American Academy of Pediatrics
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2022 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 (MPFS) 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 MPFS 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/qualified healthcare professional (QHP) 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 MPFS to pay physicians/qualified healthcare professionals (QHP), while others are exploring its implementation.

ELEMENTS OF RBRVS

Physician/Qualified Healthcare Professional (QHP) Work (Work)
The physician/qualified healthcare professional (QHP) work component of the MPFS 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 32 members, consisting of 22 representatives from national medical specialty societies. Four seats rotate on a two-year basis, with one seat reserved for a primary care representative, two reserved for an internal medicine subspecialty, and the remaining seat is open to any other specialty society not a member of the RUC, except internal medicine subspecialties or primary care representatives. The RUC Chairperson, the Co-Chairperson of the RUC Health Care Professionals Advisory Committee (HCPAC), the Chairperson of the Practice Expense Subcommittee and representatives of the American Medical Association, American Osteopathic Association and CPT Editorial Panel hold the remaining six seats. The American Academy of Pediatrics (AAP) holds one of the 22 seats designated for national medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units (RVUs) of physician/QHP work to establish the Medicare RBRVS Physician Fee Schedule (MPFS).

The physician/QHP work component represents approximately 50.9% of the total RVUs for each service. Physician/QHP 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/QHP work contained in the MPFS for each service consists of the following components:

- Physician/QHP time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with physician's/QHP'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 2022.

Professional Liability Insurance (PLI) (Malpractice)

Professional liability insurance (malpractice) expense relative values amount to approximately 4.3% of the MPFS 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 MPFS, 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 MPFS 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/QHP work, practice expense, and professional liability insurance in a Medicare locality compared to the national average relative costs.

- Cost of Living GPCI: Applied to physician/QHP work relative values

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

2022 Medicare Geographic Practice Cost Indices (GPCIs)

Medicare Locality	Work	Practice Expense (PE)	Professional Liability Insurance (PLI)
ALABAMA	1.000	0.888	0.921
ALASKA*	1.500	1.118	0.614
ARIZONA	1.000	0.951	0.857
ARKANSAS	1.000	0.847	0.465
BAKERSFIELD	1.036	1.065	0.726
CHICO	1.027	1.065	0.597
EL CENTRO	1.027	1.065	0.620
FRESNO	1.027	1.065	0.597
HANFORD-CORCORAN	1.027	1.065	0.597
LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES CNTY)	1.048	1.175	0.757
LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)	1.048	1.175	0.757
MADERA	1.027	1.065	0.597
MERCED	1.027	1.065	0.597
MODESTO	1.027	1.065	0.597
NAPA	1.044	1.220	0.504
SAN FRANCISCO-OAKLAND-BERKELEY (ALAMEDA/CONTRA COSTA CNTY)	1.077	1.329	0.458
OXNARD-THOUSAND OAKS-VENTURA	1.027	1.179	0.726
REDDING	1.027	1.065	0.597
RIVERSIDE-SAN BERNARDINO-ONTARIO	1.027	1.065	0.955
SACRAMENTO-ROSEVILLE-FOLSOM	1.038	1.081	0.597
SALINAS	1.064	1.133	0.597
SAN DIEGO-CHULA VISTA-CARLSBAD	1.037	1.160	0.620
SAN FRANCISCO-OAKLAND-BERKELEY (SAN FRANCISCO CNTY)	1.077	1.329	0.458
SAN FRANCISCO-OAKLAND-BERKELEY (MARIN CNTY)	1.077	1.329	0.504
SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY)	1.096	1.383	0.597
SAN LUIS OBISPO-PASO ROBLES	1.027	1.089	0.597
SAN FRANCISCO-OAKLAND-BERKELEY (SAN MATEO CNTY)	1.077	1.329	0.458
SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1.096	1.383	0.414
SANTA CRUZ-WATSONVILLE	1.045	1.205	0.597
SANTA MARIA-SANTA BARBARA	1.041	1.175	0.597
SANTA ROSA-PETALUMA	1.045	1.177	0.597
STOCKTON	1.027	1.065	0.597
VALLEJO	1.044	1.220	0.504
VISALIA	1.027	1.065	0.597
YUBA CITY	1.027	1.065	0.597
REST OF CALIFORNIA	1.027	1.065	0.597
COLORADO	1.001	1.047	0.767
CONNECTICUT	1.037	1.114	0.934

