Review all notes and nursing staff assessment for discharge readiness.
- Answer all parents questions.
- Write discharge orders for special nutritional formulas and enteral pump, TPN if necessary, anti-reflux medications, diuretics if necessary.
- Arrange home nursing or home health care.
- Arrange for weekly labs if still on TPN.
- Discuss with insurance company.
- Dictate discharge summary.

Post-op Office Work – After discharge from hospital

- Examine patient.
- Review weight gain and biometric measurements.
- Check character of stool.
- Review outpatient labs if still on TPN or special enteral formula.
- Gradually wean to enteral and oral feedings
- Discuss progress and follow-up plans with community pediatrician.

- Answer parents' questions and detail feeding progression.
- Arrange future follow-up visits.

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 31 (57%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	28.00	47.50	76.00	92.50	160.00
Pre-Service			110		
Intra-Service	60	90	120	135	200
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	50				
Critical Care	1620	99291x9 99292x2			
Other Hospital	450	99233x5 99232x5 99231x5			
Discharge Day Mgmt	40	99239			
Office Visits	114	99214x3			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
14.50	90	44120	Enterectomy, resection of small intestine; single resection and anastomosis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 49605 (n=31)	Ref CPT 44120 (n=10)
Pre-service time	110	78
Intra-service time	120	108
Immediate Post-service time	50	30
Total critical care time	1620	0
Total other hospital visit time	450	117
Discharge management time	40	35
Total office visit time	114	35

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.30	3.30
Intra-service	4.37	3.10
Post-service	4.67	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.30
Urgency of medical decision making	4.70	3.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.07	3.20
Physical effort required	3.73	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.67	2.90
Outcome depends on the skill and judgment of physician	4.60	3.10
Estimated risk of malpractice suit with poor outcome	3.90	2.70

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI - II). A consensus panel (see Attachment I) reviewed the survey and made final recommendation. Primary repair without silo is more typically performed than previously. Neonates requiring this procedure are "typically" in the hospital 30 days (survey 25th pctl LOS was 24 days and 75th pctl LOS was 34 days), with 14 days of critical neonatal care. A recent study addressing LOS and complexity of postoperative care is attached (Attachment IV). Daily care is significant – as described in the service description. These infants are initially hemodynamically unstable and require precise ventilator management. There is prolonged need for parenteral nutrition management due to delayed intestinal function. We also note that the neonatal codes were not valued when this code was last reviewed and the post service work alone exceeds the recommended RVWs.

Since the survey median RVW of 76.00 does not fully compensate for even the post-op work of this code, the consensus panel debated recommending significantly more RVWs, but ultimately agreed to retain the survey median in consideration of RUC precedent. We would like *consideration* given to changing the global period from 90 days to 0 days to deal with the unique post service work.

We also recommend that the global period for 49606 be changed to 000 days, as, when performed, this is an additional procedure performed within the global period of 49605. If this recommendation is accepted by the RUC and by HCFA, APSA will be pleased to re-survey CPT 49606 as a 000-day global procedure to determine an accurate value. Current mini-survey data indicates the intraop time is 75 minutes for 49606.

Note: the RUC database incorrectly indicates that 49605 was performed 57% of the time in an *outpatient* setting. This procedure – if correctly coded – would never be performed in an outpatient setting. The 1996, 1997, and 1998 HCFA utilization files do not indicate any nonfacility frequency for this code.

Simplified building block comparison:

76.00 Recommended RVW

93.04 Subtract postop HV & OV RVWs

(17.04) Negative balance RVWs for pre-op and intra-op work

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatric Surgery 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: Pediatric Surgery Frequency: 1000

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Pediatric Surgery Frequency: 10

Do many physicians perform this service across the United States? No

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

- a. Has the work of performing this service changed in the past 5 years?**
4 Yes
16 No
- b. This service represents new technology that has become more familiar (i.e., less work).**
0 I agree
4 I do not agree
- c. Patients requiring this service are now:**
3 more complex (more work)
0 less complex (less work)
1 no change
- d. The usual site-of-service has changed:**
0 from outpatient to inpatient
0 from inpatient to outpatient
4 no change

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 60100 Tracking Number: _____ Global Period: 000 Recommended RVW: 1.56

CPT Code Descriptor:

Clinical description of service: Bx thyroid, percutaneous core needle

Vignette Used in Survey: A 50 year old male presents with a 3 cm mass in the lower pole of the right lobe of the thyroid. Percutaneous core biopsy of this mass has been requested

Description of Pre-Service Work: The patient's history is reviewed for potential risk factors and etiologies for the mass. Previous imaging studies, which may have prompted request for biopsy, are reviewed along with any potential contraindications. Procedure is discussed with the patient including risks, complications, and alternatives.

Description of Intra-Service Work: The mass is localized for biopsy and a core of tissue is obtained. A frozen section may be obtained for adequacy of tissue. If imaging guidance is used, it is coded separately.

Description of Post-Service Work: Report is dictated regarding procedure. Patient is observed for complications. Postprocedure care is discussed with the patient including how they will obtain their results.

Survey data:

Presenter(s): James P. Borgstede, MD
 Specialty(s): American College of Radiology
 Sample Size: 262 Response Rate (%): 42 (16%) Median RVU: 1.8

Type of Sample: Random _____ Panel X Convenience _____

Explanation of sample size: _____

25th Percentile RVW: 1.56 75th Percentile RVW: 1.9 Low: 0.67 High: 3.2

Median Pre-Service Time (min): 15.0 Median Intra-Service Time (min): 25.0

25th Percentile Intra-Svc Time (min): 20.0 75th Percentile Intra-Svc Time (min): 30.0 Low: 5.0 High: 60.0

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code</u> <u>(List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>10.0</u>	_____
Critical Care	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Ice Visits	_____	_____

Key reference service:CPT Code
47000CPT Descriptor
Biopsy of liver, needle; percutaneousRVW
1.90**Relationship of code being reviewed to key reference service(s):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)**CPT Code****Reference
Service 1 CPT:**

Median Pre-Time	15.0	15.0
Median Intra-Time	25.0	25.0
Median Immediate Post-service Time	10.0	10.0
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.70	3.0
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	2.92
Urgency of medical decision making	2.48	2.65

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.73
Physical effort required	2.83	2.92

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.05	3.58
Outcome depends on the skill and judgement of physician	3.67	3.77
Estimated risk of malpractice suit with poor outcome	3.07	3.23

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.69	2.69
Intra-Service intensity/complexity	3.43	3.62
Post-Service intensity/complexity	2.17	2.50

Additional rationale

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

It is the opinion of the specialty society that the 25th percentile RVU most appropriately reflects the work of this procedure. This value would appropriately place this code and correct an existing rank order anomaly.

Frequency information

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Commonly X Sometimes _____ Rarely _____
 Specialty: _____ Commonly _____ Sometimes _____ Rarely _____

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Frequency 15,000
 Specialty: _____ Frequency _____

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Radiology Frequency 5,039*
 Specialty: _____ Frequency _____

Do many physicians perform this service across the United States?

Yes X No _____

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years?

Yes 11 No 29

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 6 I disagree 15

b. Patients requiring this service are now:

More complex (more work) 9 Less Complex (less work) _____ No change 14

c. The usual site-of-service has changed:

From outpatient to inpatient 1 From inpatient to outpatient 2 No change 20

Recommended RVW: 7.20

CPT Code/ Tracking: 6226X (S1) **Global Period:** 010

CPT Descriptor: Percutaneous lysis of epidural adhesions, with or without endoscopic guidance, using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., spring-wound catheter) including x-ray localization with or without contrast

Vignette Used in Survey: A 35-year-old male has severe pain (rated at 8/10) located in the right lower back and radiates down the outside of the right leg to the top of the foot and the big toe after multiple back operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. A catheter is placed percutaneously in the epidural space; an epidurogram is performed to identify the areas of scar, nerve constriction, and possible nerve inflammation and degree of fluid flow (or lack thereof) in the epidural space; and the epidural adhesions are lysed. [*Please note that this service has a global period of 10 days.*]

CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):

Description of Pre-Service Work:

Review of records and any pertinent imaging studies (e.g., spine MRI); examine patient for evidence of a single nerve root or spinal nerve dysfunction; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the catheter puncture site.

Description of Intra-Service Work:

The skin is locally anesthetized. The introduction needle is directed into the epidural space at the proper vertebral level or the caudal epidural space, under x-ray fluoroscopy. A flexible, directable catheter is introduced through the needle into the epidural space. The catheter tip is carefully maneuvered in the epidural space around bands of scar tissue until it is in the focal scar tissue at the target spinal nerve-nerve root. A contrast injection is performed to confirm needle tip or catheter location and determine degree of free flow of liquid in the epidural space (e.g., determine areas of scarring in the epidural space). This injection also is used with temporary fluorogram monitor views to evaluate the nerve roots and spinal nerves in the area and any focal constriction or swelling of the nerve. The free flow of dye through the epidural space adjacent to this target spinal nerve-nerve root is also determined. A decision on the number, type, and quantity of injections/infusions is made. For the typical patient described above, an injection is given at this point of hyaluronidase, local anesthetic, and steroid, followed 30 minutes later by an injection of hypertonic (10%) saline. The catheter exit site is dressed for sterility and secured and the patient is admitted to the hospital for two days. At 12-24 hours and at 24-48 hours later, injections are repeated, using local anesthetic, hyaluronidase, steroid, and hypertonic saline. Also, at each series of injections, a repeat epidural contrast injection is performed with temporary fluorogram monitor views to verify correct catheter placement. Also evaluated is the surrounding epidural space, including the gradual opening of constricted scar areas around the target nerves/nerve roots. After the third series of injections, the catheter is removed and a sterile dressing applied.

Description of Post-Service Work:

The patient is closely observed for one to two hours after each injection/infusion, for any new/ unexpected neurologic deficits. The physician communicates findings with the patient and other professionals (including written and telephone reports and orders). Additionally, two follow-up office visits are scheduled within the 10-day global period to monitor the patient for clinical response to the procedure and for wound care.

SURVEY DATA

Presenter(s): Samuel Hassenbusch, MD (AANS/CNS)
Peter Dempsey, MD (AANS)

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 59 **Response Rate (No. and %):** 34 (58%)

Type of Sample: Random

<u>Survey RVW</u>	Low: 3.40	25th%: 11.43	Med: 12.45	75th%: 13.43	High: 21.00
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TIME (min) AND VISITS

24 Hr Preceding Service: **Med: 38**

Day of Service

Pre-service time: **Med: 20**

Intra-service time: Low: 30 25th%: 60 **Med: 75** 75th%: 90 High: 150

Post ServiceTotal TimeCPT Code / # of visits

Same Day:	40	99233
After Same Day:		
Critical Care	0	
Other Hospital	20	99232 x 1
Discharge Mgmt	30	99238
Office	20	99212 x 2

KEY REFERENCE SERVICE(S):

<u>99 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
6.74	90	63650	Percutaneous implantation of neurostimulator electrode array, epidural
2.33	10	62282	Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); epidural, lumbar or caudal
0.60*	XXX	7600X	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint) including neurolytic agent destruction, paravertebral facet joint nerve or sacroiliac joint

*This RVW is proposed for new code 7600X (M13). To be presented at April/May 1999 RUC meeting.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Time Estimates (Median)	<i>Mean</i> Intensity/Complexity Measures		
	6226X (S1)	62282	63650
PRE-service time	58	40	65
INTRA-service time	75	75	60
POST-service time	110	40	45
Mental Effort and Judgment			
The number of possible diagnosis and/or the number of management options that must be considered	4.48	4.00	4.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	4.21	3.14	4.58
Urgency of medical decision making	2.91	2.29	3.25
Technical Skill/physical Effort			
Technical skill required	4.76	3.86	4.50
Physical effort required	3.79	3.14	3.75
Psychological Stress			
The risk of significant complications, morbidity and/or mortality	4.52	3.86	4.17
Outcome depends on skill and judgment of physician	4.58	4.14	4.42
Estimated risk of malpractice suit with poor outcome	4.70	4.14	4.17
Time Segments			
PRE-service intensity/complexity	3.48	2.29	4.25
INTRA-service intensity complexity	4.58	3.57	4.50
POST-service intensity complexity	3.42	2.00	4.00

ADDITIONAL RATIONALE :

New code 6226X (S1) describes percutaneous catheter-based treatment to reduce or eliminate inflammation and scarring in and around nerve roots or spinal nerves. After the catheter is placed, under fluoroscopic guidance, a series of injections or infusions are given over a span of one to four days, with repeat epidurograms to verify correct catheter placement and evaluate the opening of constricted scar areas around the target nerves/nerve roots.

The consensus committee reviewing the survey data for this code determined that the survey respondents may have used a "building block" approach to include all the services provided within the 10-day global, but may not have "adjusted" for multiple procedures with different global periods. For this reason, the survey median and survey 25th percentile have not been recommended.

