American Academy of Ped

2019 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.

ELEMENTS OF 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 2019.

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

2019 Medicare Geographic Practice Cost Indices (GPCIs)

Medicare Locality	Work*	Practice Expense (PE)	Professional Liability Insurance (PLI)
Alabama	1.000	0.890	0.492
Alaska**	1.500	1.117	0.708
Arizona	1.000	0.971	0.834
Arkansas	1.000	0.872	0.576
Bakersfield, CA	1.020	1.074	0.618
Chico, CA	1.020	1.074	0.562
El Centro, CA	1.020	1.074	0.570
Fresno, CA	1.020	1.074	0.562
Hanford-Corcoran, CA	1.021	1.074	0.562
Los Angeles-Long Beach-Anaheim (Los Angeles County), CA	1.046	1.177	0.694
Los Angeles-Long Beach-Anaheim (Orange County), CA	1.046	1.177	0.694
Madera, CA	1.020	1.074	0.562
Merced, CA	1.020	1.074	0.562
Modesto, CA	1.020	1.074	0.562
Napa, CA	1.055	1.256	0.458
Oxnard-Thousand Oaks-Ventura, CA	1.024	1.176	0.673
Redding, CA	1.020	1.074	0.562
Riverside-San Bernardino-Ontario, CA	1.021	1.074	0.753
Sacramento-Roseville-Arden-Arcade, CA	1.027	1.092	0.562
Salinas, CA	1.026	1.101	0.562
San Diego-Carlsbad, CA	1.023	1.116	0.570
San Francisco-Oakland-Hayward (Alameda/Contra Costa County), CA	1.075	1.325	0.421
San Francisco-Oakland-Hayward (Marin County), CA	1.065	1.291	0.458
San Francisco-Oakland-Hayward (San Francisco County), CA	1.075	1.325	0.421
San Francisco-Oakland-Hayward (San Mateo County), CA	1.075	1.325	0.421
San Jose-Sunnyvale-Santa Clara (San Benito County), CA	1.052	1.214	0.562
San Jose-Sunnyvale-Santa Clara (Santa Clara County), CA	1.083	1.354	0.388
San Luis Obispo-Paso Robles-Arroyo Grande, CA	1.020	1.084	0.562
Santa Cruz-Watsonville, CA	1.030	1.161	0.562
Santa Maria-Santa Barbara, CA	1.032	1.126	0.562
Santa Rosa, CA	1.024	1.130	0.562
Stockton-Lodi, CA	1.020	1.074	0.562
Vallejo-Fairfield, CA	1.055	1.256	0.458

Visalia-Porterville, CA	1.020	1.074	0.562
Yuba City, CA	1.020	1.074	0.562
Rest of California	1.020	1.074	0.562
Colorado	1.000	1.018	1.042
Connecticut	1.021	1.112	1.255
DC + MD/VA Suburbs	1.045	1.205	1.261
Delaware	1.007	1.019	1.119
Fort Lauderdale, FL	1.000	1.012	1.797
Miami, FL	1.000	1.029	2.566
Rest of Florida	1.000	0.952	1.358
Atlanta, GA	1.000	0.997	1.088
Rest of Georgia	1.000	0.899	1.073
Hawaii/Guam	1.001	1.146	0.614
Idaho	1.000	0.902	0.512
Chicago, IL	1.008	1.034	1.925
East St Louis, IL	1.000	0.936	1.785
Suburban Chicago, IL	1.009	1.053	1.565
Rest of Illinois	1.000	0.919	1.208
Indiana	1.000	0.919	0.379
Iowa	1.000	0.907	0.423
Kansas	1.000	0.911	0.615
Kentucky	1.000	0.880	0.819
New Orleans, LA	1.000	0.966	1.273
Rest of Louisiana	1.000	0.887	1.199
Southern Maine	1.000	1.007	0.670
Rest of Maine	1.000	0.922	0.670
Baltimore/Surrounding Counties, MD	1.023	1.095	1.295
Rest of Maryland	1.009	1.033	1.082
Metropolitan Boston, MA	1.033	1.179	1.061
Rest of Massachusetts	1.020	1.067	1.061
Detroit, MI	1.000	0.989	1.691
Rest of Michigan	1.000	0.919	1.018
Minnesota	1.000	1.011	0.362
Mississippi	1.000	0.870	0.370
Metropolitan Kansas City, MO	1.000	0.963	1.073
Metropolitan St Louis, MO	1.000	0.959	1.053
Rest of Missouri	1.000	0.863	0.993
Montana***	1.000	1.000	1.631
Nebraska	1.000	0.910	0.318
Nevada***	1.002	1.017	0.909
New Hampshire	1.000	1.045	1.050
Northern New Jersey	1.041	1.180	0.938

