American Academy of Pediatrics
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2017 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 (PFS) 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 a 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, please go to http://pediatrics.aappublications.org/content/133/6/1158.

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 American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 31 members, consisting of 21 representatives from major medical specialty societies, as well as representatives from the American Medical Association (AMA), 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 21 seats designated for medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units (RVUs) of physician work to establish the Medicare RBRVS physician fee schedule.

The physician work component represents approximately 50.9% 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 44.8% 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 and was completed in 2010. A third four-year transition started in 2010 and was completed in 2013, during which CMS made additional practice expense revisions using: 1) the results of the Physician Practice Information (PPI) Survey, sponsored by the AMA and 72 medical specialty societies and health professional organizations; and 2) the assumption that diagnostic imaging equipment such as CT and MRI are in use 90 percent of the time that an office is open instead of 50 percent of the time.

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 2017.

Professional Liability Insurance (PLI) (Malpractice)
Professional liability insurance (malpractice) expense relative values amount to approximately 4.3% 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 is statutorily required to review, and if necessary, adjust the malpractice RVUs no less than every 5 years based on updated and expanded malpractice premium data collection.

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 Designation	Definition	Explanation (Example)
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, 90460)
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, 90461)
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 post-operative 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

2017 Medicare Geographic Practice Cost Indices (GPCIs)

Medicare Locality	Work (with 1.0 floor)	Practice Expense (PE)	Professional Liability Insurance (PLI)
Alabama	1.000	0.888	0.552
Alaska*	1.500	1.112	0.710
Arizona	1.000	0.986	0.856
Arkansas	1.000	0.870	0.555
Bakersfield, CA	1.024	1.079	0.610
Chico, CA	1.024	1.079	0.610
El Centro, CA	1.024	1.079	0.610
Fresno, CA	1.024	1.079	0.610
Hanford-Corcoran, CA	1.024	1.079	0.610
Los Angeles-Long Beach-Anaheim (Los Angeles County), CA	1.047	1.169	0.801
Los Angeles-Long Beach-Anaheim (Orange County), CA	1.041	1.197	0.801
Madera, CA	1.024	1.079	0.610
Merced, CA	1.024	1.079	0.610
Modesto, CA	1.024	1.079	0.610
Napa, CA	1.057	1.271	0.477
Oxnard-Thousand Oaks-Ventura, CA	1.027	1.178	0.754
Redding, CA	1.024	1.079	0.610
Riverside-San Bernardino-Ontario, CA	1.024	1.079	0.626
Sacramento-Roseville-Arden-Arcade, CA	1.024	1.080	0.610
Salinas, CA	1.024	1.083	0.610
San Diego-Carlsbad, CA	1.024	1.088	0.610
San Francisco-Oakland-Hayward (Alameda/Contra Costa County), CA	1.068	1.293	0.439
San Francisco-Oakland-Hayward (Marin County), CA	1.058	1.271	0.477
San Francisco-Oakland-Hayward (San Francisco County), CA	1.077	1.357	0.439
San Francisco-Oakland-Hayward (San Mateo County), CA	1.077	1.349	0.419
San Jose-Sunnyvale-Santa Clara (San Benito County), CA	1.031	1.121	0.610
San Jose-Sunnyvale-Santa Clara (Santa Clara County), CA	1.086	1.351	0.402
San Luis Obispo-Paso Robles-Arroyo Grande, CA	1.024	1.079	0.610