The RVW of 7.20 recommended for this code is based on a building block approach that estimates the typical patient as having 2.5 injections/infusions over a two-three day hospital stay.

Component 1, catheter placement and injection of anesthetic and contrast: CPT 62279 most accurately covers this phase of the service, since it includes insertion of a catheter into the lumbar epidural space for injection of a diagnostic or therapeutic substance. Twice the total work of CPT 62279 is approximately equal to the first part of 6226X (S1) that covers catheter insertion into a scarred epidural space, injection of contrast and analgesic, and steering the catheter tip into position to deliver a neurolytic substance aimed at the adhesions. This equates to 3.16 RVUs (2 x 1.58 RVUs).

Component 2, injections/infusions: CPT 62282 is used as reference for this component since it covers the injection of neurolytic material into the lumbar epidural space. CPT 62282 has an RVW of 2.33 and a global of 10 days. We estimate that the "injection" portion of 62282 is approximately 1/3 of the total work or 0.77 RVUs. We also estimate

that the typical patient will receive between two to three injections. This equates to 1.94 RVUs (2.33 RVUs x 33% x 2.5 injections).

Component 3, fluoroscopic guidance: New code 7600X (M13) is used as reference for this component which is included as part of new code 6226X (S1) and not separately billable. We estimate that fluoroscopic guidance will be required for the initial catheter steering and placement, and once more during one of the repeat injections to further examine catheter position.. This equates to 1.20 RVUs (2 x 0.60 RVUs).

Component 4, evaluation and management: The survey indicates, and we concur, that there will be two level 2 post discharge office visits. This equates to 0.90 RVUs (2 x 0.45 RVUs).

These components equal 7.20 RVUs (3.16 + 1.94 + 1.20 + 0.90), which we believe to be a reasonable recommendation for this new code, which has "bundled" procedures and work from several codes into one.

FREQUENCY INFORMATION

How was this service previously reported?

64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service?

Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?

This procedure is performed about 1,000-2,000 times annually at multiple centers. This is a very selected technique for a specific subset of patients with chronic low back pain with radiculopathy.

Is this service performed by many physicians across the United States?

Yes No

Recommended RVW: 2.20

CPT Code/ Tracking: 62X01 (K1) **Global Period:** 000

CPT Descriptor: Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic

Vignette Used in Survey:

A 45-year-old male has severe pain (rated at 8/10) involving both arms and the neck after multiple neck operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. The patient is given a single subarachnoid or epidural narcotic injection in the cervical or thoracic space.

CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):

Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the injection site.

Description of Intra-Service Work:

An injection needle is directed into the subarachnoid or epidural space at the proper vertebral level, possibly under x-ray fluoroscopy. Care has to be taken to avoid damaging any nerve roots or spinal cord. A contrast injection is performed as necessary to confirm needle tip or catheter location and determine degree of free flow of liquid in the space to assure both safety and accuracy. The therapeutic injection(s) is performed through the same needle. The injection needle is removed and dressing applied.

Description of Post-Service Work:

The patient is closely observed for two to eight hours post-procedure in a monitored setting for any new, unexpected neurologic deficits and/or any change in vital signs (respiratory depression, bradycardia, altered mental status). The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Time Estimates (Median)	<i>Mean</i> Intensity/Complexity Measures		
	62X01 (K1)	62275	62298
Survey response count	63	31	24
PRE-service time	35	25	38
INTRA-service time	30	25	30
POST-service time	20	15	20
Mental Effort and Judgment			
The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.29	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	3.44	3.35	3.38
Urgency of medical decision making	2.74	2.45	2.75
Technical Skill/physical Effort			
Technical skill required	4.18	4.10	4.13
Physical effort required	3.16	3.06	3.04
Psychological Stress			
The risk of significant complications, morbidity and/or mortality	4.13	4.13	4.13
Outcome depends on skill and judgment of physician	4.20	4.23	4.17
Estimated risk of malpractice suit with poor outcome	4.25	4.29	4.04
Time Segments			
PRE-service intensity/complexity	2.82	2.77	2.75
INTRA-service intensity complexity	3.98	3.97	3.96
POST-service intensity complexity	2.84	2.63	2.83

ADDITIONAL RATIONALE (describe the process by which your specialty society reached your final recommendation):

New codes 62X01-62X04 were developed to systematically organize different routes for injection (subarachnoid, epidural), at different levels (cervical, thoracic, lumbar, caudal), for different substances (narcotic, anesthetic, steroid, antispasmodic).

The most difficult of the four procedures is 62X03, followed by 62X01 and 62X04 (approximately equal), and then 62X02.

Nine current CPT codes were deleted and crosswalked into these four new codes. Additionally, three of the codes include procedures that did not have specific codes assigned: 62X01 now includes injection, epidural, cervical of steroid or narcotic; 62X03 now includes infusion, epidural, cervical of antispasmodic, narcotic, or steroid; and 62X04 now includes infusion, epidural, lumbar of steroid.

It should also be noted that Harvard post-service data for each of the nine codes being deleted was predicted at 7 to 9 minutes. These services, whether performed in a facility or non-facility, will require frequent post-service monitoring of the patient and discharge management. The survey median post-service time for the four new codes 62X01-62X04 ranges from 15 to 30 minutes which is two to three times more than Harvard's predicted estimates. Harvard's pre-service time is also lower by 5 to 15 minutes. Harvard's intraservice time is only slightly lower than the new codes.

The survey median 2.20 is recommended for 62X01. This is the current RVW for deleted CPT 62298, most closely related to the new code as it is used in current practice. This RVW is slightly more than the other three codes (62274, 62275, 62288) being crosswalked to this new code, but less than the amount of work for the cervical procedure, which previously would have been coded using 64999. The consensus committee believes the survey median represents a fair balance of the portions of all codes combined.

FREQUENCY INFORMATION**How was this service previously reported?**

- 62274 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, single
- 62275 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, cervical or thoracic, single
- 62288 Injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; subarachnoid (separate procedure)
- 62298 Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural, cervical or thoracic (separate procedure)
- 64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service?

~~Commonly~~ Sometimes ~~Rarely~~

Estimate the number of times this service might be provided nationally in a one-year period?

Based on estimated percentages and 1997 Medicare frequency data, it is estimated that this new service will be provided to the Medicare population approximately 60,000 times. However, this service is more often provided to patients outside the Medicare population to treat intractable pain, primarily patients suffering from the effects of cancer therapy (eg, radiation damage, chemotherapy neuropathy, postsurgical scarring. Rarely, the injection might be used to treat spasticity of other motor dysfunction in a nerve, nerve root, or spinal cord level. Occasionally, the injection might be used for a non-cancer pain that is very severe and localized to a nerve, nerve root, or spinal cord dermatome level that could be ablated without causing significant functional impairment to the patient.

Is this service performed by many physicians across the United States?

Yes ~~No~~

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 1999)

Recommended RVW: 1.78

CPT Code/ Tracking: 62X02 (K2)

Global Period: 000

CPT Descriptor: Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

Vignette Used in Survey:

A 45-year-old male has severe pain (rated at 8/10) involving both legs and the lower back after multiple back operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. The patient is given a single subarachnoid or epidural narcotic injection in the lumbar or sacral space.

CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):

Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the injection site.

Description of Intra-Service Work:

An injection needle is directed into the subarachnoid or epidural space at the proper vertebral level, under x-ray fluoroscopy, as necessary. Care has to be taken to avoid damaging any nerve roots, cauda equina, or spinal cord. A contrast injection is performed as necessary to confirm needle tip or catheter location and determine degree of free flow of liquid in the space to assure both safety and accuracy. The therapeutic injection(s) is performed through the same needle. The injection needle is removed and dressing applied.

Description of Post-Service Work:

The patient is closely observed for two to eight hours post-procedure in a monitored setting for any new, unexpected neurologic deficits and/or any change in vital signs (respiratory depression, bradycardia, altered mental status). The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Time Estimates (Median)	<i>Mean</i> Intensity/Complexity Measures		
	62X02 (K2)	62278	62274
Survey response count	63	26	18
PRE-service time	35	30	35
INTRA-service time	20	20	23
POST-service time	15	10	15
Mental Effort and Judgment			
The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.04	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	3.25	3.08	3.22
Urgency of medical decision making	2.43	2.27	2.22
Technical Skill/physical Effort			
Technical skill required	3.43	3.35	3.24
Physical effort required	2.67	2.62	2.53
Psychological Stress			
The risk of significant complications, morbidity and/or mortality	3.35	3.12	3.59
Outcome depends on skill and judgment of physician	3.62	3.50	3.59
Estimated risk of malpractice suit with poor outcome	3.37	3.35	3.65
Time Segments			
PRE-service intensity/complexity	2.52	2.50	2.28
INTRA-service intensity complexity	3.19	3.04	3.17
POST-service intensity complexity	2.48	2.36	2.50

ADDITIONAL RATIONALE (describe the process by which your specialty society reached your final recommendation):

New codes 62X01-62X04 were developed to systematically organize different routes for injection (subarachnoid, epidural), at different levels (cervical, thoracic, lumbar, caudal), for different substances (narcotic, anesthetic, steroid, antispasmodic).

The most difficult of the four procedures is 62X03, followed by 62X01 and 62X04 (approximately equal), and then 62X02.

Nine current CPT codes were deleted and crosswalked into these four new codes. Additionally, three of the codes include procedures that did not have specific codes assigned: 62X01 now includes injection, epidural, cervical of steroid or narcotic; 62X03 now includes infusion, epidural, cervical of antispasmodic, narcotic, or steroid; and 62X04 now includes infusion, epidural, lumbar of steroid.

It should also be noted that Harvard post-service data for each of the nine codes being deleted was predicted at 7 to 9 minutes. These services, whether performed in a facility or non-facility, will require frequent post-service monitoring of the patient and discharge management. The survey median post-service time for the four new codes 62X01-62X04 ranges from 15 to 30 minutes which is two to three times more than Harvard's predicted estimates. Harvard's pre-service time is also lower by 5 to 15 minutes. Harvard's intraservice time is only slightly lower than the new codes.

The survey median 1.78 is recommended for 62X02. This is the current value for deleted CPT 62274, which has time and intensity/complexity measures closely related to the new code. The second referenced code 62278 has lower time and intensity/complexity measures across the board as compared with new code 62X02.

FREQUENCY INFORMATION**How was this service previously reported?**

- 62274 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, single
- 62278 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, single
- 62288 Injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; subarachnoid (separate procedure)
- 62289 Injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; lumbar or caudal epidural (separate procedure)

How often do physicians in your specialty perform this service?

~~Commonly~~ Sometimes ~~Rarely~~

Estimate the number of times this service might be provided nationally in a one-year period?

Based on estimated percentages and 1997 Medicare frequency data, it is estimated that this new service will be provided to the Medicare population approximately 560,000 times. However, this service is more often provided to patients outside the Medicare population to treat intractable pain. Rarely, the injection might be used to treat spasticity of other motor dysfunction in a nerve, nerve root, or spinal cord level. Less commonly, these procedures might be used for reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS).

Is this service performed by many physicians across the United States?

Yes ~~No~~

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 1999)

Recommended RVW: 2.35

CPT Code/ Tracking: 62X03 (K3)

Global Period: 000

CPT Descriptor: Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic

Vignette Used in Survey:

A 45-year-old male has severe pain (rated at 8/10) involving both arms and the neck after multiple neck operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. A catheter (subarachnoid or epidural) is placed in the cervical or thoracic space and an intermittent bolus of a narcotic is injected.

CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):

Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the catheter puncture site.

Description of Intra-Service Work:

An injection needle is directed into the subarachnoid or epidural space at the proper vertebral level, under x-ray fluoroscopy, as necessary. Care has to be taken to avoid damaging any nerve roots or spinal cord. A contrast injection is performed as necessary to confirm needle tip or catheter location and determine degree of free flow of liquid in the space to assure both safety and accuracy. An infusion catheter is threaded through the needle in the subarachnoid or epidural space. The therapeutic injection(s) or infusion is performed through the same needle. The injection catheter is removed and dressing applied, with detailed attention given to wound care to prevent infection which may lead to meningitis or epidural abscess.

