

2009 RBRVS

WHAT IS IT AND HOW DOES IT AFFECT PEDIATRICS?

The Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule on January 1, 1992. The Medicare RBRVS physician fee schedule replaced the Medicare physician payment system of “customary, prevailing, and reasonable” (CPR) charges under which physicians were paid according to the historical record of the charge for the provision of each service. The current Medicare RBRVS physician fee schedule is derived from the “relative value” of services provided and based on the resources they consume. The relative value of each service is quantifiable and is based on the concept that there are three components of each service: the amount of physician work that goes into the service, the practice expense associated with the service, and the professional liability expense for the provision of the service. The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation is the Medicare payment amount for the provision of a particular service. It is critical to note that 77% of public and private payers, including Medicaid programs, have adopted components of the Medicare RBRVS to pay physicians, while others are exploring its implementation. For more information on RBRVS, go to <http://pediatrics.aappublications.org/cgi/content/abstract/113/5/1437> or <http://www.ama-assn.org/ama/pub/category/2292.html>.

ELEMENTS OF THE RBRVS

Physician Work (Work)

The physician work component of the Medicare RBRVS physician fee schedule is maintained and updated by CMS with input from the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 29 members, consisting of 23 representatives from major medical specialty societies, as well as representatives from the American Medical Association, the American Osteopathic Association, the Health Care Professionals Advisory Committee, the Practice Expense Subcommittee, and the CPT Editorial Panel. The American Academy of Pediatrics (AAP) holds one of the 23 seats designated for medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units (RVUs) of physician work and establishes payment policy, which is published in the *Federal Register* (<http://www.cms.hhs.gov/PhysicianFeeSched/>).

The physician work component represents approximately 52% of the total RVUs for each service. Physician work is divided into pre-service, intra-service, and post-service periods that equal the total value of work for each service. The total value of physician work contained in the Medicare RBRVS physician fee schedule for each service consists of the following components:

- Physician time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with physician’s concern about the iatrogenic risk to the patient

Practice Expense (PE)

The practice expense component represents approximately 44% of the total RVUs for each service. In 2002, an initial four-year transition to resource-based practice expense RVUs was completed. A second four-year transition using a revised practice expense methodology started in 2007. CMS uses many sources and methodologies to determine practice expense RVUs. Beginning in 1998, some CPT codes were assigned two (2) practice expense RVUs: a lesser one for procedures performed in a facility (ie, a hospital, skilled nursing facility, or ambulatory surgical center) and a greater one for procedures/services performed at a non-facility site (ie, physician's office or patient's home). This policy continues for 2009.

Professional Liability Insurance (PLI) (Malpractice)

Professional liability insurance (malpractice) expense relative values amount to approximately 4% of the physician fee schedule payment. CMS replaced the cost-based professional liability insurance relative values with resource-based professional liability insurance RVUs in 2000. The end result of its computations was to retain the same total professional liability insurance RVUs as they were under the charge-based system.

Medicare Global Period

On the Medicare physician fee schedule, each CPT code is assigned a designation in the Medicare "global period" column. Medicare Global Periods define the post-operative period for procedures and affect how follow-up services are reported for a given CPT code. The Medicare Global Period designations are defined as follows:

Medicare Global Period

<u>Designation</u>	<u>Definition</u>	<u>Explanation (Example)</u>
000	Zero-day Medicare Global Period	Payment for a 0-day global code includes the procedure/service plus any associated care provided on the same day of service (eg, 54150)
010	Ten-day Medicare Global Period	Payment for a 10-day global code includes the procedure/service plus any associated follow-up care for 10 days (eg, 24640)
090	Ninety-day Medicare Global Period	Payment for a 90-day global code includes the procedure/service plus any associated follow-up care for 90 days (eg, 25600)
XXX	The Medicare Global Period concept does not apply	Payment for an XXX code includes only the procedure/service (eg, 90471)
ZZZ	Code related to another service that is always included in the Medicare Global Period of another service	Payment for a ZZZ code includes only the procedure/service; ZZZ codes are usually add-on codes to XXX codes (eg, 90472)
YYY	The global period is to be set by the carrier	This designation is usually reserved for unlisted surgery codes (eg, 24999)

Components of a Medicare Global Period including the following:

- Pre-operative visits: Pre-operative visits *after the decision is made to operate* beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures

- Intra-operative services: Intra-operative services that are normally a usual and necessary part of a surgical procedure
- Complications following surgery: All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room

Payers that adopt Medicare's RBRVS RVUs should also be following Medicare policy with respect to Medicare Global Periods.

Geographic Practice Cost Indices (GPCIs)

The Geographic Practice Cost Indices (GPCIs) reflect the relative costs associated with physician work, practice, and professional liability insurance in a Medicare locality compared to the national average relative costs.