DC + MD/VA SUBURBS	1.054	1.236	1.294
DELAWARE	1.005	1.022	0.927
FORT LAUDERDALE	1.000	1.001	1.860
MIAMI	1.000	1.023	2.629
REST OF FLORIDA	1.000	0.939	1.435
ATLANTA	1.000	0.998	0.904
REST OF GEORGIA	1.000	0.878	0.904
HAWAII, GUAM	1.010	1.143	0.675
IDAHO	1.000	0.877	0.416
CHICAGO	1.011	1.044	1.871
EAST ST. LOUIS	1.000	0.942	1.661
SUBURBAN CHICAGO	1.006	1.062	1.504
REST OF ILLINOIS	1.000	0.912	1.182
INDIANA	1.000	0.900	0.465
IOWA	1.000	0.907	0.425
KANSAS	1.000	0.908	0.458
KENTUCKY	1.000	0.869	0.827
NEW ORLEANS	1.000	0.927	1.528
REST OF LOUISIANA	1.000	0.872	1.307
SOUTHERN MAINE	1.000	0.997	0.652
REST OF MAINE	1.000	0.898	0.652
BALTIMORE/SURR. CNTYS	1.028	1.096	1.313
REST OF MARYLAND	1.011	1.037	1.070
METROPOLITAN BOSTON	1.049	1.203	0.842
REST OF MASSACHUSETTS	1.026	1.061	0.842
DETROIT	1.000	0.997	1.622
REST OF MICHIGAN	1.000	0.911	0.979
MINNESOTA	1.000	1.013	0.353
MISSISSIPPI	1.000	0.842	0.671
METROPOLITAN KANSAS CITY	1.000	0.955	0.890
METROPOLITAN ST. LOUIS	1.000	0.976	0.889
REST OF MISSOURI	1.000	0.852	0.828
MONTANA**	1.000	1.000	0.977
NEBRASKA	1.000	0.908	0.235
NEVADA**	1.005	1.000	1.351
NEW HAMPSHIRE	1.000	1.038	0.917
NORTHERN NJ	1.049	1.199	0.959
REST OF NEW JERSEY	1.037	1.141	0.959
NEW MEXICO	1.000	0.896	1.166
MANHATTAN	1.056	1.203	2.031
NYC SUBURBS/LONG ISLAND	1.046	1.223	2.702
POUGHKPSIE/N NYC SUBURBS	1.027	1.105	1.646
QUEENS	1.056	1.228	2.661
REST OF NEW YORK	1.000	0.955	0.752

NORTH CAROLINA	1.000	0.928	0.819
NORTH DAKOTA**	1.000	1.000	0.431
OHIO	1.000	0.913	1.094
OKLAHOMA	1.000	0.881	0.782
PORTLAND	1.022	1.063	0.535
REST OF OREGON	1.000	0.947	0.535
METROPOLITAN PHILADELPHIA	1.022	1.083	1.199
REST OF PENNSYLVANIA	1.000	0.939	0.888
PUERTO RICO	1.000	1.008	0.986
RHODE ISLAND	1.021	1.048	0.981
SOUTH CAROLINA	1.000	0.903	0.695
SOUTH DAKOTA**	1.000	1.000	0.347
TENNESSEE	1.000	0.892	0.492
AUSTIN	1.000	1.059	0.539
BEAUMONT	1.000	0.944	0.550
BRAZORIA	1.032	1.023	0.550
DALLAS	1.023	1.026	0.546
FORT WORTH	1.016	0.995	0.539
GALVESTON	1.032	1.026	0.550
HOUSTON	1.032	1.029	0.900
REST OF TEXAS	1.000	0.955	0.584
UTAH	1.000	0.919	0.799
VERMONT	1.000	1.001	0.569
VIRGINIA	1.000	0.995	0.897
VIRGIN ISLANDS	1.000	1.008	0.986
SEATTLE (KING CNTY)	1.036	1.194	0.776
REST OF WASHINGTON	1.000	1.014	0.744
WEST VIRGINIA	1.000	0.858	1.198
WISCONSIN	1.000	0.942	0.296
WYOMING**	1.000	1.000	0.841

*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.

Note: The 1.0 Work GPCI floor required by Section 101 of the Consolidated Appropriations Act 2021 [December 27, 2020] extended the Work GPCI floor through December 31, 2023.