Description of Post-Service Work:

The patient is closely observed for two to eight hours post-procedure in a monitored setting for any new, unexpected neurologic deficits and/or any change in vital signs (respiratory depression, bradycardia, altered mental status). The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

SURVEY DATA

Presenter(s): Michael Ashburn, MD (AAPM)
 Karl Becker, MD (ASA)
 Peter Dempsey, MD (AANS)
 Paul Dreyfuss, MD (AAPM&R)
 Thomas Faciszewski, MD (NASS)
 Samuel Hassenbusch, MD (AANS/CNS)

Specialty(s): American Academy of Pain Medicine, American Academy of Physical Medicine and Rehabilitation, American Society of Anesthesiologists, American Association of Neurological Surgeons/Congress of Neurological Surgeons, North American Spine Society

Sample Size: 209 **Response Rate (No. and %):** 60 (29%)

Type of Sample: random and panel

<u>Survey RVW</u>	Low: 1.80	25th%: 2.20	Med: 2.35	75th%: 3.00	High: 7.00
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TIME (min) AND VISITS

24 Hr Preceding Service: **Med: 30**

Day of Service

Pre-service time: **Med: 20**

Intra-service time: Low: 15 25th%: 30 **Med: 40** 75th%: 60 High: 120

<u>Post Service</u>	<u>Total Time</u>	<u>CPT Code / # of visits</u>
Same Day:	30	99238

KEY REFERENCE SERVICE(S):HVD

<u>Tot Min</u>	<u>99 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
55	2.15	000	62277	Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, continuous
n/a*	2.20	000	62298	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural, cervical or thoracic (separate procedure)

*There is no data available in the Harvard data files for these codes. We do not know how these codes were originally valued.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Time Estimates (Median)	Mean Intensity/Complexity Measures		
	62X03 (K3)	62277	62298
Survey response count	60	30	11
PRE-service time	50	50	40
INTRA-service time	40	30	40
POST-service time	30	30	20
Mental Effort and Judgment			
The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.73	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	3.88	3.70	3.36
Urgency of medical decision making	3.08	3.07	2.55
Technical Skill/physical Effort			
Technical skill required	4.47	4.10	4.27
Physical effort required	3.47	3.37	2.64
Psychological Stress			
The risk of significant complications, morbidity and/or mortality	4.42	4.17	4.27
Outcome depends on skill and judgment of physician	4.37	4.30	4.09
Estimated risk of malpractice suit with poor outcome	4.35	4.33	3.82
Time Segments			
PRE-service intensity/complexity	3.50	3.23	3.00
INTRA-service intensity complexity	4.38	4.13	4.09
POST-service intensity complexity	3.57	3.47	2.91

ADDITIONAL RATIONALE (describe the process by which your specialty society reached your final recommendation):

New codes 62X01-62X04 were developed to systematically organize different routes for injection (subarachnoid, epidural), at different levels (cervical, thoracic, lumbar, caudal), for different substances (narcotic, anesthetic, steroid, antispasmodic).

The most difficult of the four procedures is 62X03, followed by 62X01 and 62X04 (approximately equal), and then 62X02.

Nine current CPT codes were deleted and crosswalked into these four new codes. Additionally, three of the codes include procedures that did not have specific codes assigned: 62X01 now includes injection, epidural, cervical of steroid or narcotic; 62X03 now includes infusion, epidural, cervical of antispasmodic, narcotic, or steroid; and 62X04 now includes infusion, epidural, lumbar of steroid.

It should also be noted that Harvard post-service data for each of the nine codes being deleted was predicted at 7 to 9 minutes. These services, whether performed in a facility or non-facility, will require frequent post-service monitoring of the patient and discharge management. The survey median post-service time for the four new codes 62X01-62X04 ranges from 15 to 30 minutes which is two to three times more than Harvard's predicted estimates. Harvard's pre-service time is also lower by 5 to 15 minutes. Harvard's intraservice time is only slightly lower than the new codes.

The survey median 2.35 is recommended for 62X03. This is slightly more than the current values for deleted crosswalked codes 62276 and 62277, but less than the amount of work for the cervical procedure, which previously would have been coded using 64999. The consensus committee believes the survey median represents a fair balance of the portions of all codes combined for this infrequently performed procedure.

FREQUENCY INFORMATION**How was this service previously reported?**

62277 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, continuous

62298 Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural, cervical or thoracic (separate procedure)

64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service?

Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?

Based on estimated percentages and 1997 Medicare frequency data, it is estimated that this new service will be provided to the Medicare population approximately 3,800 times. However, this service is more often provided to patients outside the Medicare population to treat complicated pain in patients with unclear sources of pain. Rarely, the injection might be used to treat spasticity of other motor dysfunction in a nerve, nerve root, or spinal cord level. Less commonly, these procedures might be used for reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS).

Is this service performed by many physicians across the United States?

Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 1999)

Recommended RVW: 2.15

CPT Code/ Tracking: 62X04 (K4) **Global Period:** 000

CPT Descriptor: Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

Vignette Used in Survey:

A 45-year-old male has severe pain (rated at 8/10) involving both legs and the back after multiple back operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. A catheter (subarachnoid or epidural) is placed in the lumbar or sacral space and an intermittent bolus of a narcotic is injected.

CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):

Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the catheter puncture site.

Description of Intra-Service Work:

An injection needle is directed into the subarachnoid or epidural space at the proper vertebral level, under x-ray fluoroscopy, as necessary. Care has to be taken to avoid damaging any nerve roots or spinal cord. A contrast injection is performed as necessary to confirm needle tip or catheter location and determine degree of free flow of liquid in the space to assure both safety and accuracy. An infusion catheter is threaded through the needle in the subarachnoid or epidural space. The therapeutic injection(s) or infusion is performed through the same catheter. The injection catheter is removed and dressing applied, with detailed attention given to wound care to prevent infection which may lead to meningitis or epidural abscess.

Description of Post-Service Work:

The patient is closely observed for two to eight hours post-procedure in a monitored setting for any new, unexpected neurologic deficits and/or any change in vital signs (respiratory depression, bradycardia, altered mental status). The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Time Estimates (Median)	<i>Mean</i> Intensity/Complexity Measures		
	62X04 (K4)	62277	62279
Survey response count	59	29	23
PRE-service time	48	40	35
INTRA-service time	30	30	23
POST-service time	30	30	25
Mental Effort and Judgment			
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.62	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	3.56	3.59	3.22
Urgency of medical decision making	2.86	3.00	2.48
Technical Skill/physical Effort			
Technical skill required	3.86	3.97	3.43
Physical effort required	3.10	3.03	2.87
Psychological Stress			
The risk of significant complications, morbidity and/or mortality	3.88	3.97	3.52
Outcome depends on skill and judgment of physician	4.00	4.11	3.74
Estimated risk of malpractice suit with poor outcome	3.90	3.76	3.70
Time Segments			
PRE-service intensity/complexity	3.10	2.93	3.09
INTRA-service intensity complexity	3.83	3.83	3.65
POST-service intensity complexity	3.25	3.21	3.00

ADDITIONAL RATIONALE (describe the process by which your specialty society reached your final recommendation):

New codes 62X01-62X04 were developed to systematically organize different routes for injection (subarachnoid, epidural), at different levels (cervical, thoracic, lumbar, caudal), for different substances (narcotic, anesthetic, steroid, antispasmodic).

The most difficult of the four procedures is 62X03, followed by 62X01 and 62X04 (approximately equal), and then 62X02.

Nine current CPT codes were deleted and crosswalked into these four new codes. Additionally, three of the codes include procedures that did not have specific codes assigned: 62X01 now includes injection, epidural, cervical of steroid or narcotic; 62X03 now includes infusion, epidural, cervical of antispasmodic, narcotic, or steroid; and 62X04 now includes infusion, epidural, lumbar of steroid.

It should also be noted that Harvard post-service data for each of the nine codes being deleted was predicted at 7 to 9 minutes. These services, whether performed in a facility or non-facility, will require frequent post-service monitoring of the patient and discharge management. The survey median post-service time for the four new codes 62X01-62X04 ranges from 15 to 30 minutes which is two to three times more than Harvard's predicted estimates. Harvard's pre-service time is also lower by 5 to 15 minutes. Harvard's intraservice time is only slightly lower than the new codes.

The survey median 2.15 is recommended for 62X04. This is the current value for deleted CPT 62277 and most closely related to the new code as it is used in current practice, but less than the amount of work for the cervical procedure, which previously would have been coded using 64999. The second referenced code 62279 has lower time and intensity/complexity measures across the board as compared with new code 62X04. The consensus committee believes the survey median represents a fair balance of the portions of all codes combined.

FREQUENCY INFORMATION**How was this service previously reported?**

- 62276 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, differential
- 62277 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, continuous
- 62279 Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, continuous
- 64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service?

~~Commonly~~ **xx Sometimes** ~~Rarely~~

Estimate the number of times this service might be provided nationally in a one-year period?

Based on estimated percentages and 1997 Medicare frequency data, it is estimated that this new service will be provided to the Medicare population approximately 122,000 times. However, this service is more often provided to patients outside the Medicare population to treat complicated pain in patients with unclear sources of pain. Rarely, the injection might be used to treat spasticity of other motor dysfunction in a nerve, nerve root, or spinal cord level. Less commonly, these procedures might be used for reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS).

Is this service performed by many physicians across the United States?

xx Yes ~~No~~

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 7227X Tracking Number: K5 Global Period: XXX Recommended RVW: 0.83

CPT Descriptor:

Epidurography, radiological supervision and interpretation

(For injection procedure, see codes 62280-62282, 62X01-62X04)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

1) A 45 year old male with extensive rectal carcinoma involving the left lumbosacral plexus has intractable left perirectal pain but has lost much of his control of both bladder and bowel function. Various systemic medications (oral narcotic and non-narcotic), physical therapy, radiation therapy, chemotherapy have all failed to provide significant long-term pain relief. There are no further operative resection possible for the tumor.

This patient is a good candidate for a neurolytic injection because of the severity of the pain and the diminished control of bladder and bowel function. A neurolytic injection to ablate the left S2-4 nerve roots is recommended. The injection could be performed subarachnoid or epidural and an epidural approach is selected. A diagnostic epidurogram is performed to define the anatomic extent of the epidural space in this patient, and exclude adhesions or other reasons that the neurolytic substance cannot be delivered to the selected nerve roots.

2) A 62 year old female with chronic low back pain and a left L4 radiculopathy who is status post multiple lumbar surgeries. She has had a prior epidural steroid injection without significant response. She is referred for a diagnostic epidurogram to exclude epidural adhesion/fibrosis, and possible repeat therapeutic injection.

Description of Pre-Service Work:

The patient's prior imaging examinations (Radiographs, CT scans, MRI exams, ect.) of the level to be studied are reviewed in order to be familiar with the anatomy, anatomic variants, prior surgery and pathology.

Description of Intra-Service Work:

The patient is placed on an x-ray table in the prone, oblique or decubitus position. Preliminary fluoroscopy is performed to identify the appropriate level and approach for the initial needle placement, and the skin entry site marked. During the needle/catheter placement (the needle/catheter placement is a separate procedure and separately codeable and should not be considered in your assessment of physician work or practice expense for this code), intermittent fluoroscopy is used to confirm the correct approach and need for needle repositioning or realignment. When the needle position appears correct, a small test dose of radiographic contrast is injected to confirm proper position. If position is not correct (eg, subarachnoid or venous opacification), additional fluoroscopic guidance is provided during repositioning until proper position is achieved. If catheter is to be placed, additional fluoroscopic guidance is provided during and after the catheter placement to confirm proper position for injection of the full diagnostic dose of contrast. Following epidural space injection of appropriate radiographic contrast (separately codeable and not included in the physician work for this code), multiple radiographic images are obtained from different angles. These images are formally interpreted. The results are discussed with the physician performing the injection procedure (if different than the interpreting physician) to determine if there is any abnormality of the epidural space that would limit the desired distribution of therapeutic substances to be injected.

Description of Post-Service Work:

A report is dictated for the medical record. The findings are discussed with the referring physician and patient.

SURVEY DATA:

Presenter(s): William T. Thorwarth Jr., M.D.
ACR RUC Advisor

J. Arliss Pollock, M.D.
ASNR RUC Advisor

Specialty(s): Radiology

Sample Size: 357 Response Rate (%): 39 (11%) Median RVW 0.83

Type of Sample (Circle one): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 0.8 75th Percentile RVW: 1.28 Low: 0.2 High: 7.5

Median Pre-Service Time: 12.5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 0 High: 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List # of Visits)
Immediate Post Service Time:	<u>2</u>	_____
Critical Care:	_____	_____
Other Hospital Visit:	_____	_____
Discharge Day Mgmt:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
<u>72265</u>	<u>Myelography, lumbosacral (S&I)</u>	<u>0.83</u>

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u>	<u>Reference Service 1</u>	<u>Reference Service 2</u>
Median Pre-Time	12.5	7.5	
Median Intra-Time	30	30	
Median Post-Time	2	1	

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	3.4	3.3	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.4	3.3	
Urgency of medical decision making	3.2	2.5	

Technical Skill/Physical Effort (Mean)

Technical skill required	3.8	3.3	
Physical effort required	3.5	3.0	

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.5	2.6	
Outcome depends on the skill and judgement of physician	3.6	3.1	
Estimated risk of malpractice suit with poor outcome	3.2	2.8	

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

**Reference
Service 2**

Time Segments (Mean)

Pre-Service intensity/complexity	3.0	2.6	
Intra-Service intensity/complexity	3.6	3.4	
Post-Service intensity/complexity	2.8	2.4	

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The committee recommends the median survey value, the same value as the key reference code, though the intensity/complexity values are consistently slightly higher.