- Cost of Living GPCI: Applied to physician work relative values
- Practice Cost GPCI: Applied to practice expense relative values
- Professional Liability Insurance Cost GPCI: Applied to professional liability insurance relative values

2009
Geographic Practice Cost Indices (GPCIs) By Medicare Locality

Medicare Locality Name	Work	Practice Expense	Professional Liability Insurance
Alabama	1.000	0.853	0.496
Alaska	1.500	1.090	0.646
Arizona	1.000	0.957	0.822
Arkansas	1.000	0.846	0.446
Anaheim/Santa Ana, California	1.034	1.269	0.811
Los Angeles, California	1.041	1.225	0.804
Marin/Napa/Solano, California	1.034	1.265	0.432
Oakland/Berkeley, California	1.053	1.286	0.425
San Francisco, California	1.059	1.441	0.414
San Mateo, California	1.072	1.433	0.394
Santa Clara, California	1.083	1.294	0.377
Ventura, California	1.027	1.265	0.766
Rest of California	1.007	1.058	0.549
Colorado	1.000	0.992	0.641
Connecticut	1.038	1.185	0.980
District of Columbia + Maryland/Virginia Suburbs	1.047	1.218	1.032
Delaware	1.011	1.046	0.678
Fort Lauderdale, Florida	1.000	1.018	2.250
Miami, Florida	1.000	1.069	3.167
Rest of Florida	1.000	0.939	1.724
Atlanta, Georgia	1.009	1.014	0.836
Rest of Georgia	1.000	0.883	0.829
Hawaii/Guam	1.000	1.161	0.665
Idaho	1.000	0.883	0.546
Chicago, Illinois	1.025	1.080	1.940
East St Louis, Illinois	1.000	0.919	1.793
Suburban Chicago, Illinois	1.017	1.068	1.629
Rest of Illinois	1.000	0.880	1.219
Indiana	1.000	0.918	0.599
Iowa	1.000	0.870	0.434
Kansas	1.000	0.882	0.557
Kentucky	1.000	0.860	0.652
New Orleans, Louisiana	1.000	1.044	0.956
Rest of Louisiana	1.000	0.878	0.892
Southern Maine	1.000	1.025	0.492
Rest of Maine	1.000	0.893	0.492
Baltimore/Surrounding Counties, Maryland	1.012	1.057	1.086
Rest of Maryland	1.000	0.982	0.874
Metropolitan Boston	1.029	1.291	0.764
Rest of Massachusetts	1.007	1.106	0.764
Detroit, Michigan	1.036	1.040	1.906
Rest of Michigan	1.000	0.923	1.083
Minnesota	1.000	0.983	0.245
Mississippi	1.000	0.854	0.808

Medicare Locality Name	Work	Practice Expense	Professional Liability Insurance
Metropolitan Kansas City, Missouri	1.000	0.945	1.188
Metropolitan St Louis, Missouri	1.000	0.931	1.075
Rest of Missouri	1.000	0.821	0.997
Montana	1.000	0.847	0.673
Nebraska	1.000	0.890	0.245
Nevada	1.002	1.026	1.083
New Hampshire	1.000	1.039	0.462
Northern New Jersey	1.057	1.228	1.116
Rest of New Jersey	1.042	1.126	1.116
New Mexico	1.000	0.890	1.096
Manhattan, New York	1.064	1.298	1.010
New York City Suburbs/Long Island, New York	1.051	1.289	1.235
Poughkeepsie/ Northern New York City Suburbs, New York	1.014	1.077	0.822
Queens, New York	1.032	1.239	1.220
Rest of New York	1.000	0.921	0.425
North Carolina	1.000	0.925	0.634
North Dakota	1.000	0.844	0.387
Ohio	1.000	0.927	1.232
Oklahoma	1.000	0.850	0.627
Portland, Oregon	1.002	1.015	0.472
Rest of Oregon	1.000	0.927	0.472
Metropolitan Philadelphia, Pennsylvania	1.016	1.097	1.617
Rest of Pennsylvania	1.000	0.925	1.081
Puerto Rico	1.000	0.694	0.250
Rhode Island	1.013	1.088	0.996
South Carolina	1.000	0.906	0.446
South Dakota	1.000	0.864	0.420
Tennessee	1.000	0.889	0.608
Austin, Texas	1.000	0.984	0.969
Beaumont, Texas	1.000	0.875	1.346
Brazoria, Texas	1.019	0.922	1.223
Dallas, Texas	1.009	1.001	1.110
Forth Worth Texas	1.000	0.953	1.110
Galveston, Texas	1.000	0.959	1.223
Houston, Texas	1.016	0.986	1.345
Rest of Texas	1.000	0.879	1.065
Utah	1.000	0.907	1.026
Vermont	1.000	0.983	0.489
Virginia	1.000	0.942	0.657
Virgin Islands	1.000	0.978	1.009
Seattle (King County), Washington	1.014	1.085	0.706
Rest of Washington	1.000	0.974	0.693
West Virginia	1.000	0.827	1.353
Wisconsin	1.000	0.921	0.409
Wyoming	1.000	0.842	0.889

NOTE: The Medicare Improvements for Patients and Providers Act of 2008 extended the work GPCI floor (1.000) through December 31, 2009 and provided a 1.500 work GPCI for Alaska starting in 2009.