Rest of New Jersey	1.024	1.123	0.938
New Mexico	1.000	0.921	1.247
Manhattan, NY	1.052	1.180	1.615
NYC Suburbs/Long Island, NY	1.041	1.205	2.149
Poughkeepsie/Northern NYC Suburbs, NY	1.016	1.070	1.313
Queens, NY	1.052	1.200	2.121
Rest of New York	1.000	0.950	0.595
North Carolina	1.000	0.931	0.695
North Dakota***	1.000	1.000	0.540
Ohio	1.000	0.917	1.005
Oklahoma	1.000	0.891	0.954
Portland, OR	1.010	1.054	0.783
Rest of Oregon	1.000	0.967	0.783
Metropolitan Philadelphia, PA	1.022	1.074	1.379
Rest of Pennsylvania	1.000	0.936	1.033
Puerto Rico	1.000	1.007	0.990
Rhode Island	1.027	1.050	0.999
South Carolina	1.000	0.912	0.553
South Dakota***	1.000	1.000	0.389
Tennessee	1.000	0.901	0.526
Austin, TX	1.000	1.021	0.747
Beaumont, TX	1.000	0.924	0.839
Brazoria, TX	1.020	0.997	0.839
Dallas, TX	1.012	1.014	0.768
Fort Worth, TX	1.007	0.986	0.747
Galveston, TX	1.020	1.011	0.839
Houston, TX	1.020	1.012	0.936
Rest of Texas	1.000	0.938	0.796
Utah	1.000	0.927	1.165
Vermont	1.000	1.015	0.595
Virginia	1.000	0.986	0.908
Virgin Islands	1.000	1.007	0.990
Seattle (King County), WA	1.027	1.146	0.931
Rest of Washington	1.000	1.011	0.902
West Virginia	1.000	0.857	1.296
Wisconsin	1.000	0.957	0.347
Wyoming***	1.000	1.000	0.880

***January 1, 2019 through December 31, 2019, the GPCIs reflect a 1.0 Work GPCI floor as required by the Bipartisan Budget Act of 2018 (February 9, 2018).**
****Work GPCI reflects a 1.5 floor in 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.

History of Medicare Conversion Factors

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	$35.8887	0.0025						
2018	$35.9996	0.0041						
2019	**$36.0391**	**0.0039**						

Initially, the Medicare Physician Fee Schedule 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.

2019: The update adjustment factor for 2019, as required by section 53106 of the Bipartisan Budget Act of 2018, is 0.25 percent (1.0025) before applying the 2019 RVU Budget Neutrality Adjustment of -0.14 percent (-0.9986).

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 Green Bay, Wisconsin ('Wisconsin' 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: Green Bay, Wisconsin ('Wisconsin' Medicare Locality)	
Work RVUs	0.97	Work GPCI	1.000
Non-Facility Practice Expense RVUs	1.05	Practice Expense GPCI	0.957
Professional Liability Insurance RVUs	0.07	Professional Liability Insurance GPCI	0.347

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) + (1.05) + (0.07) = 2.09

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 2019 Medicare conversion factor of $36.0391).

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)
(2.09) x (38.00) = $79.42

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 Green Bay, Wisconsin. 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) + (1.05 x 0.957) + (0.07 x 0.347)
(0.97) + (1.00485) + (0.02429) = 1.99914

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

2019 Medicare conversion factor (CF) = $36.0391

Total Medicare payment for the provision of CPT code 99213 in Green Bay, Wisconsin =
Total geographically adjusted RVUs for CPT code 99213 x 2019 Medicare conversion factor
(1.99914 x $36.0391 = $72.05)

In this example, a physician practicing in Green Bay, Wisconsin will receive $72.05 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, please access the 2019 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.