FREQUENCY INFORMATION

How was this service previously reported?

72265-52 Lumbar Myelography; Supervision and Interpretation - Reduced Service

Note: 72240-52 and 72255-52 are used for cervical and thoracic injection; respectively.

How often do physicians in your specialty perform this service? ___ Commonly X Sometimes ___ Rarely

Estimate the number of times this service might be provided nationally in a one-year period?

Estimating the number of times this service might be provided nationally in a one-year period is difficult. We have taken 3 percent of the frequency reported for the myelography code (72265) reported in HCFA's 1997 Part B Physician/Supplier file (BMAD) data (80,814) to arrive at 2424 times this service may be performed for Medicare patients in a one-year period.

Do many physicians perform this service across the United States? X Yes ___ No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 7600X Tracking Number: M13 Global Period: XXX Recommended RVW: 0.6

CPT Descriptor:

Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint) including neurolytic agent destruction, paravertebral facet joint nerve or sacroiliac joint.

(Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is included in the respective supervision and interpretation codes 72240, 72255, 72265, 72270)

(For epidural, or subarachnoid needle or catheter placement and injection, see codes 62270-62273, 62280-62282, 62X03-62X04)

(For sacroiliac joint arthrography, see codes 2709Z, 7354X)

(For paravertebral facet joint injection, see 6447X1-6447X4. For transforaminal epidural needle placement and injection, see 6447X5-6447X6, 6447X7-6447X8)

(For destruction by neurolytic agent, see 64600-64680)

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:****Typical Patient/Service:**

A 45 year old male has severe pain (rated at 8 on a scale of 0-10, where 10 is the worst pain imaginable) involving both legs and the lower back after multiple back operations over a 10 year period. Various systemic medications (oral narcotic and non-narcotic), and physical therapy have all failed to provide significant long-term pain relief. There are no further operations on his spine that are felt likely to provide further relief.

The physician provides fluoroscopic guidance during the performance of any one of a series of possible needle/catheter procedures described below to confirm the proper position of the needle/catheter. (Note the physician work of the needle/catheter placement is not included in code 7600X, but rather is included in the respective injection codes. These are described below so that the survey respondent may estimate the time and complexity of the fluoroscopic service).

For code 62X01: This patient is a good candidate for a subarachnoid narcotic injection because of the severity of the pain and the lack of other treatment options. A test subarachnoid injection of morphine is recommended to determine if a long-term infusion (using an external or implanted infusion pump) could provide significant pain relief for this patient.

For codes 62X01 and 62X03: This patient is a good candidate for an epidural narcotic injection because of the severity of the pain and the lack of other treatment options. A test epidural injection of morphine is recommended to determine if a long-term infusion (using an external or implanted infusion pump) could provide significant pain relief for this patient. The code 62X01

would be appropriate for a cervical or thoracic epidural injection if the patient's pain were in the neck, arms, chest, or high back area. The code 62X03 would be appropriate for a lumbar or caudal injection if the pain were in the legs and /or lower back-buttock area.

For codes 62X02 and 62X04: This patient is a good candidate for an epidural narcotic infusion or series of intermittent bolus injections. A continuous infusion of narcotic and local anesthetic could be used for several days during aggressive physical therapy to try and break a cycle of sympathetic dysfunction (e.g., from reflex sympathetic dysfunction or, by its new term "complex regional pain syndrome"). Many physicians feel that a continuous infusion of narcotic (as compared to a single injection) is a better predictor of long-term pain relief. The catheter could also be used for a series of single injections over several hours or 1-2 days to test for narcotic pain relief versus pain relief from saline injections. The code 62X01 would be appropriate for a cervical or thoracic epidural injection if the patient's pain were in the neck, arms, chest, or high back area. The code 62X03 would be appropriate for a lumbar or caudal injection if the pain were in the legs and /or lower back-buttock area.

For code 62X04: This patient is a good candidate for a subarachnoid narcotic infusion or series of intermittent bolus injections. A continuous infusion could be used for several days during aggressive physical therapy to try and break a cycle of sympathetic dysfunction (e.g., from reflex sympathetic dysfunction or, by its new term "complex regional pain syndrome"). The continuous infusion of narcotic also is used by physicians as a better test for pain relief than a single injection. The catheter could also be used for a series of single injections over several hours or 1-2 days to test for narcotic pain relief versus pain relief from alternating, blinded saline injections.

Description of Pre-Service Work

The physician reviews the patients prior imaging studies (radiographs, CT scans, MRI exams) to be familiar with the patients spine anatomy (numbering of levels, anatomic variants, prior surgery, pathology, etc.)

Description of Intra-Service Work

The patient is placed on an x-ray table in the prone, decubitus or prone oblique position, depending on the type of injection to be performed. Preliminary fluoroscopy is performed to identify the appropriate level and approach for initial needle placement, and the skin entry site marked. During the needle/catheter placement, intermittent fluoroscopy is used to confirm the correct approach and need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm proper position. If position is not correct, additional fluoroscopy is provided during repositioning until proper position is achieved. If a catheter is to be placed, additional fluoroscopic guidance is provided during and after the catheter positioning to confirm proper positioning, and additional contrast injection may be performed.

If a different physician is performing the needle/catheter placement, there is continuous consultation with that physician regarding the placement and positioning.

Description of Post-Service Work

A report describing the guidance procedure, including the final position of the needle/catheter is dictated, proofread and submitted for the patient record.

SURVEY DATA:

Presenter(s): William T. Thorwarth Jr., M.D.
ACR RUC Advisor

J. Artiss Pollock, M.D.
ASNR RUC Advisor

Specialty(s): Radiology

Sample Size: 390 Response Rate (%): 43 (11%) Median RVW 0.6

Type of Sample (Circle one): random, panel, convenience Explanation of sample size: _____

25th Percentile RVW: 0.54 75th Percentile RVW: 1.2 Low: 0.15 High: 10

Median Pre-Service Time: 10 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 30 Low: 0 High: 60

Median Post-Service Time: _____

	Total Time	Level of Service by CPT Code (List # of Visits)
Immediate Post Service Time:	<u>5</u>	_____
Critical Care:	_____	_____
Other Hospital Visit:	_____	_____
Discharge Day Mgmt:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76003	Fluoroscope localization for needle biopsy or fine needle aspiration	0.54

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including the data from the service that you are rating as well as the key reference services.

TIME ESTIMATES (Median)

	<u>CPT Code</u>	<u>Reference Service 1</u>	<u>Reference Service 2</u>
Median Pre-Time	10	5	
Median Intra-Time	20	20	
Median Post-Time	5	0	

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	3.2	2.8	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.4	3.1	
Urgency of medical decision making	2.7	2.6	

Technical Skill/Physical Effort (Mean)

Technical skill required	3.6	3.1	
Physical effort required	3.3	2.9	

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.0	2.5	
Outcome depends on the skill and judgement of physician	3.6	3.3	
Estimated risk of malpractice suit with poor outcome	3.0	2.5	

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

**Reference
Service 2**

Time Segments (Mean)

Pre-Service intensity/complexity	2.5	1.7	
Intra-Service intensity/complexity	3.3	3.0	
Post-Service intensity/complexity	2.4	2.0	

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Committee recommends the median survey value, though the time and intensity/complexity values were consistently higher than the key reference (76003) with the same value.

FREQUENCY INFORMATION

How was this service previously reported? 76000, 76001, 76003

How often do physicians in your specialty perform this service? Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?

Estimating the number of times this service might be provided nationally in a one-year period is difficult. We are working with the societies presenting the spine injection surveys to arrive at a number. We will provide an estimate at the time of the RUC presentations.

Do many physicians perform this service across the United States? Yes No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 76065 **Tracking Number:** _____ **Global Period:** xxx **Recommended RVW:** 0.7

CPT Code Descriptor: Radiologic exam, osseous survey, infant

Clinical description of service:

Vignette Used in Survey: After a clinical examination of an infant, multiple skeletal lesions (which could be caused by child abuse) are suspected.

Description of Pre-Service Work: Clinical history prompting the exam is reviewed.

Description of Intra-Service Work: Separate films of each anatomic region obtained in two projections are reviewed. Particular attention is given to systemic conditions, which could explain the clinical findings. Typically, additional views of selected areas may then be necessary to fully document suspected abnormalities. These additional views are part of the same service and are not billed separately

Description of Post-Service Work: Report is dictated and discussed immediately with the appropriate clinical staff. Additional review of films, without additional reimbursement, is commonly required for legal purposes.

Survey data:

Presenter(s): James P. Borgstede, MD
Specialty(s): American College of Radiology

Sample Size: 367 **Response Rate (%):** 54 (15%) **Median RVU:** 0.7

Type of Sample: Random _____ Panel X Convenience _____

Explanation of sample size: _____

25th Percentile RVW: 0.54 **75th Percentile RVW:** 1.0 **Low:** 0.36 **High:** 3.4

Median Pre-Service Time (min): 3.0 **Median Intra-Service Time (min):** 10.0

25th Percentile Intra-Svc Time (min): 6.13 **75th Percentile Intra-Svc Time (min):** 15.0 **Low:** 3.0 **High:** 6.0

Median Post-Service Time:

Total Time

Level of Service by CPT Code
(List CPT Code & # of Visits)

Immediate Post Service Time: _____ 5.0 _____

Critical Care _____

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits _____

Key reference service:

CPT Code	CPT Descriptor	RVW
76062	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)	0.54

Relationship of code being reviewed to key reference service(s):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	3.0	2.5
Median Intra-Time	10.0	10.0
Median Immediate Post-service Time	5.0	5.0
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	3.54	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.03
Urgency of medical decision making	4.41	3.35

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	2.98
Physical effort required	1.96	2.10

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.27
Outcome depends on the skill and judgement of physician	4.57	3.59
Estimated risk of malpractice suit with poor outcome	3.85	3.34

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.29	2.09
Intra-Service intensity/complexity	3.81	3.39
Post-Service intensity/complexity	3.37	2.66

Additional rationale

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

The intensity of this procedure has increased with the consequences of the interpretation of normal or abnormal being extremely significant. It is the opinion of the specialty society that the time and intensity of this code are greater than that of the reference service code and, thus, justify the median RVU.

Frequency information

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Commonly X Sometimes _____ Rarely _____
 Specialty: _____ Commonly _____ Sometimes _____ Rarely _____

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Frequency 120,000
 Specialty: _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Radiology Frequency 63*
 Specialty: _____ Frequency _____

Do many physicians perform this service across the United States?

Yes X .No _____

*Based on 1998 BMAD Data

Five Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years?

Yes 11 No 43

a. This service represents new technology that has become more familiar (i.e., less work).

I agree _____ I disagree 31

b. Patients requiring this service are now:

More complex (more work) 12 Less Complex (less work) _____ No change 23

c. The usual site-of-service has changed:

From outpatient to inpatient _____ From inpatient to outpatient 4 No change 33

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 76090 Tracking Number: _____ Global Period: xxx Recommended RVW: 0.93
0.70 RUC

CPT Code Descriptor: Mammography; unilat

Clinical description of service:

Vignette Used in Survey: A 55-year old female recently had a screening mammogram. An asymmetrical density was suspected in the left breast. Further supplemental mammographic views were recommended to clarify the features, location, and reality of this suspected lesion. After reviewing the screening mammogram, it was determined that diagnostic views in a craniocaudal spot compression/magnification, medial lateral spot compression/magnification and 90-degree lateral view were necessary. At the completion of the examination, the radiologist conveys the findings of the examination to the patient. Report was dictated and the results were discussed with the referring physician.

Description of Pre-Service Work: The screening mammogram is reviewed. Often the screening examination is from another institution. A decision as made as to which diagnostic views would further elucidate the asymmetric density.

Description of Intra-Service Work: The diagnostic views requested are reviewed and are compared with the screening study. Additional views of the breast may be necessary based on the review of the initial diagnostic views. When the asymmetric density has been completely evaluated an interpretation of the examination is rendered and a report is dictated for the referring physician. Per federal legislative requirement (MQSA) the exam is coded using BIRADS terminology and a separate report in lay language is dictated and sent to the patient.

Description of Post-Service Work: Due to the patient's anxiety typically associated with this service, the findings are typically called to the referring physician at the completion of the examination. The findings are typically discussed with the patient at the completion of the examination.