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/QHPs 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	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

Year	Conversion Factor
1998	$36.6873
1999	$34.7315
2000	$36.6137
2001	$38.2581
2002	$36.1992
2003	$36.7856
2004	$37.3374
2005	$37.8975
2006	$37.8975
2007	$37.8975
2008	$38.0870
2009	$36.0666
1/1/10-5/31/10	$36.0791
6/1/10-12/31/10	$36.8729
2011	$33.9764
2012	$34.0376
2013	$34.0230
2014	$35.8228
1/1/15-6/30/15	$35.7547
7/1/15-12/31/15	$35.9335
2016	$35.8043
2017	$35.8887
2018	$35.9996
2019	$36.0391
2020	$36.0896
2021	$34.8931
2022	$34.6062

Initially, the Medicare Physician Fee Schedule (MPFS) 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.

Initially, the CY2022 MPFS conversion factor was $33.5983, based on budget neutrality adjustment to account for changes in RVUs (required by law) and expiration of the 3.75 percent temporary CY2021 payment increase provided by the Consolidated Appropriations Act, 2021 (CAA).

However, with passage of the Protecting Medicare & American Farmers from Sequester Cuts Act, a 4% statutory cut from the PAYGO provisions was avoided and the moratorium on the 2% Medicare payment sequester was extended, mitigating the 3.75% Medicare physician payment cut and resulting in a CY2022 MPFS conversion factor of $34.6062.

HOW TO USE THE RBRVS

CMS publishes RVUs for CPT codes in the *Federal Register*. To calculate the Medicare physician/QHP payment for a service, the RVUs for each of the three components of the MPFS 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 MPFS incorporated into the final payment for physician/QHP services. Please note that third-party payers other than Medicare may not use all of the elements of the MPFS to determine physician/QHP 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 Corrales, New Mexico ('New Mexico' Medicare locality).

The following RVUs, GPCIs, and Medicare conversion factor are based on the information published by CMS.

CPT Code 99213		Location: Corrales, New Mexico ('New Mexico' Medicare Locality)	
Work RVUs	1.30	Work GPCI	1.000
Non-Facility Practice Expense RVUs	1.26	Practice Expense GPCI	0.896
Professional Liability Insurance RVUs	0.10	Professional Liability Insurance GPCI	1.166

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

This is an example of a physician/QHP payment mechanism in a non-facility setting that takes into consideration the total RVUs from the MPFS but excludes all other components of the MPFS. 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/QHP 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
(1.30) + (1.26) + (0.10) = 2.66

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 2022 Medicare conversion factor of $34.6062).

For example: Payer-specific primary care conversion factor = $35.00

Total physician/QHP payment for the provision of CPT code 99213 by this third-party payer =
(Total Medicare RVUs) x (Payer CF)
(2.66) x (35.00) = $93.10

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

METHOD 2 (GEOGRAPHICALLY ADJUSTED & USING MEDICARE CONVERSION FACTOR)

This is an example of the MPFS payment in a non-facility setting for CPT code 99213 in Corrales, New Mexico. The following example assumes that a physician/QHP 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/QHP 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)
(1.30 x 1.000) + (1.26 x 0.896) + (0.10 x 1.166)
(1.30) + (1.12896) + (0.1166) = 2.54556

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

2022 Medicare conversion factor (CF) = $34.6062

Total Medicare payment for the provision of CPT code 99213 in Corrales, New Mexico =
Total geographically adjusted RVUs for CPT code 99213 x 2022 Medicare conversion factor
(2.54556 x $34.6062 = $88.09)