CMS EVALUATION & MANAGEMENT PROPOSALS: STATUS FOR 2019

In its 2019 RBRVS proposed rule, CMS outlined the following evaluation and management (E/M)-related proposals:

1) Documentation Guidelines
2019 Proposed Rule: CMS proposed to allow use of (1) 1995 or 1997 documentation guidelines; (2) medical decision-making, or (3) time.

Status for 2019 (per 2019 RBRVS final rule): Physicians will still have to utilize either the 1995 or 1997 documentation guidelines. However, there has been some degree of 'relaxation' as follows:

- CMS changed the required documentation of the patient's history to focus only on the interval history since the previous visit
- CMS eliminated the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient

For 2021, CMS is finalizing the following policies:

- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;
- For E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented—specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making.
- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

2) Blending of E/M Codes
2019 Proposed Rule: CMS proposed collapsing payment for office/outpatient visits (99201-99205 and 99211-99215), with new patient office visit (99202-99205) payments blended to be $135 and established office visits (99212-99215) blended to be paid at $93. These rates represented a weighted average across all Part B utilization regardless of specialties.

Status for 2019 (per 2019 RBRVS final rule): E/M codes will remain unchanged for 2019.

For 2021, CMS is finalizing the following policy:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients

3) MPPR (Multiple Procedure Payment Reduction)

2019 Proposed Rule: CMS proposed to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit.

Status for 2019 (per 2019 RBRVS final rule): No MPPR for 2019. After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have reduced payment when E/M office/outpatient visits are furnished on the same day as procedures.

4) Creation of Three New Supplemental G Codes
2019 Proposed Rule: New HCPCS Level II G codes would be created to provide add-on payments to office visits for specific specialties ($14), primary care physicians ($5), and prolonged services ($67).

Status for 2019 (per 2019 RBRVS final rule): No new G codes for 2019.
For 2021, CMS is finalizing the following policies:

- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements
- Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient

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.

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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	0.76	0.23	0.05	1.29	0.76	$46.49	$27.39
99202	0.93	1.14	0.42	0.08	2.15	1.43	$77.48	$51.54
99203	1.42	1.49	0.59	0.14	3.05	2.15	$109.92	$77.48
99204	2.43	1.99	1.00	0.21	4.63	3.64	$166.86	$131.18
99205	3.17	2.38	1.31	0.27	5.82	4.75	$209.75	$171.19
Office Or Other Outpatient Services, Established Patient								
99211	0.18	0.45	0.07	0.01	0.64	0.26	$23.07	$9.37
99212	0.48	0.75	0.20	0.04	1.27	0.72	$45.77	$25.95
99213	0.97	1.05	0.40	0.07	2.09	1.44	$75.32	$51.90
99214	1.50	1.46	0.62	0.10	3.06	2.22	$110.28	$80.01
99215	2.11	1.84	0.87	0.15	4.10	3.13	$147.76	$112.80
Office Or Other Outpatient Consultations*								
99241[I]	0.64	0.66	0.24	0.04	1.34	0.92	$48.29	$33.16
99242[I]	1.34	1.10	0.51	0.08	2.52	1.93	$90.82	$69.56
99243[I]	1.88	1.46	0.71	0.11	3.45	2.70	$124.33	$97.31
99244[I]	3.02	1.96	1.14	0.18	5.16	4.34	$185.96	$156.41
99245[I]	3.77	2.30	1.38	0.22	6.29	5.37	$226.69	$193.53
Prolonged Service With Face-To-Face Patient Contact; Outpatient								
99354	2.33	1.18	0.95	0.16	3.67	3.44	$132.26	$123.97
99355	1.77	0.91	0.71	0.12	2.8	2.60	$100.91	$93.70
Preventive Medicine Services, New Patient								
99381[N]	1.50	1.54	0.58	0.09	3.13	2.17	$112.80	$78.20
99382[N]	1.60	1.58	0.62	0.10	3.28	2.32	$118.21	$83.61
99383[N]	1.70	1.61	0.66	0.10	3.41	2.46	$122.89	$88.66
99384[N]	2.00	1.73	0.76	0.12	3.85	2.88	$138.75	$103.79
99385[N]	1.92	1.69	0.73	0.11	3.72	2.76	$134.07	$99.47
Preventive Medicine Services, Established Patient								
99391[N]	1.37	1.37	0.53	0.08	2.82	1.98	$101.63	$71.36
99392[N]	1.50	1.42	0.58	0.09	3.01	2.17	$108.48	$78.20
99393[N]	1.50	1.41	0.58	0.09	3.00	2.17	$108.12	$78.20
99394[N]	1.70	1.49	0.66	0.10	3.29	2.46	$118.57	$88.66
99395[N]	1.75	1.51	0.68	0.10	3.36	2.53	$121.09	$91.18
Immunization Administration Through Age 18 With Counseling								
90460	0.17	0.29	NA	0.01	0.47	NA	$16.94	NA
90461	0.15	0.20	NA	0.01	0.36	NA	$12.97	NA
Immunization Administration								
90471	0.17	0.29	NA	0.01	0.47	NA	$16.94	NA
90472	0.15	0.20	NA	0.01	0.36	NA	$12.97	NA
90473[R]	0.17	0.29	NA	0.01	0.47	NA	$16.94	NA