Medicare Conversion Factor (CF)

The Medicare Conversion Factor (CF) is a national value that converts the total RVUs into payment amounts for the purpose of paying physicians for services provided. Since January 1, 1998, there has been one Medicare Conversion Factor, as specified by the Balanced Budget Act of 1997. Anesthesia has a separate conversion factor, but is paid using a different formula. The Medicare Conversion Factor is updated annually. Medicare Conversion Factors in past years have been \$36.6137 (2000), \$38.2581 (2001), \$36.1992 (2002), \$36.7856 (2003), \$37.3374 (2004), \$37.8975 (2005), \$37.8975 (2006), \$37.8975 (2007), and \$38.0870 (2008).

2009 Medicare Conversion Factor = \$36.0666

Additional components of the Medicare RBRVS physician fee schedule factored into the payment structure include the following:

- **MEI:** The allocation of RVUs to pools for physician work, practice expense, and professional liability insurance have been revised to correspond with the Medicare Economic Index. Work is now allocated 52% of the total RVUs, practice expense is 44%, and professional liability insurance is 4%.
- **HPSA:** Incentive payments for physician services provided to patients in Health Professional Shortage Areas (HPSAs), which are medically underserved communities, urban and rural locations that have a documented shortage of medical professionals.
- **Nonparticipating Physicians:** Reduced payments for physicians, called “nonparticipating” physicians, who do not accept Medicare “assignment.” The law sets the payment amount for nonparticipating physicians at 95% of the payment amount for participating physicians (ie, the fee schedule amount).
- **Budget Neutrality:** Statutory guidelines indicate that revisions to the RVUs for physician services may not alter physician expenditures within the Medicare RBRVS physician fee schedule by more than \$20 million from the principal expenditures that would have resulted if the RVU adjustments were never initiated. In 2007 and 2008, the Medicare program applied a separate budget neutrality adjustment factor to the physician work RVUs to ensure Medicare budget neutrality in light of work RVU increases tied to the 2005 Five-Year Review. However, by virtue of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS is now required to maintain Medicare budget neutrality exclusively via annual adjustments to the Medicare Conversion Factor starting in 2009.

HOW TO USE THE RBRVS

CMS publishes RVUs for CPT codes in the *Federal Register*. To calculate the Medicare physician payment for a service, the RVUs for each of the three components of the Medicare RBRVS physician fee schedule are multiplied by their corresponding GPICs to account for geographic differences in resource costs. The sum of these calculations is then multiplied by a dollar conversion factor. When determining payment, it is important to take into consideration all the mechanisms within the Medicare RBRVS physician fee schedule incorporated into the final payment for physician services. Please note that third-party payers other than Medicare may not use all of the elements of the RBRVS to determine physician payment. For example, they may use their own conversion factor or not factor in the GPICs.

Example: Level 3 office visit for the evaluation and management of an established patient in Marco Island, Florida (“Rest of Florida” Medicare Locality).

[Remember that in order for the physician to code 99213, the appropriate history, physical examination, and medical decision-making must be documented.]

The following RVUs, GPCIs, and Medicare Conversion Factor are based on the information provided by CMS in the *Federal Register* on November 19, 2008.

CPT Code 99213		Location: Marco Island, Florida ("Rest of Florida" Medicare Locality)	
Work RVUs	0.92	Work GPCI	1.000
Non-Facility Practice Expense RVUs	0.75	Practice Expense GPCI	0.939
Professional Liability Insurance RVUs	0.03	Professional Liability Insurance GPCI	1.724

METHOD 1 (NON-GEOGRAPHICALLY ADJUSTED & USING NON-MEDICARE CONVERSION FACTOR)

This is an example of a physician payment mechanism in a non-facility setting that takes into consideration the total RVUs from the Medicare RBRVS but excludes all other components of the physician fee schedule. Often the total RVUs are multiplied by a payer-specific conversion factor that is not associated with the Medicare Conversion Factor.

STEP 1

Add together the physician work, non-facility practice expense, and professional liability insurance RVUs to obtain the total non-facility RVUs for the office visit.

$$\begin{aligned} &\text{Total non-facility RVUs for CPT code 99213} = \\ &\text{Work RVUs} + \text{Non-Facility Practice Expense RVUs} + \text{Professional Liability Insurance RVUs} \\ &(0.92) + (0.75) + (0.03) = 1.70 \end{aligned}$$

STEP 2

Multiply the total Medicare RVUs for CPT code 99213 by a non-Medicare, payer-specific primary care conversion factor (which may or may not be different than the 2009 Medicare Conversion Factor of \$36.0666).

For example: Payer-specific primary care conversion factor = \$38.00

$$\begin{aligned} &\text{Total physician payment for the provision of CPT code 99213 by this third-party payer} = \\ &(\text{Total Medicare RVUs}) \times (\text{Payer CF}) \\ &(1.70) \times (38.00) = \$64.60 \end{aligned}$$

Note: In some cases, payers will not use the Medicare total RVUs for a service in their calculation of physician payment. Instead, they may apply their own relative value adjustments.

METHOD 2 (GEOGRAPHICALLY ADJUSTED & USING MEDICARE CONVERSION FACTOR)

This is an example of the Medicare RBRVS physician fee schedule payment in a non-facility setting for CPT code 99213 in Marco Island, Florida. The following example assumes that a physician has accepted assignment and is practicing in an area of the country that does not have a shortage of medical professionals.