Survey data:

Presenter(s): James P. Borgstede, MD
 Specialty(s): American College of Radiology

Sample Size: 250 Response Rate (%): 62 (25%) Median RVU: 0.93

Type of Sample: Random Panel X Convenience

Explanation of sample size: _____

25th Percentile RVW: 0.7 75th Percentile RVW: 1.16 Low: 0.3 High: 2.0

Median Pre-Service Time (min): 4.5 Median Intra-Service Time (min): 7.0

25th Percentile Intra-Svc Time (min): 5.0 75th Percentile Intra-Svc Time (min): 10.0 Low: 0.5 High: 60.0

Median Post-Service Time:

Total Time

Level of Service by CPT Code
(List CPT Code & # of Visits)

Immediate Post Service Time:	<u>8.0</u>	_____
Critical Care	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits	_____	_____

Key reference service:

CPT Code	CPT Descriptor	RVW
76645	Echography, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation	0.54

Relationship of code being reviewed to key reference service(s):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	4.5	4.0
Median Intra-Time	7.0	5.0
Median Immediate Post-service Time	8.0	7.0
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	3.71	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	2.75
Urgency of medical decision making	3.73	3.41

Technical Skill/Physical Effort (Mean)

Technical skill required	3.58	3.58
Physical effort required	2.06	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.79	2.92
Outcome depends on the skill and judgement of physician	4.76	4.42
Estimated risk of malpractice suit with poor outcome	4.92	4.33

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.85	2.18
Intra-Service intensity/complexity	3.98	3.42
Post-Service intensity/complexity	3.72	3.08

Additional rationale

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

It is the specialty society's opinion that the median RVU obtained in the survey reflects the time and intensity of this procedure. Both time and intensity have increased over the past five years due to MQSA coding requirements, MQSA direct patient reporting requirements, an increase in psychological stress due to increase in frequency of litigation and award amounts, and an increase in the number of diagnostic views obtained per examination.

Frequency information

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Commonly X Sometimes _____ Rarely _____
 Specialty: _____ Commonly _____ Sometimes _____ Rarely _____

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Frequency 1,200,000
 Specialty: _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Radiology Frequency 636,939*
 Specialty: _____ Frequency _____

Do many physicians perform this service across the United States?

Yes X No _____

*Based on 1998 BMAD Data

ive Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years?

Yes 48 No 14

a. This service represents new technology that has become more familiar (i.e., less work).

I agree _____ I disagree 53

b. Patients requiring this service are now:

More complex (more work) 48 Less Complex (less work) _____ No change 5

c. The usual site-of-service has changed:

From outpatient to inpatient _____ From inpatient to outpatient 5 No change 48

Key reference service:

CPT Code	CPT Descriptor	RVW
<u>76645</u>	<u>Echography, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation</u>	<u>0.54</u>

Relationship of code being reviewed to key reference service(s):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT:</u>
Median Pre-Time	5.0	3.0
Median Intra-Time	10.0	7.0
Median Immediate Post-service Time	8.0	6.0
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	3.92	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	2.92
Urgency of medical decision making	3.93	3.54

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.77
Physical effort required	2.34	2.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.82	3.0
Outcome depends on the skill and judgement of physician	4.72	4.54
Estimated risk of malpractice suit with poor outcome	4.93	4.38

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.0	2.42
Intra-Service intensity/complexity	4.13	3.54
Post-Service intensity/complexity	3.97	3.15

Additional rationale

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

It is the specialty society's opinion that the median RVU obtained in the survey reflects the time and intensity of this procedure. Both time and intensity have increased over the past five years due to MQSA coding requirements, MQSA direct patient reporting requirements, an increase in psychological stress due to increase in frequency of litigation and award amounts, and an increase in the number of diagnostic views obtained per examination.

Frequency information

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Commonly X Sometimes _____ Rarely _____
Specialty: _____ Commonly _____ Sometimes _____ Rarely _____

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology Frequency 2,400,000
Specialty: _____ Frequency _____

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: Radiology Frequency 1,199,114*
Specialty: _____ Frequency _____

Do many physicians perform this service across the United States?

Yes X No _____

*Based on 1998 BMAD Data

Five Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years?

Yes 46 No 16

a. This service represents new technology that has become more familiar (i.e., less work).

I agree 1 I disagree 49

b. Patients requiring this service are now:

More complex (more work) 46 Less Complex (less work) _____ No change 6

c. The usual site-of-service has changed:

From outpatient to inpatient _____ From inpatient to outpatient 6 No change 46

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93350 Tracking Number: 1 Global Period: XXX Recommended RVW: 1.75
1.48 RUC

CPT Descriptor: CPT Code Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report.

(The appropriate stress testing code from the 93015-93018 series should be reported in addition to 93350 to capture the exercise stress portion of the study).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 48 year old man with hypertension and a history of cigarette smoking describes occasional exertional chest discomfort that is thought to be possible, but not definite, angina pectoris. His resting electrocardiogram demonstrates LVH with QRS widening and secondary repolarization changes. A treadmill stress echocardiogram is requested to evaluate for inducible myocardial ischemia and to aid in risk-stratification.

The physician reviews the referral information (e.g. request for the procedure) and relevant clinical data with the patient to clarify the indications for the procedure and determine the clinical questions that need to be answered. A sequence of baseline tomographic images from apical and precordial windows is recorded on videotape and into computer memory using cine-loop format. The physician may verify the suitability of the baseline images and consider the need for border enhancement using echocardiographic contrast material.

The patient then undergoes conventional treadmill exercise using a symptom-limited protocol. Immediately on completion of treadmill exercise, the patient is again imaged and a sequence of post-stress tomographic images is recorded from apical and precordial windows, again using both videotape and digital recording techniques.

The interpreting physician reviews the video-taped and digitally recorded views of the heart, analyzing global and regional left ventricular function both at rest and following stress. Regional changes are evaluated carefully. Other cardiac causes of chest pain (such as valvular disease or cardiomyopathy) are also assessed. Where appropriate, geometric measures of cardiac structure and function are made. A diagnostic interpretation is developed, and a report is dictated, edited, and signed. The findings may be reviewed in detail with the requesting physician.

Description of Service Period

The physician reviews existing information and relevant clinical data to clarify the indications for the procedure, refine the clinical questions that need to be addressed, and determine the suitability stress echocardiography and the most appropriate testing method.

A sequence of tomographic images, recorded both at baseline and again immediately following completion of treadmill exercise, is reviewed using both video-tape and digital cine-loop formats. Global and regional ventricular performance is evaluated carefully. Other cardiac causes of chest pain are also assessed. Where appropriate, geometric measures of cardiac structure and function are made. A diagnostic interpretation is developed.

A report is dictated, edited and signed. The findings may be reviewed in detail with the requesting physician.

SURVEY DATA:

Presenter(s) James Maloney, M.D. and Alan Pearlman, M.D.

Specialty(s): Cardiology

Sample Size: 105 Response Rate: (%): 29.5% (31) Median RVW: 1.75

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Random sample of American College of Cardiology members, half of whom are also members of the American Society of Echocardiography.

25th Percentile RVW: 1.48 75th Percentile RVW: 2.19 Low: 1.20 High: 2.99

Median Pre-Service Time: N/A Median Intra-Service Time: 40 minutes

25th Percentile Intra-Svc Time: 33.75 minutes 75th Percentile Intra-Svc Time: 50 minutes
Low: 15 minutes High: 60 minutes

KEY REFERENCE SERVICE:

CPT Code
78465

CPT Descriptor
Myocardial perfusion imaging; (planar) tomographic (SPECT), multiple studies at rest or stress (exercise and/or pharmacologic), and redistribution and/or rest injection with or without quantification

RVW: 1.46

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service CPT:</u>
Median Pre-Time	N/A	N/A
Median Intra-Time	40 min.	20 min.
Median Immediate Post-service Time	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.50
Urgency of medical decision making	4.08	3.79

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	3.64
Physical effort required	2.95	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.07
Outcome depends on the skill and judgement of physician	4.47	3.64
Estimated risk of malpractice suit with poor outcome	4.05	4.14

INTENSITY/COMPLEXITY MEASURES**CPT Code** **Reference Service****Time Segments (Mean)**

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	4.12	3.46
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years.**

The American College of Cardiology has a Cardiovascular RUC committee who met by phone conference to discuss the recommended work RVU.

In 1994, code 93350 was revised to describe the analysis, interpretation, and reporting of transthoracic echocardiographic images acquired during (before and after) cardiovascular stress. The exercise stress portion of the stress imaging procedure, previously included in 93350, was removed from the descriptor and reported separately (using the 93015-93018 series). Since that time, stress echocardiography (93350) has been assigned .78 work RVUs. During the first five-year review, other echocardiographic imaging codes were re-valued upward, but 93350 was not considered at that time because it had been modified recently. In addition, there has been a shift in site of service toward the outpatient/office setting, and patients sent for stress echocardiography are generally more complex and sicker.

In order to readdress this service, the ACC proposed that it be considered during the second five-year review process. A standard RUC survey was sent to 105 randomly selected American College of Cardiology members, half of whom are also members of the American Society of Echocardiography. Thirty-one responses were received for a 29.5% response rate indicating a median RVU of 1.75 (range 1.20-2.99). The comparison code most commonly selected from the reference list was 78465, nuclear stress echo.

The CV RUC thought that the 1.75 RVUs was an appropriate representation of where the stress echo code should be currently valued.

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology Commonly Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology Frequency similar to Medicare population

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 Cardiology Frequency 175,000 total service/12,000 professional component only per year

Do many physicians perform this service across the United States? Yes No

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

Has the work of performing this service changed in the past 5 years? Yes 21 No 8 No response 2

- a. **This service represents new technology that has become more familiar (i.e., less work). I agree 20 I do not agree 6 No response 5**
- b. **Patients requiring this service are now: more complex (more work) 23 less complex (less work) 0 no change 4 No response 4**
- c. **The usual site-of-service has changed: from outpatient to inpatient 3 from inpatient to outpatient 10 no change 14 No response 4**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

5-yr-rev

(August 2000)

CPT Code: 99291

Current RVW: 3.60
Recommended RVW: **5.00**
4.00 RUC

CPT Descriptor: Critical Care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

Global Period: XXX

Typical Patient (*Survey Vignette*):

A 65-year old man with a subarachnoid hemorrhage and clipping of aneurysm five days ago with residual left hemiparesis and pulmonary edema. Patient requires mechanical ventilation. Time spent over 30 minutes.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service work :

Review of available data from multiple databases (e.g. [not all-inclusive], telemetry, central venous/intracardiac measurements or blood gases, as well as other diagnostic laboratory, radiological, and nuclear medicine data in correlation with the patient's signs, symptoms, and reactions to therapeutic interventions) and reading of films, rhythm strips, etc. Explanation of procedure(s)/service(s) not separately billable to patient/family members, and risks and benefits outlined.

Intra-service work:

Patient is examined, assessing all body systems. Any necessary procedures are performed – for example (not all-inclusive) consultations with nurses, respiratory care practitioners and other physicians; adjustments to the ventilator settings; titration of fluid replacement; calculation of needed parenteral nutritional support; titration of amounts of vasoactives to maintain patient's blood pressure; determining need for blood and volume expanders.

Post-service work:

Lengthy explanatory notes are written describing, for example, the patient's signs and symptoms as well as procedures performed. Notes include explanations of interpretations of data and planned course of action. Discussions with consultants are held. Detailed instructions are written for staff. Consultation with family members also occurs because of the need to obtain information not available for the patient because of the severity of the patient's condition.

SURVEY DATA

Presenter(s): George Sample, MD
Scott Manaker, MD

Specialty(s): American College of Chest Physicians (ACCP)
Society of Critical Care Medicine (SCCM)
American Thoracic Society (ATS)
American College of Cardiology (ACC)
American Society of Anesthesiologists (ASA)

Type of Sample: Random (website/mail/fax) Convenience (committee meeting)

Sample Size:	6600 email/website	Response:	84		
	16 e-mail		(1.3%)		
	46 fax or mail				
	Low	25th pctl	Median	75th pctl	High
Survey RWV	2.00	4.40	5.00	6.00	20.00
Pre-Service			15		
Intra-Service	0	30	45	53.75	90
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	15				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	0				
Office Visits	0				

KEY REFERENCE SERVICE(S):

<u>CPT</u>	<u>DESCRIPTOR</u>	<u>2000 rrw</u>	<u>GLOB</u>
92950	Cardiopulmonary resuscitation (e.g., in cardiac arrest)	3.60	XXX

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	99291	92950
Pre-service time	15	0
Intra-service time	45	30
Immediate Post-service time	15	20
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	0	0
Total office visit time	0	0
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.54	0
Intra-service	4.53	5.0
Post-service	3.86	3.81
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.55	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	4.15
Urgency of medical decision making	4.69	4.85
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.59	4.19
Physical effort required	3.88	4.23
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.82	4.77
Outcome depends on the skill and judgment of physician	4.76	4.31
Estimated risk of malpractice suit with poor outcome	4.57	3.58

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

FREQUENCY INFORMATION

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Pulmonary Medicine: Commonly
 Critical Care Medicine: Commonly
 Cardiology: Sometimes
 Anesthesiology: Sometimes

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.

Cannot estimate national 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.