90474[R]	0.15	0.20	NA	0.01	0.36	NA	$12.97	NA

Hydration, Therapeutic, Prophylactic, & Diagnostic Injections & Infusions, & Chemotherapy & Other Highly Complex Drug Or Highly Complex Biologic Agent Administration

96360	0.17	0.88	NA	0.02	1.07	NA	$38.56	NA
96361	0.09	0.28	NA	0.01	0.38	NA	$13.69	NA
96365	0.21	1.77	NA	0.04	2.02	NA	$72.80	NA
96366	0.18	0.42	NA	0.01	0.61	NA	$21.98	NA
96374	0.18	0.90	NA	0.02	1.10	NA	$39.64	NA

Vision & Hearing Screening

99173[N]	0.00	0.07	NA	0.01	0.08	NA	$2.88	NA
99174[N]	0.00	0.15	NA	0.01	0.16	NA	$5.77	NA
99177[N]	0.00	0.12	NA	0.01	0.13	NA	$4.69	NA
92551[N]	0.00	0.32	NA	0.01	0.33	NA	$11.89	NA
92552	0.00	0.88	NA	0.01	0.89	NA	$32.07	NA

Developmental Screening & Testing

96110[N]	0.00	0.27	NA	0.01	0.28	NA	$10.09	NA
96112	2.56	1.13	0.91	0.14	3.83	3.61	$138.03	$130.10
96113	1.16	0.48	0.42	0.07	1.71	1.65	$61.63	$59.46

Emotional/Behavioral Assessment

96127	0.00	0.14	NA	0.01	0.15	NA	$5.41	NA

Health Risk Assessment

96160	0.00	0.09	NA	0.00	0.09	NA	$3.24	NA
96161	0.00	0.09	NA	0.00	0.09	NA	$3.24	NA

Topical Application of Fluoride Varnish

99188[N]	0.20	0.14	0.08	0.01	0.35	0.29	$12.61	$10.45

Care Plan Oversight

99339[B]	1.25	0.85	NA	0.07	2.17	NA	$78.20	NA
99340[B]	1.80	1.14	NA	0.11	3.05	NA	$109.92	NA

Behavioral/Psychiatric Collaborative Care Management

99484	0.61	0.70	0.26	0.04	1.35	0.91	$48.65	$32.80
99492	1.70	2.69	0.70	0.11	4.50	2.51	$162.18	$90.46
99493	1.53	1.96	0.64	0.10	3.59	2.27	$129.38	$81.81
99494	0.82	0.99	0.35	0.05	1.86	1.22	$67.03	$43.97