In this example, a physician/QHP practicing in Corrales, New Mexico will receive $88.09 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, please access the accompanying 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 our 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 MPFS to determine physician/QHP payment rates. In order for a physician/QHP to succeed in the changing marketplace, measurements of the costs involved in providing services will need to be ascertained; these costs include physician/QHP 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/QHP 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								
99202	0.93	1.12	0.41	0.09	2.14	1.43	$74.06	$49.49
99203	1.60	1.52	0.67	0.17	3.29	2.44	$113.85	$84.44
99204	2.60	2.06	1.11	0.24	4.90	3.95	$169.57	$136.69
99205	3.50	2.66	1.54	0.32	6.48	5.36	$224.25	$185.49
Office Or Other Outpatient Services, Established Patient								
99211	0.18	0.49	0.07	0.01	0.68	0.26	$23.53	$9.00
99212	0.70	0.89	0.29	0.07	1.66	1.06	$57.45	$36.68
99213	1.30	1.26	0.55	0.10	2.66	1.95	$92.05	$67.48
99214	1.92	1.71	0.82	0.12	3.75	2.86	$129.77	$98.97
99215	2.80	2.28	1.24	0.21	5.29	4.25	$183.07	$147.08
Prolonged Service With or Without Direct Patient Contact on the Date of an Office Visit								
99417[I]	0.61	0.00	0.00	0.05	0.66	0.66	$22.84	$22.84
G2212	0.61	0.30	0.27	0.05	0.96	0.93	$33.22	$32.18
Office Or Other Outpatient Consultations*								
99241[I]	0.64	0.66	0.24	0.05	1.35	0.93	$46.72	$32.18
99242[I]	1.34	1.10	0.51	0.11	2.55	1.96	$88.25	$67.83
99243[I]	1.88	1.46	0.71	0.17	3.51	2.76	$121.47	$95.51
99244[I]	3.02	1.96	1.14	0.25	5.23	4.41	$180.99	$152.61
99245[I]	3.77	2.30	1.38	0.31	6.38	5.46	$220.79	$188.95
Prolonged Service With Face-To-Face Patient Contact; Outpatient								
99354	2.33	1.21	0.97	0.17	3.71	3.47	$128.39	$120.08
99355	1.77	0.80	0.57	0.11	2.68	2.45	$92.74	$84.79
Preventive Medicine Services, New Patient								
99381[N]	1.50	1.60	0.58	0.11	3.21	2.19	$111.09	$75.79
99382[N]	1.60	1.63	0.62	0.12	3.35	2.34	$115.93	$80.98
99383[N]	1.70	1.66	0.66	0.12	3.48	2.48	$120.43	$85.82
99384[N]	2.00	1.78	0.77	0.18	3.96	2.95	$137.04	$102.09
99385[N]	1.92	1.75	0.74	0.17	3.84	2.83	$132.89	$97.94
Preventive Medicine Services, Established Patient								
99391[N]	1.37	1.42	0.53	0.11	2.90	2.01	$100.36	$69.56
99392[N]	1.50	1.47	0.58	0.11	3.08	2.19	$106.59	$75.79
99393[N]	1.50	1.46	0.58	0.11	3.07	2.19	$106.24	$75.79
99394[N]	1.70	1.54	0.66	0.12	3.36	2.48	$116.28	$85.82
99395[N]	1.75	1.56	0.68	0.12	3.43	2.55	$118.70	$88.25
Immunization Administration Through Age 18 With Counseling								
90460	0.17	0.31	NA	0.01	0.49	NA	$16.96	NA
90461	0.15	0.21	NA	0.01	0.37	NA	$12.80	NA
Immunization Administration								
90471	0.17	0.31	NA	0.01	0.49	NA	$16.96	NA
90472	0.15	0.21	NA	0.01	0.37	NA	$12.80	NA
90473[R]	0.17	0.31	NA	0.01	0.49	NA	$16.96	NA
90474[R]	0.15	0.21	NA	0.01	0.37	NA	$12.80	NA

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

96360	0.17	0.82	NA	0.02	1.01	NA	$34.95	NA
96361	0.09	0.28	NA	0.01	0.38	NA	$13.15	NA
96365	0.21	1.75	NA	0.04	2.00	NA	$69.21	NA
96366	0.18	0.43	NA	0.01	0.62	NA	$21.46	NA
96372	0.17	0.24	NA	0.01	0.42	NA	$14.53	NA
96374	0.18	0.96	NA	0.02	1.16	NA	$40.14	NA

Vision & Hearing Screening

99173[N]	0.00	0.08	NA	0.01	0.09	NA	$3.11	NA
99174[N]	0.00	0.16	NA	0.01	0.17	NA	$5.88	NA
99177[N]	0.00	0.13	NA	0.01	0.14	NA	$4.84	NA
92551[N]	0.00	0.33	NA	0.01	0.34	NA	$11.77	NA
92552	0.00	0.98	NA	0.01	0.99	NA	$34.26	NA

Developmental Screening & Testing

96110[N]	0.00	0.30	NA	0.01	0.31	NA	$10.73	NA
96112	2.56	1.05	1.01	0.12	3.73	3.69	$129.08	$127.70
96113	1.16	0.53	0.42	0.07	1.76	1.65	$60.91	$57.10