STEP 1

Multiply the physician work, non-facility practice expense, and professional liability insurance RVUs by the appropriate GPCIs; add the figures thus obtained to get the total geographically adjusted RVUs for the office visit.

$$\begin{aligned} &\text{Total non-facility RVUs for CPT code 99213 (geographically adjusted) =} \\ &(\text{Work RVUs} \times \text{Work GPCI}) + (\text{Non-Facility Practice Expense RVUs} \times \text{Practice Expense GPCI}) + (\text{PLI RVUs} \times \text{PLI GPCI}) \\ &(0.92 \times 1.000) + (0.75 \times 0.939) + (0.03 \times 1.724) \\ &(0.92) + (0.70425) + (0.05172) = 1.67597 \end{aligned}$$

STEP 2

Multiply the total geographically adjusted RVUs by the Medicare Conversion Factor to obtain the physician payment for the office visit.

2009 Medicare Conversion Factor (CF) = \$36.0666

$$\begin{aligned} &\text{Total Medicare payment for the provision of CPT code 99213 in Marco Island, Florida =} \\ &\text{Total geographically adjusted RVUs for CPT code 99213} \times \text{2009 Medicare Conversion Factor} \\ &(1.67597 \times \$36.0666 = \$60.45) \end{aligned}$$

In this example, a physician practicing in Marco Island, Florida would receive \$60.45 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, access the 2009 RBRVS Conversion Spreadsheet at <http://www.aap.org/visit/RBRVSConversionSpreadsheet.xls>.

A table that provides RVUs for a series of CPT codes commonly reported by pediatricians has been included at the end of this document. Please refer to this table to determine Medicare RVUs for other pediatric services and procedures.

CONCLUDING REMARKS

In today's rapidly changing health care environment, it is crucial to understand the Medicare RBRVS physician fee schedule. Many third-party payers, including Medicaid programs, Blue Cross Blue Shield carriers, and managed care organizations are utilizing variations of the Medicare RBRVS to determine physician payment rates. In order for a physician to succeed in the changing marketplace, measurements of the costs involved in providing services will need to be ascertained; these costs include physician income and benefits, practice expenses, professional liability insurance premiums, as well as the frequency of services provided. Once this information is determined and the appropriate RVUs for each service are obtained, a physician will be able to calculate the costs involved in the provision of each service, as well as the average cost per service provided and per member per month estimates.

For further information, please contact the Division of Health Care Finance and Quality Improvement at dhcfqi@aap.org.

Developed by the Committee on Coding and Nomenclature, with contributions by Linda Walsh and Becky Dolan.

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2009 MEDICARE RELATIVE VALUE UNITS (RVUs)