Santa Cruz-Watsonville, CA	1.024	1.103	0.610
Santa Maria-Santa Barbara, CA	1.024	1.091	0.610
Santa Rosa, CA	1.024	1.093	0.610
Stockton-Lodi, CA	1.024	1.079	0.610
Vallejo-Fairfield, CA	1.057	1.271	0.477
Visalia-Porterville, CA	1.024	1.079	0.610
Yuba City, CA	1.024	1.079	0.610
Rest of California	1.024	1.079	0.610
Colorado	1.000	1.015	1.066
Connecticut	1.023	1.117	1.244
DC + MD/VA Suburbs	1.048	1.205	1.271
Delaware	1.010	1.025	1.101
Fort Lauderdale, FL	1.000	1.021	1.756
Miami, FL	1.000	1.031	2.528
Rest of Florida	1.000	0.956	1.337
Atlanta, GA	1.000	1.001	1.016
Rest of Georgia	1.000	0.899	0.989
Hawaii/Guam	1.002	1.154	0.616
Idaho	1.000	0.900	0.510
Chicago, IL	1.012	1.036	1.972
East St Louis, IL	1.000	0.935	1.835
Suburban Chicago, IL	1.011	1.055	1.601
Rest of Illinois	1.000	0.914	1.231
Indiana	1.000	0.920	0.498
Iowa	1.000	0.902	0.458
Kansas	1.000	0.907	0.639
Kentucky	1.000	0.876	0.807
New Orleans, LA	1.000	0.975	1.332
Rest of Louisiana	1.000	0.887	1.202
Southern Maine	1.000	1.007	0.656
Rest of Maine	1.000	0.920	0.656
Baltimore/Surrounding Counties, MD	1.023	1.096	1.238
Rest of Maryland	1.012	1.035	1.027
Metropolitan Boston, MA	1.025	1.171	0.839
Rest of Massachusetts	1.019	1.067	0.839
Detroit, MI	1.000	0.992	1.510
Rest of Michigan	1.000	0.920	0.986
Minnesota	1.000	1.016	0.341
Mississippi	1.000	0.867	0.492
Metropolitan Kansas City, MO	1.000	0.958	1.049
Metropolitan St Louis, MO	1.000	0.957	1.039
Rest of Missouri	1.000	0.856	0.970

Montana**	1.000	1.000	1.429
Nebraska	1.000	0.909	0.340
Nevada**	1.004	1.034	0.946
New Hampshire	1.000	1.052	0.962
Northern New Jersey	1.041	1.181	1.014
Rest of New Jersey	1.025	1.124	1.014
New Mexico	1.000	0.920	1.204
Manhattan, NY	1.052	1.174	1.690
NYC Suburbs/Long Island, NY	1.044	1.207	2.182
Poughkeepsie/Northern NYC Suburbs, NY	1.013	1.072	1.399
Queens, NY	1.052	1.200	2.151
Rest of New York	1.000	0.948	0.678
North Carolina	1.000	0.931	0.732
North Dakota**	1.000	1.000	0.547
Ohio	1.000	0.918	0.999
Oklahoma	1.000	0.882	0.900
Portland, OR	1.008	1.052	0.746
Rest of Oregon	1.000	0.967	0.746
Metropolitan Philadelphia, PA	1.022	1.081	1.322
Rest of Pennsylvania	1.000	0.933	1.010
Puerto Rico	1.000	0.856	0.642
Rhode Island	1.025	1.052	0.879
South Carolina	1.000	0.912	0.634
South Dakota**	1.000	1.000	0.395
Tennessee	1.000	0.900	0.525
Austin, TX	1.000	1.020	0.757
Beaumont, TX	1.000	0.913	0.897
Brazoria, TX	1.020	0.994	0.897
Dallas, TX	1.015	1.012	0.770
Fort Worth, TX	1.006	0.991	0.760
Galveston, TX	1.020	1.012	0.897
Houston, TX	1.020	1.009	0.946
Rest of Texas	1.000	0.929	0.809
Utah	1.000	0.925	1.167
Vermont	1.000	1.010	0.639
Virginia	1.000	0.985	0.866
Virgin Islands	1.000	1.006	0.993
Seattle (King County), WA	1.026	1.151	0.713
Rest of Washington	1.000	1.013	0.689
West Virginia	1.000	0.847	1.289
Wisconsin	1.000	0.956	0.457
Wyoming**	1.000	1.000	1.050

*Work GPCI reflects a 1.5 floor for Alaska established by the MIPPA.
**PE GPCI reflects a 1.0 floor for frontier states established by the ACA.