Emotional/Behavioral Assessment

96127	0.00	0.13	NA	0.01	0.14	NA	$4.84	NA

Health Risk Assessment

96160	0.00	0.08	NA	0.00	0.08	NA	$2.77	NA
96161	0.00	0.08	NA	0.00	0.08	NA	$2.77	NA

Topical Application of Fluoride Varnish

99188[N]	0.20	0.13	0.08	0.02	0.35	0.30	$12.11	$10.38

Principal Care Management

99424	1.45	0.86	0.63	0.10	2.41	2.18	$83.40	$75.44
99425	1.00	0.66	0.44	0.08	1.74	1.52	$60.21	$52.60
99426	1.00	0.75	0.38	0.08	1.83	1.46	$63.33	$50.53
99427	0.71	0.64	0.27	0.05	1.40	1.03	$48.45	$35.64

Care Plan Oversight

99339[B]	1.25	0.87	NA	0.10	2.22	NA	$76.83	NA
99340[B]	1.80	1.17	NA	0.14	3.11	NA	$107.63	NA

Behavioral/Psychiatric Collaborative Care Management

99484	0.61	0.64	0.23	0.04	1.29	0.88	$44.64	$30.45
99492	1.88	2.45	0.73	0.11	4.44	2.72	$153.65	$94.13
99493	2.05	2.13	0.82	0.12	4.30	2.99	$148.81	$103.47
99494	0.82	0.97	0.35	0.05	1.84	1.22	$63.68	$42.22

Chronic Care Management

99487	1.81	1.96	0.76	0.11	3.88	2.68	$134.27	$92.74
99489	1.00	0.97	0.41	0.07	2.04	1.48	$70.60	$51.22
99490	1.00	0.78	0.42	0.07	1.85	1.49	$64.02	$51.56
99491	1.50	0.89	0.64	0.10	2.33	2.33	$80.63	$80.63
99437	1.00	0.69	0.43	0.08	2.33	2.33	$80.63	$80.63
99439	0.70	0.65	0.30	0.05	2.33	2.33	$80.63	$80.63

Transitional Care Management

99495	2.78	3.07	1.21	0.19	6.04	4.18	$209.02	$144.65
99496	3.79	4.11	1.63	0.24	8.14	5.66	$281.69	$195.87

Remote Therapeutic Monitoring

98975	0.00	0.54	NA	0.02	0.56	NA	$19.38	NA
98976	0.00	1.60	NA	0.01	1.61	NA	$55.72	NA
98977	0.00	1.60	NA	0.01	1.61	NA	$55.72	NA