41,955	general practice	1,140	urology
42,008	general surgery	785	nuclear medicine
332	allergy/immunology	2,832	pediatric medicine
694	otolaryngology	2,937	geriatric medicine
29,321	anesthesiology	42,559	nephrology
180,488	cardiology	17,724	infectious disease
95282	family practice	7,534	endocrinology
23,285	gastroenterology	2,379	rheumatology
529,279	internal medicine	1,137	vascular surgery
930	Osteopathic manipul. therapy	70,698	critical care (intensivists)
30,370	neurology	1,148	hematology
5,316	neurosurgery	15,033	hematology/oncology
381	obstetrics/gynecology	3,410	medical oncology
528	plastic/reconstruc surgery	105,019	emergency medicine
380	physical med and rehab	83,983	multipec clin/grp practice
826	psychiatry	551	physician assistant
346,278	pulmonary disease	1,988	spec other than above
669	diagnostic radiology		
4,123	thoracic surgery	1,873,255	TOTAL

Do many physicians perform this service across the United States? Yes

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

74 Yes

10 No

b. This service represents new technology that has become more familiar (i.e., less work).

6 I agree

68 I do not agree

10 No response**c. Patients requiring this service are now:**71 more complex (more work)

0 less complex (less work)

1 no change

12 no response

d. The usual site-of-service has changed:

6 from outpatient to inpatient

0 from inpatient to outpatient

65 no change

13 no response

**AMA/Specialty Society RVS Update Committee
RBRVS Five-Year Review
RUC Recommendations
Issues Adopted on April Consent Calendar**

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion	0.81	0.81	Under age 12: these procedures require physician to spend more time prior to performing the procedure. Preparing a child and parent regarding what the child may expect in terms of discomfort, potential complications of the procedure, taking into account the developmental aspects of this age group. The physician must utilize physical restraint (not required for adults) in order to perform this procedure and to lessen possible sequelae which may result from poor closure (eg, scarring or infection). Additionally and particularly in infants and children, the physician must utilize careful local anesthetic measures prior to the actual injection of local anesthetic medications. During biopsies, physicians caring for children must proceed cautiously so as not to unduly upset the patient.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
11730	Avulsion of nail plate, partial or complete, simple; single	1.13	1.13	Under age 12: these procedures require physician to spend more time prior to performing the procedure. Preparing a child and parent regarding what the child may expect in terms of discomfort, potential complications of the procedure, taking into account the developmental aspects of this age group. The physician must utilize physical restraint (not required for adults) in order to perform this procedure and to lessen possible sequelae which may result from poor closure (eg, scarring or infection). Additionally and particularly in infants and children, the physician must utilize careful local anesthetic measures prior to the actual injection of local anesthetic medications. During biopsies, physicians caring for children must proceed cautiously so as not to unduly upset the patient.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	1.70	Will require sedation or general anesthesia in a child. Lesions are a larger percentage of involved anatomical site. Higher chance of hypertrophic scarring.	The RUC recommends that this issue be referred to the CPT Editorial Panel for consideration.	5
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.86	1.86	Will require sedation or general anesthesia in a child. Lesions are a larger percentage of involved anatomical site. Higher chance of hypertrophic scarring.	The RUC recommends that this issue be referred to the CPT Editorial Panel for consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15001	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15100	Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.05	9.05	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15101	Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.72	1.72	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.83	9.83	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15121	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	2.67	2.67	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15350	Application of allograft, skin; 100 sq cm or less	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15351	Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15400	Application of xenograft, skin; 100 sq cm or less	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15401	each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
17000	Destruction by any method, including laser, with or without surgical curettment, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion	0.60	0.60	Under age 12: these procedures require physician to spend more time prior to performing the procedure. Preparing a child and parent regarding what the child may expect in terms of discomfort, potential complications of the procedure, taking into account the developmental aspects of this age group. The physician must utilize physical restraint (not required for adults) in order to perform this procedure and to lessen possible sequelae which may result from poor closure (eg, scarring or infection). Additionally and particularly in infants and children, the physician must utilize careful local anesthetic measures prior to the actual injection of local anesthetic medications. During biopsies, physicians caring for children must proceed cautiously so as not to unduly upset the patient.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
17003	Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; second through 14 lesions, each (List separately in addition to code for first lesion)	0.15	0.15	Under age 12: these procedures require physician to spend more time prior to performing the procedure. Preparing a child and parent regarding what the child may expect in terms of discomfort, potential complications of the procedure, taking into account the developmental aspects of this age group. The physician must utilize physical restraint (not required for adults) in order to perform this procedure and to lessen possible sequelae which may result from poor closure (eg, scarring or infection). Additionally and particularly in infants and children, the physician must utilize careful local anesthetic measures prior to the actual injection of local anesthetic medications. During biopsies, physicians caring for children must proceed cautiously so as not to unduly upset the patient.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
17004	Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia, 15 or more lesions	2.79	2.79	Under age 12: these procedures require physician to spend more time prior to performing the procedure. Preparing a child and parent regarding what the child may expect in terms of discomfort, potential complications of the procedure, taking into account the developmental aspects of this age group. The physician must utilize physical restraint (not required for adults) in order to perform this procedure and to lessen possible sequelae which may result from poor closure (eg, scarring or infection). Additionally and particularly in infants and children, the physician must utilize careful local anesthetic measures prior to the actual injection of local anesthetic medications. During biopsies, physicians caring for children must proceed cautiously so as not to unduly upset the patient.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66	0.66	Relative work in children is increased because of size of joints, need for anesthesia (often general), potential for joint destruction.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	0.68	The ASGS commented that the work RVU for this service is currently undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)	7.76	7.76	The ASGS commented that the work RVU for this service is currently undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
32095	Thoracotomy, limited, for biopsy of lung or pleura	8.36	8.36	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC has recently reviewed this service and, therefore, recommends no change in the current work RVU.	2
32491	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure	21.25	21.25	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC has recently reviewed this service and, therefore, recommends no change in the current work RVU.	2
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	8.04	8.04	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	7.82	7.82	This relatively uncommon procedure is undervalued for the level of difficulty associated with lead extraction. In addition, the level of physician stress associated with this procedure and the risk to the patient is high compared to other codes. The work value for code 33234 should be increased in value to more appropriately represent the work intensity associated with these procedures.	The RUC has recently reviewed this service and, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
33235	Removal of transvenous pacemaker electrode(s); dual lead system	9.40	9.40	This relatively uncommon procedure is undervalued for the level of difficulty associated with lead extraction. In addition, the level of physician stress associated with this procedure and the risk to the patient is high compared to other codes. The work value for code 33235 should be increased in value to more appropriately represent the work intensity associated with these procedures.	The RUC has recently reviewed this service and, therefore, recommends no change in the current work RVU.	2
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	32.46	32.46	Changes in surgical techniques and in the typical patient have changed the work of the procedure.	The RUC has recently reviewed this service and, therefore, recommends no change in the current work RVU.	2
33875	Descending thoracic aorta graft, with or without bypass	33.06	33.06	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	42.60	42.60	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
34001	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	12.91	12.91	The ASGS commented that the work RVU for this service is currently undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
35381	Thromboendarterectomy, with or without patch graft; femoral and/or popliteal, and/or tibioperoneal	15.81	15.81	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
35541	Bypass graft, with vein; aortoiliac or bi-iliac	25.80	25.80	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35546	Bypass graft, with vein; aortofemoral or bifemoral	25.54	25.54	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35551	Bypass graft, with vein; aortofemoral-popliteal	26.67	26.67	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35582	In-situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in-situ)	27.13	27.13	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35641	Bypass graft, with other than vein; aortoiliac or bi-iliac	24.57	24.57	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35646	Bypass graft, with other than vein; aortofemoral or bifemoral	25.81	25.81	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35840	Exploration for postoperative hemorrhage, thrombosis or infection; abdomen	9.77	9.77	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35860	Exploration for postoperative hemorrhage, thrombosis or infection; extremity	5.55	5.55	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36520	Therapeutic apheresis; plasma and/or cell exchange	1.74	1.74	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The RUC recommends that this service be referred to CPT for further consideration.	5
36600	Arterial puncture, withdrawal of blood for diagnosis	0.32	0.32	Reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture (RVW = 0.18)) does not require as much work as these codes, yet still has the same physician work RVUs assigned. This work is slightly greater than the work of the office/outpatient visit of a new patient. In addition, caring for young children requires both special skill and greater cognitive work.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	3.73	3.73	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37720	Ligation and division and complete stripping of long or short saphenous veins	5.66	5.66	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU. The ASGS commented that this service is presently undervalued.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
37730	Ligation and division and complete stripping of long and short saphenous veins	7.33	7.33	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	10.53	10.53	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37760	Ligation of perforators, subfascial, radical (Linton type), with or without skin graft	10.47	10.47	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37785	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg	3.84	3.84	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
43305	Esophagoplasty, (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula	17.15	17.15	The APSA commented that the work RVU for this service is currently undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
46705	Anoplasty, plastic operation for stricture; infant	7.17	6.90	The APSA commented that this service should be slightly decreased to retain overall relativity within this family of services.	The RUC recommends that the suggested decrease in work RVUs be implemented as the requested change is less than 10% of the current work RVU.	3
46715	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)	7.46	7.20	The APSA commented that this service should be slightly decreased to retain overall relativity within this family of services.	The RUC recommends that the suggested decrease in work RVUs be implemented as the requested change is less than 10% of the current work RVU.	3