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 under the Medicare program. 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.

Year	Conversion Factor	% Change	Primary Care Conversion Factor	% Change	Surgical Conversion Factor	% Change	Other Nonsurgical Conversion Factor	% Change
1992	$31.0010		N/A		N/A		N/A	
1993	N/A				$31.9620		$31.2490	
1994	N/A		$33.7180		$35.1580	10.0	$32.9050	5.3
1995	N/A		$36.3820	7.9	$39.4470	12.2	$34.6160	5.2
1996	N/A		$35.4173	-2.7	$40.7986	3.4	$34.6293	0.0
1997	N/A		$35.7671	1.0	$40.9603	0.4	$33.8454	-2.3
1998	$36.6873							
1999	$34.7315	-5.3						
2000	$36.6137	5.4						
2001	$38.2581	4.5						
2002	$36.1992	-5.4						
2003	$36.7856	1.6						
2004	$37.3374	1.5						
2005	$37.8975	1.5						
2006	$37.8975	0.0						
2007	$37.8975	0.0						
2008	$38.0870	0.5						
2009	$36.0666	-5.3						
1/1/10-5/31/10	$36.0791	0.03						
6/1/10-12/31/10	$36.8729	2.2						
2011	$33.9764	-7.9						
2012	$34.0376	0.18						
2013	$34.0230	-0.04						
2014	$35.8228	5.3						
1/1/15-6/30/15	$35.7547	-0.19						
7/1/15-12/31/15	$35.9335	0.5						
2016	$35.8043	-0.36						
2017	**$35.89**	**0.0025**						

Initially, the Medicare Physician Fee Schedule (PFS) included distinct conversion factors for various categories of services. In 1998, a single conversion factor was offset by elimination of the work adjustor and increases in the practice expense and PLI RVUs.

2017

After consideration of public comments, CMS finalized misvalued code changes that achieve 0.32 percent in net expenditure reductions. These changes do not fully meet the misvalued code target of 0.5 percent, thus requiring an adjustment to the 2017 overall physician update. After applying this and other adjustments required by law, the 2017 PFS conversion factor is $35.89, an increase to the 2016 PFS conversion factor of $35.80.

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 GPCIs 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 GPCIs.

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 published by CMS.

CPT Code 99213		Location: Marco Island, Florida ('Rest of Florida' Medicare Locality)	
Work RVUs	0.97	Work GPCI	1.000
Non-Facility Practice Expense RVUs	1.02	Practice Expense GPCI	0.956
Professional Liability Insurance RVUs	0.07	Professional Liability Insurance GPCI	1.337

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.

Total non-facility RVUs for CPT code 99213 =
Work RVUs + Non-Facility Practice Expense RVUs + Professional Liability Insurance RVUs
(0.97) + (1.02) + (0.07) = 2.06

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 2017 Medicare conversion factor of $35.89).

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

Total physician payment for the provision of CPT code 99213 by this third-party payer =
(Total Medicare RVUs) x (Payer CF)
(2.06) x (38.00) = $78.28

Note: In some cases, payers will not use the Medicare total RVUs for a service in the 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.

Total non-facility RVUs for CPT code 99213 (geographically adjusted) =
(Work RVUs x Work GPCI) + (Non-Facility Practice Expense RVUs x Practice Expense GPCI) + (PLI RVUs x PLI GPCI)
(0.97 x 1.000) + (1.02 x 0.956) + (0.07 x 1.337)
(0.97) + (0.97512) + (0.09359) = 2.03871

STEP 2
Multiply the total geographically adjusted RVUs by the Medicare conversion factor to obtain the physician payment for the office visit.