Chronic Care Management

99487	1.00	1.52	0.41	0.06	2.58	1.47	$92.98	$52.98
99489	0.50	0.76	0.21	0.03	1.29	0.74	$46.49	$26.67
99490	0.61	0.52	0.25	0.04	1.17	0.90	$42.17	$32.44

Transitional Care Management

99495	2.11	2.38	0.87	0.13	4.62	3.11	$166.50	$112.08
99496	3.05	3.27	1.26	0.20	6.52	4.51	$234.97	$162.54

Physician Telephone/Interprofessional Internet Consultation/Online E/M Services

99441[N]	0.25	0.13	0.10	0.01	0.39	0.36	$14.06	$12.97
99442[N]	0.50	0.23	0.19	0.03	0.76	0.72	$27.39	$25.95
99443[N]	0.75	0.33	0.29	0.04	1.12	1.08	$40.36	$38.92
99444[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
99446	0.35	NA	0.14	0.02	NA	0.51	NA	$18.38
99447	0.70	NA	0.27	0.04	NA	1.01	NA	$36.40
99448	1.05	NA	0.41	0.06	NA	1.52	NA	$54.78

99449	1.40	NA	0.55	0.08	NA	2.03	NA	$73.16
99451	0.70	0.29	0.29	0.05	1.04	1.04	$37.48	$37.48
99452	0.70	0.29	0.29	0.05	1.04	1.04	$37.48	$37.48
Medicare Virtual Communication Technology-Based Services								
G2010	0.18	0.16	0.07	0.01	0.35	0.26	$12.61	$9.37
G2012	0.25	0.14	0.10	0.02	0.41	0.37	$14.78	$13.33
Prolonged Service Before/After Direct Patient Care								
99358	2.10	0.90	0.90	0.15	3.15	3.15	$113.52	$113.52
99359	1.00	0.45	0.45	0.07	1.52	1.52	$54.78	$54.78
Physician Medical Team Conference								
99367[B]	1.10	NA	0.43	0.07	NA	1.60	NA	$57.66
Newborn Care Services								
99460	1.92	NA	0.67	0.12	NA	2.71	NA	$97.67
99461	1.26	1.24	0.44	0.08	2.58	1.78	$92.98	$64.15
99462	0.84	NA	0.29	0.06	NA	1.19	NA	$42.89
99463	2.13	NA	0.86	0.14	NA	3.13	NA	$112.80
99464	1.50	NA	0.52	0.10	NA	2.12	NA	$76.40
99465	2.93	NA	1.01	0.19	NA	4.13	NA	$148.84
Initial Hospital Care								
99221	1.92	NA	0.75	0.19	NA	2.86	NA	$103.07
99222	2.61	NA	1.04	0.21	NA	3.86	NA	$139.11
99223	3.86	NA	1.56	0.28	NA	5.70	NA	$205.42
Subsequent Hospital Care								
99231	0.76	NA	0.29	0.06	NA	1.11	NA	$40.00
99232	1.39	NA	0.56	0.10	NA	2.05	NA	$73.88
99233	2.00	NA	0.79	0.14	NA	2.93	NA	$105.59
Discharge Day Management								
99238	1.28	NA	0.69	0.09	NA	2.06	NA	$74.24
99239	1.90	NA	1.00	0.12	NA	3.02	NA	$108.84
Initial Observation Care								
99217	1.28	NA	0.69	0.09	NA	2.06	NA	$74.24
99218	1.92	NA	0.73	0.16	NA	2.81	NA	$101.27
99219	2.60	NA	1.04	0.19	NA	3.83	NA	$138.03
99220	3.56	NA	1.42	0.25	NA	5.23	NA	$188.48
Subsequent Observation Care								
99224	0.76	NA	0.30	0.06	NA	1.12	NA	$40.36
99225	1.39	NA	0.57	0.10	NA	2.06	NA	$74.24
99226	2.00	NA	0.88	0.13	NA	3.01	NA	$108.48
Emergency Department Services								
99281	0.45	NA	0.11	0.04	NA	0.60	NA	$21.62
99282	0.88	NA	0.21	0.08	NA	1.17	NA	$42.17
99283	1.34	NA	0.29	0.12	NA	1.75	NA	$63.07
99284	2.56	NA	0.53	0.23	NA	3.32	NA	$119.65
99285	3.80	NA	0.74	0.35	NA	4.89	NA	$176.23
Prolonged Service With Face-To-Face Patient Contact; Inpatient								
99356	1.71	NA	0.78	0.11	NA	2.60	NA	$93.70
99357	1.71	NA	0.79	0.11	NA	2.61	NA	$94.06
Physician Standby Services								
99360[X]	1.20	NA	0.46	0.07	NA	1.73	NA	$62.35
Critical Care Services								