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
47134	Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor	39.15	39.15	The American Society of Transplant Surgeons commented that this procedure was originally defined and valued as a procedure that included the removal of a left lateral segment from a parent to be transplanted into their child. However, now a considerable number of the living donor partial hepatectomies are right lobectomies and this service involves considerably more intraoperative work as the anatomic considerations are more critical and the risk to the donor is greater.	The RUC recommends that this issue be referred to CPT for further consideration.	5
49321	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with biopsy (single or multiple)	5.40	5.40	The ASGS commented that the service is currently undervalued.	This service had recently been reviewed by the RUC. The RUC, therefore, recommends no change in the current work RVU.	2
49322	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)	5.70	5.70	The ASGS commented that the service is currently undervalued.	This service had recently been reviewed by the RUC. The RUC, therefore, recommends no change in the current work RVU.	2
50200	Renal biopsy; percutaneous, by trocar or needle	2.63	2.63	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The RUC recommends that this service be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
52300	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	5.31	5.31	Relative work in children is markedly increased because; necessity of anesthesia, physician needs knowledge, training, experience with children and the diseases that affect them specifically.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	5.19	5.19	Relative work in children is markedly increased because; necessity of anesthesia, physician needs knowledge, training, experience with children and the diseases that affect them specifically.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
52340	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	9.68	9.68	Relative work in children is markedly increased because; necessity of anesthesia, physician needs knowledge, training, experience with children and the diseases that affect them specifically.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
57410	Pelvic examination under anesthesia	1.75	1.75	The ASGS commented that the work RVU for this service is currently undervalued.	The RUC recommended no change to the current RVU of 15.93 as no compelling evidence was provided to suggest a recommended increase in RVUs. The RUC members noted that this code had a very low frequency and were concerned that general surgery who performs this service 100% of the time, did not comment or survey. The presenters did not perform a survey for this code, but simply presented a building block approach, which the RUC agreed did not provide enough compelling evidence to increase the RVUs. Therefore, the RUC agreed to maintain the current RVU of 15.93 for code 57307.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair	8.95	8.95	This procedure combines CPT code 57550 (Excision of cervical stump; vaginal approach) (RVW = 5.53) and code 57260 (Combined anteroposterior colporrhaphy) (RVW = 8.29). However, the current work RVU falls below the value that would be assigned by applying the multiple procedure payment rules to 57550 and 57260. The ACOG recommends that HCFA increase the work RVU's assigned to code 57555 to 9.66, the combination of 57550 and 57260.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
58820	Drainage of ovarian abscess; vaginal approach, open	4.22	4.22	CPT code 58820 is virtually identical to CPT code 57010 (Colpotomy; with drainage of pelvic abscess) (6.03 RVU's). The only difference between the two procedures is that 58820 specifies an abscess on the ovary, while 57010 includes drainage of a pelvic abscess. Both procedures require making an incision in the vagina, locating and draining the abscess, and postoperative management throughout the 90 day global period. The time, technical skill, mental effort and stress are equivalent, but RVU's for 57010 are higher.	This service has recently been reviewed by the RUC. The RUC, therefore, recommends that the current work RVU be maintained.	2
60280	Excision of thyroglossal duct cyst or sinus;	6.08	6.08	The APSA commented that the work RVU for this service is currently undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	12.16	12.16	The American Academy of Ophthalmology believes that this code is undervalued relative to the physician work required to perform the service.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	15.04	15.04	The American Academy of Ophthalmology believes that this code is undervalued relative to the physician work required to perform the service.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
67108	Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	20.82	20.82	The American Academy of Ophthalmology believes that this code is undervalued relative to the physician work required to perform the service.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69000	Drainage external ear, abscess or hematoma; simple	1.45	1.45	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69005	Drainage external ear, abscess or hematoma; complicated	2.11	2.11	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69020	Drainage external auditory canal, abscess	1.48	1.48	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69100	Biopsy external ear	0.81	0.81	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69105	Biopsy external auditory canal	0.85	0.85	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69110	Excision external ear; partial, simple repair	3.44	3.44	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69120	Excision external ear; complete amputation	4.05	4.05	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69140	Excision exostosis(es), external auditory canal	7.97	7.97	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69145	Excision soft tissue lesion, external auditory canal	2.62	2.62	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69150	Radical excision external auditory canal lesion; without neck dissection	13.43	13.43	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69155	Radical excision external auditory canal lesion; with neck dissection	20.80	20.80	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69200	Removal foreign body from external auditory canal; without general anesthesia	0.77	0.77	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69205	Removal foreign body from external auditory canal; with general anesthesia	1.20	1.20	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69210	Removal impacted cerumen (separate procedure), one or both ears	0.61	0.61	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	0.83	0.83	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)	1.40	1.40	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69300	Otoplasty, protruding ear, with or without size reduction	6.36	6.36	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to trauma, infection) (separate procedure)	10.79	10.79	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69320	Reconstruction external auditory canal for congenital atresia, single stage	16.96	16.93	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69400	Eustachian tube inflation, transnasal; with catheterization	0.83	0.83	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69401	Eustachian tube inflation, transnasal; without catheterization	0.63	0.63	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69405	Eustachian tube catheterization, transtympanic	2.63	2.63	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69410	Focal application of phase control substance, middle ear (baffle technique)	0.33	0.33	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69420	Myringotomy including aspiration and/or eustachian tube inflation	1.33	1.33	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	1.73	1.73	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69424	Ventilating tube removal when originally inserted by another physician	0.85	0.85	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	1.52	1.52	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	1.96	1.96	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69440	Middle ear exploration through postauricular or ear canal incision	7.57	7.57	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69450	Tympanolysis, transcanal	5.57	5.57	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69501	Transmastoid antrotomy (simple mastoidectomy)	9.07	9.07	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69502	Mastoidectomy; complete	12.38	12.38	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69505	Mastoidectomy; modified radical	12.99	12.99	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69511	Mastoidectomy; radical	13.52	13.52	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69530	Petrous apicectomy including radical mastoidectomy	19.19	19.19	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69535	Resection temporal bone, external approach	36.14	36.14	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69540	Excision aural polyp	1.20	1.20	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69550	Excision aural glomus tumor; transcanal	10.99	10.99	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69552	Excision aural glomus tumor; transmastoid	19.46	19.46	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69554	Excision aural glomus tumor; extended (extratemporal)	33.16	33.16	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69601	Revision mastoidectomy; resulting in complete mastoidectomy	13.24	13.24	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	13.58	13.58	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69603	Revision mastoidectomy; resulting in radical mastoidectomy	14.02	14.02	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69604	Revision mastoidectomy; resulting in tympanoplasty	14.02	14.02	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69605	Revision mastoidectomy; with apicectomy	18.49	18.49	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch	4.43	4.43	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69620	Myringoplasty (surgery confined to drumhead and donor area)	5.89	5.89	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	9.86	9.86	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.75	12.75	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))	12.10	12.10	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69635	Tympanoplasty with antrotomy or mastoidectomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	13.33	13.33	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	15.22	15.22	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))	15.11	15.11	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	12.71	12.71	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.84	16.84	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	15.32	15.32	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	16.97	16.97	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	16.38	16.38	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	17.99	17.99	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69650	Stapes mobilization	9.66	9.66	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	11.90	11.90	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	15.74	15.74	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69662	Revision of stapedectomy or stapedotomy	15.44	15.44	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69666	Repair oval window fistula	9.75	9.75	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69667	Repair round window fistula	9.76	9.76	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69670	Mastoid obliteration (separate procedure)	11.51	11.51	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69676	Tympanic neurectomy	9.52	9.52	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69700	Closure postauricular fistula, mastoid (separate procedure)	8.23	8.23	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	10.44	10.44	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion	14.38	14.38	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion	25.38	25.38	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	15.96	15.96	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	16.69	16.69	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69801	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal	8.56	8.56	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69802	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy	13.10	13.10	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69805	Endolymphatic sac operation; without shunt	13.82	13.82	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69806	Endolymphatic sac operation; with shunt	12.35	12.35	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69820	Fenestration semicircular canal	10.34	10.34	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69840	Revision fenestration operation	10.26	10.26	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69905	Labyrinthectomy; transcanal	11.10	11.10	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69910	Labyrinthectomy; with mastoidectomy	13.63	13.63	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69915	Vestibular nerve section, translabyrinthine approach	21.23	21.23	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
69930	Cochlear device implantation, with or without mastoidectomy	16.81	16.81	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69950	Vestibular nerve section, transcranial approach	25.64	25.64	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69955	Total facial nerve decompression and/or repair (may include graft)	27.04	27.04	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69960	Decompression internal auditory canal	27.04	27.04	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2
69970	Removal of tumor, temporal bone	30.04	30.04	The AAO-HNS comment that this service is currently undervalued. The list of services to be reviewed was determined by calculating the ratio of work RVUs to total RVUs. Any service in which the work RVU was less than 50% of the total RVU was considered to be undervalued.	The specialty society who commented on this service to HCFA chose not to pursue the issue further in this Five-Year Review. The RUC, therefore, recommends no change in the current work RVU.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
90935	Hemodialysis procedure with single physician evaluation	1.22	1.22	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.11	2.11	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90945	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration), with single physician evaluation	1.28	1.28	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90947	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration) requiring repeated evaluations, with or without substantial revision of dialysis prescription	2.16	2.16	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
90989	Dialysis training, patient, including helper where applicable, any mode, completed course	0.00	0.00	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session	0.00	0.00	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90997	Hemoperfusion (eg, with activated charcoal or resin)	1.84	1.84	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99295	Initial neonatal intensive care, per day, for the evaluation and management of a critically ill neonate or infant This code is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician reevaluations, and constant observation by the health care team under direct physician supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code.	16.00	16.00	The American Academy of Pediatrics believes that this code is undervalued relative to the physician work required to perform the service.	The RUC recommends no change in the work RVU for this service as this code as recently been reviewed by the RUC.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99296	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant A critically ill and unstable neonate will require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision. In addition, most will require frequent ventilator changes, intravenous fluid alterations, and/or early initiation of parenteral nutrition. Neonates in the immediate post-operative period or those who become critically ill and unstable during the hospital stay will commonly qualify for this level of care. This code encompasses intensive care provided on dates subsequent to the admission date.	8.00	8.00	The American Academy of Pediatrics believes that this code is undervalued relative to the physician work required to perform the service.	The RUC recommends no change in the work RVU for this service as this code as recently been reviewed by the RUC.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99297	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant Critically ill though stable neonates require cardiac and/or respiratory support (including ventilator and nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24 hour period, and constant observation by the health care team under direct physician supervision. Neonates at this level of care would be expected to require less frequent changes in respiratory, cardiovascular and fluid and electrolyte therapy as those included under code 99296. This code encompasses intensive care provided on dates subsequent to the admission date.	4.00	4.00	The American Academy of Pediatrics believes that this code is undervalued relative to the physician work required to perform the service.	The RUC recommends no change in the work RVU for this service as this code as recently been reviewed by the RUC.	2

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
99298	Subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams) Very low birth weight neonates who are no longer critically ill continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct physician supervision. Neonates of this level of care would be expected to require infrequent changes in respiratory, cardiovascular and/or fluid and electrolyte therapy as those induced under 99296 or 99297. This code encompasses intensive care provided on days subsequent to the	2.75	2.75	The American Academy of Pediatrics believes that this code is undervalued relative to the physician work required to perform the service.	The RUC recommends no change in the work RVU for this service as this code as recently been reviewed by the RUC.	2
99436	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	1.50	1.50	The American Academy of Pediatrics believes that this code is undervalued relative to the physician work required to perform the service.	The RUC recommends no change in the work RVU for this service as this code as recently been reviewed by the RUC.	2

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AMA/Specialty Society RVS Update Committee