2017 Medicare conversion factor (CF) = $35.89

Total Medicare payment for the provision of CPT code 99213 in Marco Island, Florida =
Total geographically adjusted RVUs for CPT code 99213 x 2017 Medicare conversion factor
(2.03871 x $35.89 = $73.17)

In this example, a physician practicing in Marco Island, Florida will receive $73.17 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, please access the 2017 RBRVS Conversion Spreadsheet.

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, private 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 AAP Coding Hotline.

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

CPT Code	Work RVUs (wRVUs)	Non-Facility (NF) Practice Expense (PE) RVUs	Facility (F) Practice Expense (PE) RVUs	PLI RVUs	Total NF RVUs	Total F RVUs	100% Medicare (NF)	100% Medicare (F)
Office Or Other Outpatient Services, New Patient								
99201	0.48	0.71	0.23	0.05	1.24	0.76	$44.50	$27.28
99202	0.93	1.10	0.42	0.08	2.11	1.43	$75.73	$51.32
99203	1.42	1.48	0.60	0.15	3.05	2.17	$109.46	$77.88
99204	2.43	1.98	1.02	0.22	4.63	3.67	$166.17	$131.72
99205	3.17	2.37	1.32	0.29	5.83	4.78	$209.24	$171.55
Office Or Other Outpatient Services, Established Patient								
99211	0.18	0.38	0.07	0.01	0.57	0.26	$20.46	$9.33
99212	0.48	0.71	0.20	0.04	1.23	0.72	$44.14	$25.84
99213	0.97	1.02	0.40	0.07	2.06	1.44	$73.93	$51.68
99214	1.50	1.43	0.62	0.10	3.03	2.22	$108.75	$79.68
99215	2.11	1.82	0.88	0.15	4.08	3.14	$146.43	$112.69
Office Or Other Outpatient Consultations*								
99241[I]	0.64	0.66	0.24	0.04	1.34	0.92	$48.09	$33.02
99242[I]	1.34	1.10	0.51	0.08	2.52	1.93	$90.44	$69.27
99243[I]	1.88	1.46	0.71	0.11	3.45	2.70	$123.82	$96.90
99244[I]	3.02	1.96	1.14	0.18	5.16	4.34	$185.19	$155.76
99245[I]	3.77	2.30	1.38	0.22	6.29	5.37	$225.75	$192.73
Prolonged Service With Face-To-Face Patient Contact; Outpatient								
99354	2.33	1.17	0.96	0.16	3.66	3.45	$131.36	$123.82
99355	1.77	0.87	0.67	0.12	2.76	2.56	$99.06	$91.88
Preventive Medicine Services, New Patient								
99381[N]	1.50	1.52	0.58	0.09	3.11	2.17	$111.62	$77.88
99382[N]	1.60	1.56	0.61	0.09	3.25	2.30	$116.64	$82.55
99383[N]	1.70	1.59	0.65	0.10	3.39	2.45	$121.67	$87.93
99384[N]	2.00	1.69	0.77	0.12	3.81	2.89	$136.74	$103.72
99385[N]	1.92	1.66	0.74	0.11	3.69	2.77	$132.43	$99.42
Preventive Medicine Services, Established Patient								
99391[N]	1.37	1.34	0.53	0.08	2.79	1.98	$100.13	$71.06
99392[N]	1.50	1.39	0.58	0.09	2.98	2.17	$106.95	$77.88
99393[N]	1.50	1.38	0.58	0.09	2.97	2.17	$106.59	$77.88
99394[N]	1.70	1.46	0.65	0.10	3.26	2.45	$117.00	$87.93
99395[N]	1.75	1.48	0.67	0.10	3.33	2.52	$119.51	$90.44
Immunization Administration Through Age 18 With Counseling								
90460	0.17	0.54	NA	0.01	0.72	NA	$25.84	NA
90461	0.15	0.20	NA	0.01	0.36	NA	$12.92	NA
Immunization Administration								
90471	0.17	0.54	NA	0.01	0.72	NA	$25.84	NA