99291	4.50	2.93	1.39	0.39	7.82	6.28	$281.83	$226.33
99292	2.25	1.01	0.70	0.20	3.46	3.15	$124.70	$113.52
Pediatric Critical Care Patient Transport								
99466	4.79	NA	1.65	0.31	NA	6.75	NA	$243.26
99467	2.40	NA	0.82	0.15	NA	3.37	NA	$121.45
99485[B]	1.50	NA	0.58	0.09	NA	2.17	NA	$78.20
99486[B]	1.30	NA	0.50	0.08	NA	1.88	NA	$67.75
Inpatient Pediatric & Neonatal Critical Care								
99468	18.46	NA	6.36	1.18	NA	26.00	NA	$937.02
99469	7.99	NA	2.75	0.50	NA	11.24	NA	$405.08
99471	15.98	NA	5.51	1.02	NA	22.51	NA	$811.24
99472	7.99	NA	2.93	0.61	NA	11.53	NA	$415.53
99475	11.25	NA	3.88	0.71	NA	15.84	NA	$570.86
99476	6.75	NA	2.55	0.56	NA	9.86	NA	$355.35
Initial & Continuing Intensive Care Services								
99477	7.00	NA	2.41	0.44	NA	9.85	NA	$354.99
99478	2.75	NA	0.94	0.18	NA	3.87	NA	$139.47
99479	2.50	NA	0.86	0.16	NA	3.52	NA	$126.86
99480	2.40	NA	0.82	0.15	NA	3.37	NA	$121.45
Neonatal & Pediatric Transfusion								
36440	1.03	NA	0.36	0.07	NA	1.46	NA	$52.62
36450	3.50	NA	1.21	0.23	NA	4.94	NA	$178.03
36455	2.43	NA	0.68	0.57	NA	3.68	NA	$132.62
36456	2.00	NA	0.76	0.27	NA	3.03	NA	$109.20
Initiation of Neonatal Hypothermia								
99184	4.50	NA	1.53	0.30	NA	6.33	NA	$228.13
Moderate Sedation Provided By The Same Physician Performing The Diagnostic Or Therapeutic Service								
99151	0.50	1.57	0.17	0.05	2.12	0.72	$76.40	$25.95
99152	0.25	1.17	0.08	0.02	1.44	0.35	$51.90	$12.61
99153	0.00	0.29	NA	0.01	0.30	NA	$10.81	NA
Moderate Sedation Provided By A Physician Other Than The Provider Performing The Diagnostic Or Therapeutic Service								
99155	1.90	NA	0.46	0.18	NA	2.54	NA	$91.54
99156	1.65	NA	0.44	0.15	NA	2.24	NA	$80.73
99157	1.25	NA	0.47	0.10	NA	1.82	NA	$65.59
Allergen Immunotherapy								
95115	0.00	0.25	NA	0.01	0.26	NA	$9.37	NA
95117	0.00	0.29	NA	0.01	0.30	NA	$10.81	NA
Orthopedic Procedures								
23500	2.21	3.65	3.78	0.38	6.24	6.37	$224.88	$229.57
24640	1.25	1.53	0.90	0.08	2.86	2.23	$103.07	$80.37
25600	2.78	6.14	5.67	0.48	9.40	8.93	$338.77	$321.83
Otolaryngologic Procedures								
69200	0.77	1.45	0.48	0.10	2.32	1.35	$83.61	$48.65
69209	0.00	0.39	NA	0.01	0.40	NA	$14.42	NA
69210	0.61	0.66	0.26	0.07	1.34	0.94	$48.29	$33.88
Pulmonary Procedures								
94640	0.00	0.50	NA	0.01	0.51	NA	$18.38	NA
94664	0.00	0.47	NA	0.01	0.48	NA	$17.30	NA