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Office or Other Outpatient Services, New Patient								
99201	Problem-focused history and exam/straightforward	0.45	0.54	0.17	0.03	1.02/\$36.79	0.65/\$23.44	XXX
99202	Expanded problem-focused history and exam/straightforward	0.88	0.83	0.32	0.05	1.76/\$63.48	1.25/\$45.08	XXX
99203	Detailed history and exam/low complexity	1.34	1.12	0.46	0.09	2.55/\$91.97	1.89/\$68.17	XXX
99204	Comprehensive history and exam/moderate complexity	2.30	1.51	0.74	0.12	3.93/\$141.74	3.16/\$113.97	XXX
99205	Comprehensive history and exam/high complexity	3.00	1.81	0.96	0.15	4.96/\$178.89	4.11/\$148.23	XXX
Office or Other Outpatient Services, Established Patient								
99211	May or may not require physician presence, minimal	0.17	0.34	0.06	0.01	0.52/\$18.75	0.24/\$8.66	XXX
99212	Problem-focused history and exam/straightforward	0.45	0.55	0.16	0.03	1.03/\$37.15	0.64/\$23.08	XXX
99213	Expanded problem-focused history and exam/low complexity	0.92	0.75	0.29	0.03	1.70/\$61.31	1.24/\$44.72	XXX
99214	Detailed history and exam/moderate complexity	1.42	1.09	0.45	0.05	2.56/\$92.33	1.92/\$69.25	XXX
99215	Comprehensive history and exam/high complexity	2.00	1.38	0.65	0.08	3.46/\$124.79	2.73/\$98.46	XXX
Office or Other Outpatient Consultations								
99241	Problem focused	0.64	0.66	0.23	0.05	1.35/\$48.69	0.92/\$33.18	XXX
99242	Expanded problem-focused	1.34	1.08	0.50	0.10	2.52/\$90.89	1.94/\$69.97	XXX
99243	Detailed	1.88	1.45	0.69	0.13	3.46/\$124.79	2.70/\$97.38	XXX
99244	Comprehensive/moderate complexity	3.02	1.93	1.09	0.16	5.11/\$184.30	4.27/\$154.00	XXX
99245	Comprehensive/high complexity	3.77	2.30	1.35	0.21	6.28/\$226.50	5.33/\$192.23	XXX
Prolonged Physician Service With Face-To-Face Patient Contact; Outpatient								
99354	Prolonged physician service; first hour	1.77	0.70	0.56	0.08	2.55/\$91.97	2.41/\$86.92	ZZZ
99355	Prolonged physician service; each additional 30 minutes	1.77	0.68	0.54	0.07	2.52/\$90.89	2.38/\$85.84	ZZZ
Preventive Medicine Services, New Patient								
99381	Preventive visit, new, age under 1 yr	N _{1.19}	1.27	0.41	0.05	2.51/\$90.53	1.65/\$59.51	XXX
99382	Preventive visit, new, age 1–4	N _{1.36}	1.32	0.47	0.05	2.73/\$98.46	1.88/\$67.81	XXX
99383	Preventive visit, new, age 5–11	N _{1.36}	1.30	0.47	0.05	2.71/\$97.74	1.88/\$67.81	XXX
99384	Preventive visit, new, age 12–17	N _{1.53}	1.36	0.53	0.06	2.95/\$106.40	2.12/\$76.46	XXX
99385	Preventive visit, new, age 18–39	N _{1.53}	1.36	0.53	0.06	2.95/\$106.40	2.12/\$76.46	XXX
Preventive Medicine Services, Established Patient								
99391	Preventive visit, est, age under 1 yr	N _{1.02}	1.03	0.35	0.04	2.09/\$75.38	1.41/\$50.85	XXX
99392	Preventive visit, est, age 1–4	N _{1.19}	1.09	0.41	0.05	2.33/\$84.04	1.65/\$59.51	XXX
99393	Preventive visit, est, age 5–11	N _{1.19}	1.08	0.41	0.05	2.32/\$83.67	1.65/\$59.51	XXX
99394	Preventive visit, est, age 12–17	N _{1.36}	1.14	0.47	0.05	2.55/\$91.97	1.88/\$67.81	XXX
99395	Preventive visit, est, age 18–39	N _{1.36}	1.15	0.47	0.05	2.56/\$92.33	1.88/\$67.81	XXX
Immunization Administration								
90471	Immunization admin; one vaccine	0.17	0.40	N/A	0.01	0.58/\$20.92	N/A	XXX
90472	Immunization admin; each additional vaccine	0.15	0.13	0.06	0.01	0.29/\$10.46	0.22/\$7.93	ZZZ
90473	Immunization admin by intranasal/oral route; one vaccine	0.17	0.20	0.05	0.01	0.38/\$13.71	0.23/\$8.30	XXX
90474	Immunization admin by intranasal/oral route; each additional vaccine	0.15	0.09	0.05	0.01	0.25/\$9.02	0.21/\$7.57	ZZZ

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Immunization Administration Under Age 8 With Physician Counseling								
90465	Immunization admin, first injection	0.17	0.40	N/A	0.01	0.58/\$20.92	N/A	XXX
90466	Immunization admin, each addition injection	0.15	0.13	0.06	0.01	0.29/\$10.46	0.22/\$7.93	ZZZ
90467	Immunization admin by intranasal/oral route, first administration	0.17	0.20	0.08	0.01	0.38/\$13.71	0.26/\$9.38	XXX
90468	Immunization admin by intranasal/oral route, each additional administration	0.15	0.12	0.05	0.01	0.28/\$10.10	0.21/\$7.57	ZZZ
Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration								
96360	Intravenous infusion, hydration; i nitial, up to 1 hour	0.17	1.33	N/A	0.07	1.57/\$56.62	N/A	XXX
96361	Intravenous infusion, hydration; each additional hour	0.09	0.33	N/A	0.04	0.46/\$16.59	N/A	ZZZ
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour	0.21	1.63	N/A	0.07	1.91/\$68.89	N/A	XXX
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour	0.18	0.39	N/A	0.04	0.61/\$22.00	N/A	ZZZ
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion, up to 1 hour	0.19	0.73	N/A	0.04	0.96/\$34.62	N/A	ZZZ
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	0.17	0.36	N/A	0.04	0.57/\$20.56	N/A	ZZZ
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	0.17	0.40	N/A	0.01	0.58/\$20.92	N/A	XXX
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial	0.17	0.31	N/A	0.02	0.50/\$18.03	N/A	XXX
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug	0.18	1.29	N/A	0.04	1.51/\$54.46	N/A	XXX
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push or a new substance/drug	0.10	0.52	N/A	0.04	0.66/\$23.80	N/A	ZZZ
Vision & Hearing Screening								
99173	Screening of visual acuity, quantitative, bilateral	N _{0.00}	0.06	N/A	0.01	0.07/\$2.52	N/A	XXX
99174	Ocular photoscreening with interpretation and report, bilateral	N _{0.00}	0.69	N/A	0.01	0.70/\$25.25	N/A	XXX
92551	Screening test, pure tone, air only	N _{0.00}	0.28	N/A	0.01	0.29/\$10.46	N/A	XXX
92552	Pure tone audiometry (threshold); air only	0.00	0.55	N/A	0.04	0.59/\$21.28	N/A	XXX
Developmental Testing								
96110	Developmental testing; limited with interpretation and report	0.00	0.18	N/A	0.18	0.36/\$12.98	N/A	XXX
96111	Developmental testing; extended with interpretation and report, per hour	2.60	0.83	0.75	0.18	3.61/\$130.20	3.53/\$127.32	XXX
Care Plan Oversight								
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes	B _{1.25}	0.74	N/A	0.06	2.05/\$73.94	N/A	XXX
99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 30 minutes or more	B _{1.80}	0.99	N/A	0.07	2.86/\$103.15	N/A	XXX