90472	0.15	0.20	NA	0.01	0.36	NA	$12.92	NA
90473[R]	0.17	0.54	NA	0.01	0.72	NA	$25.84	NA
90474[R]	0.15	0.20	NA	0.01	0.36	NA	$12.92	NA
Hydration, Therapeutic, Prophylactic, & Diagnostic Injections & Infusions, & Chemotherapy & Other Highly Complex Drug Or Highly Complex Biologic Agent Administration								
96360	0.17	1.43	NA	0.03	1.63	NA	$58.50	NA
96361	0.09	0.33	NA	0.01	0.43	NA	$15.43	NA
96365	0.21	1.70	NA	0.04	1.95	NA	$69.99	NA
96366	0.18	0.34	NA	0.01	0.53	NA	$19.02	NA
96374	0.18	1.40	NA	0.04	1.62	NA	$58.14	NA
Vision & Hearing Screening								
99173[N]	0.00	0.08	NA	0.01	0.09	NA	$3.23	NA
99174[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	NA
99177[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	NA
92551[N]	0.00	0.33	NA	0.01	0.34	NA	$12.20	NA
92552	0.00	0.88	NA	0.01	0.89	NA	$31.94	NA
Developmental Screening & Testing								
96110[N]	0.00	0.26	NA	0.01	0.27	NA	$9.69	NA
96111	2.60	0.97	0.80	0.14	3.71	3.54	$133.15	$127.05
Emotional/Behavioral Assessment								
96127	0.00	0.15	NA	0.01	0.16	NA	$5.74	NA
Health Risk Assessment								
96160	0.00	0.13	NA	0.00	0.13	NA	$4.67	NA
96161	0.00	0.13	NA	0.00	0.13	NA	$4.67	NA
Topical Application of Fluoride Varnish								
99188[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
Care Plan Oversight								
99339[B]	1.25	0.86	NA	0.07	2.18	NA	$78.24	NA
99340[B]	1.80	1.15	NA	0.11	3.06	NA	$109.82	NA
Chronic Care Management								
99487	1.00	1.55	0.41	0.06	2.61	1.47	$93.67	$52.76
99489	0.50	0.78	0.21	0.03	1.31	0.74	$47.02	$26.56
99490	0.61	0.54	0.26	0.04	1.19	0.91	$42.71	$32.66
Transitional Care Management								
99495	2.11	2.37	0.88	0.13	4.61	3.12	$165.45	$111.98
99496	3.05	3.28	1.28	0.19	6.52	4.52	$234.00	$162.22
Physician Telephone & Online E/M Services								
99441[N]	0.25	0.13	0.10	0.01	0.39	0.36	$14.00	$12.92
99442[N]	0.50	0.23	0.19	0.03	0.76	0.72	$27.28	$25.84
99443[N]	0.75	0.33	0.29	0.04	1.12	1.08	$40.20	$38.76
Codes 99444-99449 are bundled by Medicare and have no published RVUs.								
Prolonged Service Before/After Direct Patient Care								
99358	2.10	0.91	0.91	0.15	3.16	3.16	$113.41	$113.41
99359	1.00	0.45	0.45	0.07	1.52	1.52	$54.55	$54.55
Physician Medical Team Conference								
99367[B]	1.10	NA	0.42	0.07	NA	1.59	NA	$57.07