94780	0.48	0.94	0.17	0.03	1.45	0.68	$52.26	$24.51
94781	0.17	0.39	0.06	0.01	0.57	0.24	$20.54	$8.65
Radiologic Procedures								
76885	0.74	3.26	NA	0.05	4.05	NA	$145.96	NA
76886	0.62	2.30	NA	0.05	2.97	NA	$107.04	NA
Urologic Procedures								
51701	0.50	0.72	0.18	0.05	1.27	0.73	$45.77	$26.31
54150	1.90	2.29	0.70	0.23	4.42	2.83	$159.29	$101.99
54160	2.53	3.52	1.37	0.27	6.32	4.17	$227.77	$150.28
54161	3.32	NA	2.00	0.38	NA	5.70	NA	$205.42
54162	3.32	3.72	2.07	0.38	7.42	5.77	$267.41	$207.95
Dermatologic Procedures								
10060	1.22	2.02	1.46	0.13	3.37	2.81	$121.45	$101.27
10120	1.22	2.96	1.60	0.14	4.32	2.96	$155.69	$106.68
17110	0.70	2.34	1.17	0.09	3.13	1.96	$112.80	$70.64
17111	0.97	2.61	1.31	0.13	3.71	2.41	$133.71	$86.85
17250	0.50	1.74	0.48	0.07	2.31	1.05	$83.25	$37.84
Health & Behavior Assessment/Intervention								
96150	0.50	0.13	0.08	0.02	0.65	0.60	$23.43	$21.62
96151	0.48	0.13	0.09	0.03	0.64	0.60	$23.07	$21.62
96152	0.46	0.11	0.07	0.02	0.59	0.55	$21.26	$19.82
96153	0.10	0.03	0.01	0.01	0.14	0.12	$5.05	$4.32
96154	0.45	0.11	0.06	0.02	0.58	0.53	$20.90	$19.10
96155	0.44	0.17	0.17	0.03	0.64	0.64	$23.07	$23.07
Medical Nutrition Therapy								
97802	0.53	0.50	0.41	0.02	1.05	0.96	$37.84	$34.60
97803	0.45	0.44	0.35	0.02	0.91	0.82	$32.80	$29.55
97804	0.25	0.22	0.19	0.01	0.48	0.45	$17.30	$16.22
Education & Training For Patient Self-Management								
98960[B]	0.00	0.75	NA	0.02	0.77	NA	$27.75	NA
98961[B]	0.00	0.37	NA	0.01	0.38	NA	$13.69	NA
98962[B]	0.00	0.27	NA	0.01	0.28	NA	$10.09	NA
Counseling Risk Factor Reduction & Behavior Change Intervention								
99401[N]	0.48	0.59	0.19	0.03	1.10	0.70	$39.64	$25.23
99402[N]	0.98	0.77	0.38	0.06	1.81	1.42	$65.23	$51.18
99403[N]	1.46	0.96	0.57	0.09	2.51	2.12	$90.46	$76.40
99404[N]	1.95	1.14	0.74	0.12	3.21	2.81	$115.69	$101.27
99406	0.24	0.16	0.09	0.02	0.42	0.35	$15.14	$12.61
99407	0.50	0.26	0.19	0.04	0.80	0.73	$28.83	$26.31
99408[N]	0.65	0.32	0.25	0.04	1.01	0.94	$36.40	$33.88
99409[N]	1.30	0.57	0.50	0.08	1.95	1.88	$70.28	$67.75
Sleep Medicine Testing								
95782	2.60	22.79	NA	0.26	25.65	NA	$924.40	NA
95783	2.83	24.20	NA	0.28	27.31	NA	$984.23	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
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