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Physician Non-Face-To-Face Services								
99441	Telephone E/M service; 5-10 minutes	N _{0.25}	0.12	0.08	0.02	0.39/\$14.07	0.35/\$12.62	XXX
99442	Telephone E/M service; 11-20 minutes	N _{0.50}	0.20	0.17	0.02	0.72/\$25.97	0.69/\$24.89	XXX
99443	Telephone E/M service; 21-30 minutes	N _{0.75}	0.28	0.25	0.03	1.06/\$38.23	1.03/\$37.15	XXX
99444	Online E/M service	N _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
Non-Physician Non-Face-To-Face Services								
98966	Telephone E/M service; 5-10 minutes	N _{0.25}	0.12	0.08	0.01	0.38/\$13.71	0.34/\$12.26	XXX
98967	Telephone E/M service; 11-20 minutes	N _{0.50}	0.20	0.17	0.02	0.72/\$25.97	0.69/\$24.89	XXX
98968	Telephone E/M service; 21-30 minutes	N _{0.75}	0.28	0.25	0.03	1.06/\$38.23	1.03/\$37.15	XXX
98969	Online E/M service	N _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
Physician Medical Team Conference								
99367	Medical team conference, patient/family not present, 30 minutes or more	1.10	0.37	0.37	0.05	1.52/\$54.82	1.52/\$54.82	XXX
Newborn Care Services								
99460	Initial care, normal newborn	1.17	0.34	0.34	0.05	1.56/\$56.26	1.56/\$56.26	XXX
99461	Newborn care not in hospital	1.26	1.01	0.42	0.07	2.34/\$84.40	1.75/\$63.12	XXX
99462	Subsequent normal newborn care	0.62	0.19	0.19	0.02	0.83/\$29.94	0.83/\$29.94	XXX
99463	Newborn admit/discharge same day	1.50	N/A	0.53	0.06	N/A	2.09/\$75.38	XXX
99464	Attendance at delivery	1.50	0.40	0.40	0.06	1.96/\$70.69	1.96/\$70.69	XXX
99465	Newborn resuscitation	2.93	0.97	0.97	0.12	4.02/\$144.99	4.02/\$144.99	XXX
Initial Hospital Care								
99221	Detailed history and exam	1.88	N/A	0.54	0.07	N/A	2.49/\$89.81	XXX
99222	Comprehensive history and exam/moderate complexity	2.56	N/A	0.74	0.10	N/A	3.40/\$122.63	XXX
99223	Detailed history and exam/high complexity	3.78	N/A	1.09	0.13	N/A	5.00/\$180.33	XXX
Subsequent Hospital Care								
99231	Problem-focused history and exam/low complexity	0.76	N/A	0.24	0.03	N/A	1.03/\$37.15	XXX
99232	Expanded problem-focused history and exam/moderate complexity	1.39	N/A	0.42	0.04	N/A	1.85/\$66.72	XXX
99233	Detailed history and exam/high complexity	2.00	N/A	0.59	0.06	N/A	2.65/\$95.58	XXX
Discharge Day Management								
99238	Discharge; 30 minutes or less	1.28	N/A	0.51	0.05	N/A	1.84/\$66.36	XXX
99239	Discharge; more than 30 minutes	1.90	N/A	0.70	0.07	N/A	2.67/\$96.30	XXX
Observation Care								
99217	Observation care discharge	1.28	N/A	0.51	0.06	N/A	1.85/\$66.72	XXX
99218	Initial observation care, per day	1.28	N/A	0.40	0.06	N/A	1.74/\$62.76	XXX
99219	Initial observation care, per day	2.14	N/A	0.64	0.10	N/A	2.88/\$103.87	XXX
99220	Initial observation care, per day	2.99	N/A	0.91	0.14	N/A	4.04/\$145.71	XXX
Prolonged Physician Service With Face-To-Face Patient Contact; Inpatient								
99356	Prolonged physician service; first hour	1.71	N/A	0.54	0.07	N/A	2.32/\$83.67	ZZZ
99357	Prolonged physician service; each additional 30 minutes	1.71	N/A	0.55	0.08	N/A	2.34/\$84.40	ZZZ
Physician Standby Services								
99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes	X _{1.20}	0.40	0.40	0.05	1.65/\$59.51	1.65/\$59.51	XXX
Critical Care Services								
99291	First 30-74 minutes	4.50	2.33	1.17	0.21	7.04/\$253.91	5.88/\$212.07	XXX
99292	Each additional 30 minutes	2.25	0.82	0.58	0.11	3.18/\$114.69	2.94/\$106.04	ZZZ