Newborn Care Services								
99460	1.92	NA	0.79	0.12	NA	2.83	NA	$101.57
99461	1.26	1.29	0.45	0.08	2.63	1.79	$94.39	$64.24
99462	0.84	NA	0.37	0.05	NA	1.26	NA	$45.22
99463	2.13	NA	1.11	0.14	NA	3.38	NA	$121.31
99464	1.50	NA	0.59	0.09	NA	2.18	NA	$78.24
99465	2.93	NA	1.21	0.18	NA	4.32	NA	$155.04
Initial Hospital Care								
99221	1.92	NA	0.76	0.19	NA	2.87	NA	$103.00
99222	2.61	NA	1.05	0.21	NA	3.87	NA	$138.89
99223	3.86	NA	1.58	0.29	NA	5.73	NA	$205.65
Subsequent Hospital Care								
99231	0.76	NA	0.29	0.06	NA	1.11	NA	$39.84
99232	1.39	NA	0.56	0.09	NA	2.04	NA	$73.22
99233	2.00	NA	0.81	0.14	NA	2.95	NA	$105.88
Discharge Day Management								
99238	1.28	NA	0.69	0.08	NA	2.05	NA	$73.57
99239	1.90	NA	1.02	0.12	NA	3.04	NA	$109.11
Initial Observation Care								
99217	1.28	NA	0.69	0.09	NA	2.06	NA	$73.93
99218	1.92	NA	0.75	0.15	NA	2.82	NA	$101.21
99219	2.60	NA	1.06	0.18	NA	3.84	NA	$137.82
99220	3.56	NA	1.45	0.24	NA	5.25	NA	$188.42
Subsequent Observation Care								
99224	0.76	NA	0.31	0.06	NA	1.13	NA	$40.56
99225	1.39	NA	0.58	0.09	NA	2.06	NA	$73.93
99226	2.00	NA	0.84	0.13	NA	2.97	NA	$106.59
Emergency Department Services								
99281	0.45	NA	0.11	0.04	NA	0.60	NA	$21.53
99282	0.88	NA	0.21	0.08	NA	1.17	NA	$41.99
99283	1.34	NA	0.29	0.12	NA	1.75	NA	$62.81
99284	2.56	NA	0.53	0.23	NA	3.32	NA	$119.15
99285	3.80	NA	0.75	0.35	NA	4.90	NA	$175.86
Prolonged Service With Face-To-Face Patient Contact; Inpatient								
99356	1.71	NA	0.78	0.11	NA	2.60	NA	$93.31
99357	1.71	NA	0.78	0.11	NA	2.60	NA	$93.31
Physician Standby Services								
99360[X]	1.20	NA	0.46	0.07	NA	1.73	NA	$62.09
Critical Care Services								
99291	4.50	2.86	1.43	0.39	7.75	6.32	$278.15	$226.82
99292	2.25	1.02	0.72	0.20	3.47	3.17	$124.54	$113.77
Pediatric Critical Care Patient Transport								
99466	4.79	NA	1.79	0.31	NA	6.89	NA	$247.28
99467	2.40	NA	0.92	0.14	NA	3.46	NA	$124.18
99485[B]	1.50	NA	0.58	0.09	NA	2.17	NA	$77.88
99486[B]	1.30	NA	0.50	0.08	NA	1.88	NA	$67.47
Inpatient Pediatric & Neonatal Critical Care								
99468	18.46	NA	7.80	1.84	NA	28.10	NA	$1,008.51
99469	7.99	NA	2.78	0.53	NA	11.30	NA	$405.56
99471	15.98	NA	6.86	1.60	NA	24.44	NA	$877.15