RBRVS Five-Year Review

RUC Recommendations

Issues Referred to CPT

CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	1.70	Will require sedation or general anesthesia in a child. Lesions are a larger percentage of involved anatomical site. Higher chance of hypertrophic scarring.	The RUC recommends that this issue be referred to the CPT Editorial Panel for consideration.	5
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.86	1.86	Will require sedation or general anesthesia in a child. Lesions are a larger percentage of involved anatomical site. Higher chance of hypertrophic scarring.	The RUC recommends that this issue be referred to the CPT Editorial Panel for consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15001	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15100	Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.05	9.05	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15101	Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.72	1.72	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	9.83	9.83	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15121	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	2.67	2.67	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15350	Application of allograft, skin; 100 sq cm or less	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15351	Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
15400	Application of xenograft, skin; 100 sq cm or less	4.00	4.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5
15401	each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	1.00	The ABA commented that codes 15000-15401 should be reviewed to 1) assign work RVUs that more closely reflect the work associated with surgical procedures and services performed during the management of the burn patient; 2) to obviate the need for G-codes by replacing them with more specific CPT codes that will permit better tracking of the use of various grafts and/or products in these procedures; and 3) to introduce an exemption from the CPT payment policies with respect to the 90-day global period, multiple procedures, and staged procedures due to the unique clinical case management of burns.	The RUC recommends that this issue to reviewed to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
20205	Biopsy, muscle; deep	2.35	2.35	The AAOS believes that this code requires the same surgical approach and the same amount of work as 20005 Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated (RVU = to 3.42).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs to be clarified to capture the types of patients and size of deep muscle biopsy performed.	5
21740	Reconstructive repair of pectus excavatum or carinatum	16.50	16.50	The work intensity and technical advances have greatly changed in recent years. A new approach is used for half of the patients. This adds tremendously to the stress and risk factors, the number of ICU and hospital follow-up days. Pain control has become a major factor requiring more intense and frequent in-hospital and post-hospital care. The APSA believes the reference codes 15946 (Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure) (RVW = 21.57 and code 44310 (Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula) (RVW = 25.00) has similar associated intra- and post-service work and intensity. Code 21740 signifies a misalignment of relativity across the MFS.	The RUC recommends that this code be referred to the CPT Editorial Panel to clarify the different approaches used.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
23076	Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular	7.63	7.63	Code 23076 requires a similar or more complicated approach and an equal amount of work and time when compared to 23450 Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation (RVU = 13.40).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. Therefore, the RUC agreed that this is a definitional problem that CPT should clarify.	5
24076	Excision, tumor, upper arm or elbow area; deep, subfascial or intramuscular	6.30	6.30	Code 24076 utilizes the same surgical approach and requires a similar amount of work and time when compared to 24301 Muscle or tendon transfer, any type, upper arm or elbow; single (RVU = 10.20).	The RUC agreed to refer this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5
25076	Excision, tumor, forearm and/or wrist area; deep, subfascial or intramuscular	4.92	4.92	Code 25076 requires the same surgical approach and involves the same amount of work as 25023 Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve) (RVW = 12.96).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs clarification to capture these kinds of patients and the work being performed.	5
27048	Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular	6.25	6.25	Code 27048 involves similar surgical approach but usually involves more work and more time than 27030 Arthrotomy, hip, with drainage (eg, infection) (RVW = 13.01).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use. The RUC also agreed that this code needs clarification to capture these kinds of patients and the work being performed.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27328	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular	5.57	5.57	Code 27328 requires the same amount of work and time when compared to code 27334 Arthrotomy, with synovectomy, knee; anterior OR posterior (RVW = 8.70).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5
27619	Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)	8.40	8.40	Code 27619 involves a more complicated surgical approach, more potential direction of nerves and vessels and a similar amount of work when compared to 27654 Repair, secondary, Achilles tendon, with or without graft (RVU = 10.02).	The RUC referred this code back to CPT for clarification of the specific type and size of tumor resection performed, to assure correct code usage as the RUC identified a problem in that the code is being reported for other than its intended use.	5
33875	Descending thoracic aorta graft, with or without bypass	33.06	33.06	The SVS/SCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	42.60	42.60	The SVS/SCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35381	Thromboendarterectomy, with or without patch graft; femoral and/or popliteal, and/or tibioperoneal	15.81	15.81	The SVS/SCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35541	Bypass graft, with vein; aortoiliac or bi-iliac	25.80	25.80	The SVS/SCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35546	Bypass graft, with vein; aortofemoral or bifemoral	25.54	25.54	The SVS/SCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
35551	Bypass graft, with vein; aortofemoral-popliteal	26.67	26.67	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35582	In-situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in-situ)	27.13	27.13	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35641	Bypass graft, with other than vein; aortoiliac or bi-iliac	24.57	24.57	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35646	Bypass graft, with other than vein; aortofemoral or bifemoral	25.81	25.81	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35840	Exploration for postoperative hemorrhage, thrombosis or infection; abdomen	9.77	9.77	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
35860	Exploration for postoperative hemorrhage, thrombosis or infection; extremity	5.55	5.55	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36406	Venipuncture, under age 3 years; other vein	0.18	0.18	Reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture (RVW = 0.18)) does not require as much work as these codes, yet still has the same physician work RVUs assigned. This work is slightly greater than the work of the office/outpatient visit of a new patient. In addition, caring for young children requires both special skill and greater cognitive work.	The RUC compared code 36406 to the reference service code 36410 (Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture) (0.18 RVW) which requires physician's skill and noted that code 36406 had less total time than the reference code. The RUC agreed to refer this code to the CPT Editorial Panel as it was unclear what physician work was included in code 36406, as well as to ask for clarification if CPT needs to add a code for venipuncture for children under age 3 years necessitating a physicians skill.	5
36520	Therapeutic apheresis; plasma and/or cell exchange	1.74	1.74	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The RUC recommends that this service be referred to CPT for further consideration.	5
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	5.32	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36533 and noted that the descriptor contains "with or without subcutaneous reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code back to CPT to create separate codes to specifically describe insertion of implantable venous access devices with subcutaneous reservoirs, and insertion of implantable venous access devices without subcutaneous reservoirs.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	2.80	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36534 and noted that the descriptor contains "and/or reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code to CPT to create specific codes to describe the revision of implantable venous access devices and reservoirs, and the revision of implantable venous access devices or subcutaneous reservoirs.	5
36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2.27	2.27	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC reviewed code 36535 and noted the descriptor states, "and/or subcutaneous reservoir." The RUC noted that there are multiple venous access capabilities for varying disease process which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this code back to CPT to create specific codes for removal of implantable venous access devices and subcutaneous reservoirs, and for removal of implantable venous access devices or subcutaneous reservoirs.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	1.15	1.15	<p>Code 36620 describes the insertion of a foreign body into a peripheral extremity artery; and in the case of the reference code 36140 (Introduction of needle or intracatheter, extremity artery (RVW = 2.01)), this is done for the purpose of a one-time injection of material prior to the performance of a diagnostic procedure. In placing an arterial catheter into a patient, greater technical skill is required as well as increased pre-procedure preparation of the injection site and increased post-procedure care to secure and continuously maintain the arterial catheter. Intra-service time would be substantially increased because of the acuteness of the patient's condition as well as the agitation. Another important variable adding to the complexity of the intra-service work is the difficulty in localizing the arterial vessel due to hypotension and hypovolemia. In an acutely ill patient, there are also greater risks for bleeding, thrombosis and infection, all of which increase the stress factors associated with increased risk of iatrogenic complications.</p> <p>Conversely, these factors most often are not present in the patient receiving the injection prior to a procedure. The data indicate that roughly one-third of the patients for whom the reference code is billed are outpatients, who certainly do not have the same signs, symptoms, or risk factors as the acutely ill patient. Also, when a needle or intracatheter is inserted for purposes of injection prior to a procedure, the image analysis and interpretation are billed separately.</p>	The RUC compared code 36620 to the reference service code 36140 (Introduction of needle or intracatheter; extremity artery) (RVU = 2.01) and noted that code 36620 (1.15) has greater intra and postoperative time than the code 36140 reference service code, but was valued less creating a rank order anomaly. To correct the rank order anomaly, the RUC agreed to increase the RVU of code 36620 to the 25th percentile (2.50). However, the RUC was concerned that anesthesiologists who perform this procedure over 80% of the time did not comment or participate in the survey. As such, the RUC concluded that CPT code 36620 should be referred to CPT to clarify the appropriate use of this code.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
				Additionally, code 36620 requires cannulization of the artery while the reference service code 36410 can be used for introduction of a needle or an intracatheter. Obviously, the insertion of a needle into an artery is less labor-intensive. Currently, the reference service code has a higher physician work value and contains disparate amounts of work (i.e., introduction of a needle versus an intracatheter). Based upon all of the reasons outlined above, ACCP recommends that the physician work for 36620 be in excess of the work values assigned to 36410.		
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	5.73	5.73	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In reviewing the work of this individual service and all of the other ligation codes for arteries in the neck, the RUC was concerned that this code was not well defined. The RUC recommends that the specialty specifically identify which arteries are specifically included in 37615 as the external and internal carotid arteries are described in codes 37600 and 37605.	5
37618	Ligation, major artery (eg, post-traumatic, rupture); extremity	4.84	4.84	ISCVS/SVS commented that vascular surgical procedures have been undervalued since the original Hsaio/Harvard studies. RUC survey data and a "building block" analysis will be presented to request increases for 94 major vascular reconstructions.	In reviewing the work of this individual service and all of the other ligation codes for arteries in the extremities, the RUC was concerned that this code was not well defined. The RUC recommends that the specialty specifically identify which arteries are specifically included in 37618.	5
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	3.73	3.73	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
37720	Ligation and division and complete stripping of long or short saphenous veins	5.66	5.66	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU. The ASGS commented that this service is presently undervalued.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37730	Ligation and division and complete stripping of long and short saphenous veins	7.33	7.33	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	10.53	10.53	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37760	Ligation of perforators, subfascial, radical (Linton type), with or without skin graft	10.47	10.47	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5
37785	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg	3.84	3.84	The SVS/ISCVS commented that this service should be redefined in CPT prior to any evaluation of the appropriate work RVU.	The RUC recommends that this service be referred to the CPT Editorial Panel for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43215	Esophagoscopy, rigid or flexible; with removal of foreign body	2.60	2.60	The ASGS believes that this code is undervalued relative to the physician work required to perform the service.	Compelling evidence was not provided to the RUC to recommend an increase in the RVU of this service. The RUC noted that there were 2 situations in which the procedure was performed for: removal of solid objects and removal of friable objects (such as meat). Because the work involved in removing an impacted foreign body is much more difficult, it was suggested that the procedure be broken into two separate CPT codes. At the request of the presenters, it was recognized that there was not enough information to support the recommended increase in RVUs. Therefore, the RUC recommends that code 43215 be referred back to CPT.	5
43310	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	25.39	25.39	This family of codes is performed on critically ill neonates and in need of realignment and significant revaluation. The newborn has one chance to have a good outcome. The long-term consequences from poor results follow the child into adult life including need for esophageal replacement. The typical patient is premature and has other associated anomalies (VACTERYL). The follow-up care far outweighs what is actually reflected in the surgical package. Using the building block approach, the code is significantly undervalued. APSA data on the typical patient includes a total of 32.24 neonatology work units plus 1.75 hospital work units and 2.01 office work units.	The RUC noted that this code was surveyed for services performed on critically ill neonates as the typical patient. However, the RUC noted that this service may also be performed on adults. The RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates, however, the RUC agreed to refer code 43310 to CPT to create new codes to accurately describe services performed on pediatric and adult populations.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
43312	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	28.42	28.42	For code 43312, APSA compared the intraservice work to that of a donor hepatectomy (47133, RVW = 19.40), believing the intrawork to have similar IWPUT and then added the pre and post-service work using building block method.	The RUC noted that this code was surveyed for services performed on critically ill neonates as the typical patient. However, the RUC noted that this service may also be performed on adults. The RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates, however, the RUC agreed to refer code 43312 to CPT to create new codes to accurately describe services performed on pediatric and adult populations.	5
47134	Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor	39.15	39.15	The American Society of Transplant Surgeons commented that this procedure was originally defined and valued as a procedure that included the removal of a left lateral segment from a parent to be transplanted into their child. However, now a considerable number of the living donor partial hepatectomies are right lobectomies and this service involves considerably more intraoperative work as the anatomic considerations are more critical and the risk to the donor is greater.	The RUC recommends that this issue be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49495	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; reducible	5.89	5.89	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	At the time this code was originally reviewed in 1993, the "typical" patient requiring this procedure was based on a mix of infant/premature infants. However, in current practice the patient population and ratio of premature to term babies has changed, as repair is now recommended prior to discharge from the NICU. The "typical" patient is now a premature neonate with very difficult anatomy, repair and postoperative care. As the typical patient has changed in that this service is typically performed on premature neonates, the RUC agreed to refer this code to CPT to create a new code that accurately describes this service performed on premature infants.	5
49496	Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; incarcerated or strangulated	8.79	8.79	The ACS commented that 322 general surgery codes have been historically misvalued and proposed new work relative values based on the "building block" approach.	The RUC noted that the "typical" patient requiring this procedure was based on a mix of infant/premature infants. However, in current practice the patient population and ratio of premature to term babies has changed, as repair is now recommended prior to discharge from the NICU. The "typical" patient is now a premature neonate with very difficult anatomy, repair and postoperative care. As the typical patient has changed in that this service is typically performed on premature neonates, the RUC agreed to refer this code to CPT to create a new code that accurately describes this service performed on premature infants.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
49905	Omental flap (eg, for reconstruction of sternal and chest wall defects) (List separately in addition to code for primary procedure)	6.55	6.55	<p>ASPS maintains that, for this code to be used as it was originally intended for reconstruction of sternal and chest wall defects, code 49905 should be designated as a primary procedure code (not an add-on code) with a 90 day global period. Accordingly, the work value of the code should be adjusted to reflect the true physician work involved in transferring an omental flap from one body cavity to another. Using 49000 (Exploratory laparotomy) and 49255 together as a basis to value the work of 49905 understates the additional pre-, intra- and post-operative work involved in transferring the omental flap from one body cavity to another.</p> <p>To appropriate estimate the value of 49905 with a 90 day global period, ASPS has chosen as a primary reference service, code 15734 (Muscle, myocutaneous or fasciocutaneous flap; trunk) which is currently valued at 17.79 and a 90 day global period. Clearly the work of 15734 is significantly higher than that of the current omental flap. Considering that a separate body cavity must be entered in order to harvest the flap, the current value for the work involved in this procedure (omental flap) does not reflect the time and effort involved in reconstruction of the sternum.</p>	The RUC noted that code 49905 should be designated as a primary procedure and not an add-on code and should have a 90 day global. The ASPS asked the RUC to disregard the STS survey, as it did not provide compelling evidence for recommending an increase in RVU's. Based upon this information presented, the RUC agreed to maintain the current RVU and to refer this issue to the CPT Editorial Panel to address whether the code should be a stand-alone code or an add-on code.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
50200	Renal biopsy; percutaneous, by trocar or needle	2.63	2.63	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The RUC recommends that this service be referred to CPT for further consideration.	5
50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	22.07	22.07	The AUA believes that the total work value does not account for all of the in-hospital and out-of-hospital post-operative care.	The RUC noted that the code descriptor for code 50230 includes the term "and/or vena caval thrombectomy." As this procedure may now be performed with the vena caval thrombectomy or without, the RUC referred this code back to CPT to separate this code into two distinct services so each may be reported and valued appropriately.	5
90935	Hemodialysis procedure with single physician evaluation	1.22	1.22	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.11	2.11	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
90945	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration), with single physician evaluation	1.28	1.28	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90947	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration) requiring repeated evaluations, with or without substantial revision of dialysis prescription	2.16	2.16	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90989	Dialysis training, patient, including helper where applicable, any mode, completed course	0.00	0.00	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session	0.00	0.00	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5

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CPT Code	Description	2000 Work RVU	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
90997	Hemoperfusion (eg, with activated charcoal or resin)	1.84	1.84	There are specialized skills that are required to place central venous catheters in vessels that are smaller than adults. Also, conscious sedation is also employed to keep these young children immobile so that the catheter can be successfully placed. There is also increased risk of complications.	The recommends that this issue be referred to CPT for further consideration.	5
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	0.00	0.00	Many times, the nebulizer treatment is provided by the physician. There is also cognitive physician work done in deciding to provide these treatments. Will require sedation or general anesthesia in a child.	The RUC noted that this code is used to report services for teaching patients how to use an inhaler and that for the typical patient, the physician does not provide this service as the code is not presently valued. Based upon the information contained in the survey, the RUC was unclear as to what physician services were included in the code. As this information was unclear, the RUC agreed that this code should be sent to CPT for clarification.	5
94665	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	0.00	0.00	Many times, the nebulizer treatment is provided by the physician. There is also cognitive physician work done in deciding to provide these treatments. Will require sedation or general anesthesia in a child.	The RUC noted that this code is used to report services for teaching patients how to use an inhaler and that for the typical patient, the physician does not provide this service as the code is not presently valued. Based upon the information contained in the survey, the RUC was unclear what physician services are included in this code. As this information was unclear, the RUC agreed that this code should be sent to CPT for clarification.	5

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