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Pediatric Critical Care Patient Transport								
99466	24 months of age or less; first 30-74 minutes	4.79	1.40	1.40	0.24	6.43/\$231.91	6.43/\$231.91	XXX
99467	24 months of age or less; each additional 30 minutes	2.40	0.69	0.69	0.12	3.21/\$115.77	3.21/\$115.77	ZZZ
Inpatient Pediatric and Neonatal Critical Care								
99468	Neonatal (28 days or less); initial	18.46	4.52	4.52	1.16	24.14/\$870.65	24.14/\$870.65	XXX
99469	Neonatal (28 days or less); subsequent	7.99	2.21	2.21	0.32	10.52/\$379.42	10.52/\$379.42	XXX
99471	Pediatric (29 days-24 mos); initial	15.98	4.47	4.47	1.12	21.57/\$777.96	21.57/\$777.96	XXX
99472	Pediatric (29 days-24 mos); subsequent	7.99	2.21	2.21	0.45	10.65/\$384.11	10.65/\$384.11	XXX
99475	Pediatric (2-5 years); initial	11.25	2.83	2.83	0.79	14.87/\$536.31	14.87/\$536.31	XXX
99476	Pediatric (2-5 years); subsequent	6.75	1.70	1.70	0.38	8.83/\$318.47	8.83/\$318.47	XXX
Initial and Continuing Intensive Care Services								
99477	Initial neonatal hospital care (28 days or less)	7.00	2.05	2.05	0.32	9.37/\$337.94	9.37/\$337.94	XXX
99478	Subsequent intensive care (<1,500 grams present body weight)	2.75	0.91	0.91	0.17	3.83/\$138.14	3.83/\$138.14	XXX
99479	Subsequent intensive care (1,500-2,500 grams present body weight)	2.50	0.71	0.71	0.16	3.37/\$121.54	3.37/\$121.54	XXX
99480	Subsequent intensive care (2501-5000 grams present body weight)	2.40	0.69	0.69	0.15	3.24/\$116.86	3.24/\$116.86	XXX
Moderate (Conscious) Sedation Provided by the Same Physician Performing the Diagnostic or Therapeutic Service								
99143	Under 5 years of age, first 30 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99144	Age 5 years or older, first 30 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99145	Each additional 15 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	ZZZ
Moderate (Conscious) Sedation Provided by a Physician Other than the Health Care Professional Performing the Diagnostic or Therapeutic Service								
99148	Under 5 years of age, first 30 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99149	Age 5 years or older, first 30 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99150	Each additional 15 minutes intra-service time	C _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	ZZZ
Miscellaneous Services								
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed, in addition to basic service	B _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	B _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	B _{0.00}	0.00	0.00	0.00	0.00/\$0.00	0.00/\$0.00	XXX
Allergen Immunotherapy								
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	0.00	0.27	N/A	0.02	0.29/\$10.46	N/A	XXX
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections	0.00	0.33	N/A	0.02	0.35/\$12.62	N/A	XXX

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Musculoskeletal Procedures								
23500	Closed treatment of clavicle fracture; without manipulation	2.13	2.69	2.66	0.30	5.12/\$184.66	5.09/\$183.58	090
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	1.22	1.55	0.79	0.12	2.89/\$104.23	2.13/\$76.82	010
25600	Closed treatment of distal radial fracture or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	2.69	3.78	3.13	0.42	6.89/\$248.50	6.24/\$225.06	090
Otolaryngology Procedures								
69200	Removal foreign body from external auditory canal; without general anesthesia	0.77	2.19	0.60	0.06	3.02/\$108.92	1.43/\$51.58	000
69210	Removal impacted cerumen (separate procedure), one or both ears	0.61	0.59	0.19	0.05	1.25/\$45.08	0.85/\$30.66	000
69401	Eustachian tube inflation, transnasal; without catheterization	0.63	1.38	0.59	0.05	2.06/\$74.30	1.27/\$45.80	000
Pulmonary Procedures								
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes	0.00	0.35	N/A	0.02	0.37/\$13.34	N/A	XXX
94664	Demonstration/evaluation of patient utilization of an aerosol generator, nebulizer, MDI, or IPPB device	0.00	0.37	N/A	0.04	0.41/\$14.79	N/A	XXX
Radiology Procedures								
76885	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)	0.74	2.88	N/A	0.13	3.75/\$135.25	N/A	XXX
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	0.62	2.04	N/A	0.11	2.77/\$99.90	N/A	XXX
Urology Procedures								
51701	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	0.50	1.17	0.24	0.04	1.71/\$61.67	0.78/\$28.13	000
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	2.73	0.75	0.16	4.79/\$172.76	2.81/\$101.35	000
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)	2.50	3.94	1.47	0.19	6.63/\$239.12	4.16/\$150.04	010
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age	3.29	N/A	2.12	0.23	N/A	5.64/\$203.42	010
54162	Lysis of excision of penile post-circumcision adhesions	3.27	4.20	2.12	0.21	7.68/\$276.99	5.60/\$201.97	0.10
Integumentary Procedures								
10060	Incision & drainage of abscess; simple or single	1.19	1.41	1.04	0.12	2.72/\$98.10	2.35/\$84.76	010
10120	Incision & removal of foreign body, subcutaneous tissues; simple	1.23	1.98	0.95	0.12	3.33/\$120.10	2.30/\$82.95	010
17110	Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	0.67	1.98	0.97	0.05	2.70/\$97.38	1.69/\$60.95	010
17111	Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	0.94	2.21	1.11	0.05	3.20/\$115.41	2.10/\$75.74	010
17250	Chemical cauterization of granulation tissue (proud flesh, sinus, or fistula)	0.50	1.28	0.37	0.06	1.84/\$66.36	0.93/\$33.54	000