99472	7.99	NA	3.00	0.67	NA	11.66	NA	$418.48
99475	11.25	NA	4.20	0.86	NA	16.31	NA	$585.37
99476	6.75	NA	2.46	0.53	NA	9.74	NA	$349.57
Initial & Continuing Intensive Care Services								
99477	7.00	NA	2.56	0.44	NA	10.00	NA	$358.90
99478	2.75	NA	1.06	0.16	NA	3.97	NA	$142.48
99479	2.50	NA	0.87	0.16	NA	3.53	NA	$126.69
99480	2.40	NA	0.85	0.16	NA	3.41	NA	$122.38
Neonatal & Pediatric Transfusion								
36440	1.03	NA	0.40	0.14	NA	1.57	NA	$56.35
36450	3.50	NA	1.45	0.45	NA	5.40	NA	$193.81
36455	2.43	NA	0.80	0.48	NA	3.71	NA	$133.15
36456	2.00	NA	0.83	0.26	NA	3.09	NA	$110.90
Initiation of Neonatal Hypothermia								
99184	4.50	NA	1.18	0.36	NA	6.04	NA	$216.78
Moderate Sedation Provided By The Same Physician Performing The Diagnostic Or Therapeutic Service								
99151	0.50	1.63	0.12	0.05	2.18	0.67	$78.24	$24.05
99152	0.25	1.18	0.08	0.02	1.45	0.35	$52.04	$12.56
99153	0.00	0.30	NA	0.01	0.31	NA	$11.13	NA
Moderate Sedation Provided By A Physician Other Than The Provider Performing The Diagnostic Or Therapeutic Service								
99155	1.90	NA	0.56	0.17	NA	2.63	NA	$94.39
99156	1.65	NA	0.35	0.15	NA	2.15	NA	$77.16
99157	1.25	NA	0.27	0.11	NA	1.63	NA	$58.50
Allergen Immunotherapy								
95115	0.00	0.24	NA	0.01	0.25	NA	$8.97	NA
95117	0.00	0.28	NA	0.01	0.29	NA	$10.41	NA
Orthopedic Procedures								
23500	2.21	3.62	3.72	0.38	6.21	6.31	$222.88	$226.47
24640	1.25	1.92	1.04	0.16	3.33	2.45	$119.51	$87.93
25600	2.78	6.04	5.54	0.50	9.32	8.82	$334.49	$316.55
Otolaryngologic Procedures								
69200	0.77	1.48	0.49	0.10	2.35	1.36	$84.34	$48.81
69209	0.00	0.35	NA	0.01	0.36	NA	$12.92	NA
69210	0.61	0.71	0.26	0.07	1.39	0.94	$49.89	$33.74
Pulmonary Procedures								
94640	0.00	0.51	NA	0.01	0.52	NA	$18.66	NA
94664	0.00	0.48	NA	0.01	0.49	NA	$17.59	NA
94780	0.48	1.17	0.19	0.03	1.68	0.70	$60.30	$25.12
94781	0.17	0.47	0.07	0.01	0.65	0.25	$23.33	$8.97
Radiologic Procedures								
76885	0.74	3.38	NA	0.05	4.17	NA	$149.66	NA
76886	0.62	2.44	NA	0.04	3.10	NA	$111.26	NA
Urologic Procedures								
51701	0.50	0.79	0.18	0.06	1.35	0.74	$48.45	$26.56
54150	1.90	2.29	0.70	0.23	4.42	2.83	$158.63	$101.57
54160	2.53	3.47	1.35	0.28	6.28	4.16	$225.39	$149.30
54161	3.32	NA	1.98	0.38	NA	5.68	NA	$203.86