CPT Code	Descriptor	Work RVUs	Non-Facility Practice Expense RVUs	Facility Practice Expense RVUs	PLI RVUs	Total Non-Facility RVUs/\$	Total Facility RVUs/\$	Medicare Global Period
Health & Behavior Assessment/Intervention								
96150	Health & behavior assessment, each 15 minutes face-to-face with the patient; initial assessment	0.50	0.12	0.11	0.01	0.63/\$22.72	0.62/\$22.36	XXX
96151	Health & behavior assessment, each 15 minutes face-to-face with the patient; re-assessment	0.48	0.12	0.11	0.01	0.61/\$22.00	0.60/\$21.64	XXX
96152	Health & behavior intervention, each 15 minutes, face-to-face; individual	0.46	0.11	0.10	0.01	0.58/\$20.92	0.57/\$20.56	XXX
96153	Health & behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	0.10	0.03	0.02	0.01	0.14/\$5.05	0.13/\$4.69	XXX
96154	Health & behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	0.45	0.11	0.10	0.01	0.57/\$20.56	0.56/\$20.20	XXX
96155	Health & behavior intervention, each 15 minutes, face-to-face; family (without the patient present)	0.44	0.16	0.15	0.02	0.62/\$22.36	0.61/\$22.00	XXX
Medical Nutrition Therapy								
97802	Medical nutrition therapy; initial assessment & intervention, individual, face-to-face with patient, each 15 minutes	0.53	0.27	0.22	0.01	0.81/\$29.21	0.76/\$27.41	XXX
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with patient, each 15 minutes	0.45	0.25	0.20	0.01	0.71/\$25.61	0.66/\$23.80	XXX
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	0.25	0.10	0.10	0.01	0.36/\$12.98	0.36/\$12.98	XXX
Education & Training for Patient Self-Management								
98960	Education & training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with patient each 30 minutes; individual patient	0.00	0.65	N/A	0.01	0.66/\$23.80	N/A	XXX
98961	Education & training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with patient each 30 minutes; 2-4 patients	0.00	0.31	N/A	0.01	0.32/\$11.54	N/A	XXX
98962	Education & training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with patient each 30 minutes; 5-8 patients	0.00	0.23	N/A	0.01	0.24/\$8.66	N/A	XXX
Counseling Risk Factor Reduction & Behavior Change Intervention								
99401	Preventive medicine counseling and/or risk factor reduction intervention(s); approximately 15 minutes	0.48	0.48	0.17	0.01	0.97/\$34.98	0.66/\$23.80	XXX
99402	Preventive medicine counseling and/or risk factor reduction intervention(s); approximately 30 minutes	0.98	0.67	0.34	0.02	1.67/\$60.23	1.34/\$48.33	XXX
99403	Preventive medicine counseling and/or risk factor reduction intervention(s); approximately 45 minutes	1.46	0.85	0.51	0.04	2.35/\$84.76	2.01/\$72.49	XXX
99404	Preventive medicine counseling and/or risk factor reduction intervention(s); approximately 60 minutes	1.95	1.03	0.68	0.05	3.03/\$109.28	2.68/\$96.66	XXX
99406	Smoking & tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	0.24	0.11	0.07	0.01	0.36/\$12.98	0.32/\$11.54	XXX
99407	Smoking & tobacco cessation counseling visit; intensive, greater than 10 minutes	0.50	0.18	0.15	0.01	0.69/\$24.89	0.66/\$23.80	XXX
99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	0.65	0.26	0.22	0.01	0.92/\$33.18	0.88/\$31.74	XXX
99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	1.30	0.48	0.44	0.03	1.81/\$65.28	1.77/\$63.84	XXX

Note: Information for table extracted from the *Federal Register*, November 19, 2008.

Key:

Work RVUs = Physician work RVUs

Non-facility practice expense RVUs = Practice expense RVUs for services provided in a non-facility (eg, physician's office) setting

Facility practice expense RVUs = Practice expense RVUs for services provided in a facility (eg, hospital) setting

PLI RVUs = Professional liability insurance RVUs

Total non-facility RVUs = The sum of the work, non-facility practice expense, and PLI RVUs

Total facility RVUs = The sum of the work, facility practice expense, and PLI RVUs

\$ = Non-geographically adjusted Medicare payment

Medicare Global Period = Medicare Global Periods define the postoperative period for procedures and affect how follow-up services are reported for a given CPT code

N = Non-covered Medicare service; if RVUs are shown, they are not used for Medicare payment

B = Bundled Medicare service; if RVUs are shown, they are not used for Medicare payment

X = Medicare statutory exclusion; if RVUs are shown, they are not used for Medicare payment

C = Medicare carrier-priced service; individual payer payment policies apply

Note: The AAP works with the RUC and CMS to have values assigned and published for *all* CPT codes.

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