54162	3.32	3.66	2.04	0.37	7.35	5.73	$263.79	$205.65
Dermatologic Procedures								
10060	1.22	1.98	1.43	0.13	3.33	2.78	$119.51	$99.77
10120	1.22	2.96	1.59	0.14	4.32	2.95	$155.04	$105.88
17110	0.70	2.35	1.21	0.09	3.14	2.00	$112.69	$71.78
17111	0.97	2.63	1.36	0.13	3.73	2.46	$133.87	$88.29
17250	0.50	1.67	0.49	0.07	2.24	1.06	$80.39	$38.04
Health & Behavior Assessment/Intervention								
96150	0.50	0.09	0.08	0.02	0.61	0.60	$21.89	$21.53
96151	0.48	0.09	0.08	0.02	0.59	0.58	$21.18	$20.82
96152	0.46	0.08	0.07	0.02	0.56	0.55	$20.10	$19.74
96153	0.10	0.02	0.01	0.01	0.13	0.12	$4.67	$4.31
96154	0.45	0.08	0.07	0.02	0.55	0.54	$19.74	$19.38
96155	0.44	0.17	0.17	0.03	0.64	0.64	$22.97	$22.97
Medical Nutrition Therapy								
97802	0.53	0.43	0.37	0.02	0.98	0.92	$35.17	$33.02
97803	0.45	0.38	0.31	0.02	0.85	0.78	$30.51	$27.99
97804	0.25	0.19	0.17	0.01	0.45	0.43	$16.15	$15.43
Education & Training For Patient Self-Management								
98960[B]	0.00	0.77	NA	0.02	0.79	NA	$28.35	NA
98961[B]	0.00	0.37	NA	0.01	0.38	NA	$13.64	NA
98962[B]	0.00	0.27	NA	0.01	0.28	NA	$10.05	NA
Counseling Risk Factor Reduction & Behavior Change Intervention								
99401[N]	0.48	0.51	0.18	0.03	1.02	0.69	$36.61	$24.76
99402[N]	0.98	0.70	0.38	0.06	1.74	1.42	$62.45	$50.96
99403[N]	1.46	0.89	0.56	0.09	2.44	2.11	$87.57	$75.73
99404[N]	1.95	1.07	0.75	0.12	3.14	2.82	$112.69	$101.21
99406	0.24	0.15	0.09	0.02	0.41	0.35	$14.71	$12.56
99407	0.50	0.25	0.19	0.04	0.79	0.73	$28.35	$26.20
99408[N]	0.65	0.30	0.25	0.04	0.99	0.94	$35.53	$33.74
99409[N]	1.30	0.55	0.50	0.08	1.93	1.88	$69.27	$67.47
Sleep Medicine Testing								
95782	2.60	25.96	NA	0.29	28.85	NA	$1,035.43	NA
95783	2.83	29.68	NA	0.28	32.79	NA	$1,176.83	NA

*While payment for consultations (including CPT codes 99241-99245) was eliminated in the Medicare program effective January 1, 2010, please note:

- Consultation codes have not been deleted from CPT nomenclature
- Consultation codes remain on the RBRVS fee schedule with their established values
- It is a *Medicare payment policy* and may not be adopted by other payers. However, if non-Medicare payers *do* choose to adopt this policy, it is imperative that they also make the budgetary accommodations as have been done in the Medicare program. The Medicare funds saved in not paying for consultations were used to increase the RBRVS relative value units for other evaluation and management (E/M) codes, including the new and established office visit codes (99201-99215) and the initial hospital care codes (99221-99223). Non-Medicare payers that follow the Medicare consultation policy must also utilize the higher RVUs for these non-consultation E/M codes.

The Academy advocates with non-Medicare payers to discourage adoption of the Medicare consultation policy. For more information, please see the AAP Position on Medicare Consultation.

Key:
Work RVUs = Physician work RVUs
Non-facility practice expense RVUs = Practice expense RVUs for services provided in a non-facility setting (eg, physician's office)
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 = Sum of the work, non-facility practice expense, and PLI RVUs
Total facility RVUs = Sum of the work, facility practice expense, and PLI RVUs
100% Medicare = Non-geographically adjusted Medicare payment (either non-facility (NF) or facility (F))

B = Bundled Medicare service; if RVUs are shown, they are not used for Medicare payment
C = Medicare carrier-priced service; individual payer payment policies apply
I = Not valid for Medicare purposes; Medicare uses another code for the reporting of these services
N = Non-covered Medicare service; if RVUs are shown, they are not used for Medicare payment
R = Restricted coverage; special coverage instructions apply; if the service is covered and no RVUs are shown, it is carrier-priced
X = Medicare statutory exclusion; if RVUs are shown, they are not used for Medicare payment
Note: AAP works with the RUC and CMS to have values assigned and published for *all* CPT codes