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

99421	0.25	0.17	0.11	0.02	0.44	0.38	$15.23	$13.15
99422	0.50	0.32	0.21	0.04	0.86	0.75	$29.76	$25.95
99423	0.80	0.53	0.34	0.07	1.40	1.21	$48.45	$41.87
99441[N]	0.70	0.89	0.29	0.05	1.64	1.04	$56.75	$35.99
99442[N]	1.30	1.26	0.55	0.09	2.65	1.94	$91.71	$67.14
99443[N]	1.92	1.71	0.82	0.12	3.75	2.86	$129.77	$98.97
99446	0.35	0.15	0.15	0.04	0.54	0.54	NA	$18.69
99447	0.70	0.29	0.29	0.07	1.06	1.06	NA	$36.68
99448	1.05	0.45	0.45	0.09	1.59	1.59	NA	$55.02
99449	1.40	0.62	0.62	0.11	2.13	2.13	NA	$73.71
99451	0.70	0.30	0.30	0.05	1.05	1.05	$36.34	$36.34
99452	0.70	0.30	0.30	0.07	1.07	1.07	$37.03	$37.03
			Medicare Virtual Communication Technology-Based Services					
G2010	0.18	0.16	0.08	0.01	0.35	0.27	$12.11	$9.34
G2012	0.25	0.15	0.10	0.02	0.42	0.37	$14.53	$12.80
			Prolonged Service Before/After Direct Patient Care					
99358	2.10	0.96	0.96	0.14	3.20	3.20	$110.74	$110.74
99359	1.00	0.47	0.47	0.09	1.56	1.56	$53.99	$53.99
			Physician Medical Team Conference					
99367[B]	1.10	NA	0.43	0.09	NA	1.62	NA	$56.06
			Newborn Care Services					
99460	1.92	NA	0.71	0.12	NA	2.75	NA	$95.17
99461	1.26	1.35	0.47	0.09	2.70	1.82	$93.44	$62.98
99462	0.84	NA	0.31	0.07	NA	1.22	NA	$42.22
99463	2.13	NA	0.92	0.12	NA	3.17	NA	$109.70
99464	1.50	NA	0.56	0.10	NA	2.16	NA	$74.75
99465	2.93	NA	1.08	0.20	NA	4.21	NA	$145.69
			Initial Hospital Care					
99221	1.92	NA	0.78	0.21	NA	2.91	NA	$100.70
99222	2.61	NA	1.08	0.22	NA	3.91	NA	$135.31
99223	3.86	NA	1.58	0.29	NA	5.73	NA	$198.29
			Subsequent Hospital Care					
99231	0.76	NA	0.29	0.07	NA	1.12	NA	$38.76
99232	1.39	NA	0.57	0.10	NA	2.06	NA	$71.29
99233	2.00	NA	0.82	0.14	NA	2.96	NA	$102.43
			Discharge Day Management					
99238	1.28	NA	0.71	0.09	NA	2.08	NA	$71.98
99239	1.90	NA	1.02	0.12	NA	3.04	NA	$105.20
			Initial Observation Care					
99217	1.28	NA	0.70	0.09	NA	2.07	NA	$71.63
99218	1.92	NA	0.73	0.18	NA	2.83	NA	$97.94
99219	2.60	NA	1.03	0.20	NA	3.83	NA	$132.54
99220	3.56	NA	1.36	0.25	NA	5.17	NA	$178.91
			Subsequent Observation Care					
99224	0.76	NA	0.30	0.07	NA	1.13	NA	$39.11
99225	1.39	NA	0.56	0.10	NA	2.05	NA	$70.94
99226	2.00	NA	0.80	0.12	NA	2.92	NA	$101.05
			Emergency Department Services					
99281	0.48	NA	0.11	0.05	NA	0.64	NA	$22.15
99282	0.93	NA	0.21	0.10	NA	1.24	NA	$42.91
99283	1.60	NA	0.33	0.18	NA	2.11	NA	$73.02
99284	2.74	NA	0.54	0.28	NA	3.56	NA	$123.20
99285	4.00	NA	0.75	0.42	NA	5.17	NA	$178.91

Prolonged Service With Face-To-Face Patient Contact; Inpatient								
99356	1.71	NA	0.79	0.11	NA	2.61	NA	$90.32
99357	1.71	NA	0.80	0.11	NA	2.62	NA	$90.67
Physician Standby Services								
99360[X]	1.20	NA	0.46	0.10	NA	1.76	NA	$60.91
Critical Care Services								
99291	4.50	3.25	1.42	0.41	8.16	6.33	$282.39	$219.06
99292	2.25	1.10	0.72	0.21	3.56	3.18	$123.20	$110.05
Pediatric Critical Care Patient Transport								
99466	4.79	NA	1.76	0.32	NA	6.87	NA	$237.74
99467	2.40	NA	0.89	0.17	NA	3.46	NA	$119.74
99485[B]	1.50	NA	0.58	0.11	NA	2.19	NA	$75.79
99486[B]	1.30	NA	0.50	0.11	NA	1.91	NA	$66.10
Inpatient Pediatric & Neonatal Critical Care								
99468	18.46	NA	6.80	1.24	NA	26.50	NA	$917.06
99469	7.99	NA	2.95	0.54	NA	11.48	NA	$397.28
99471	15.98	NA	5.90	1.06	NA	22.94	NA	$793.87
99472	7.99	NA	3.11	0.60	NA	11.70	NA	$404.89
99475	11.25	NA	4.40	0.84	NA	16.49	NA	$570.66
99476	6.75	NA	2.64	0.50	NA	9.89	NA	$342.26
Initial & Continuing Intensive Care Services								
99477	7.00	NA	2.58	0.45	NA	10.03	NA	$347.10
99478	2.75	NA	1.02	0.19	NA	3.96	NA	$137.04
99479	2.50	NA	0.93	0.18	NA	3.61	NA	$124.93
99480	2.40	NA	0.89	0.17	NA	3.46	NA	$119.74
Neonatal & Pediatric Transfusion								
36440	1.03	NA	0.38	0.08	NA	1.49	NA	$51.56
36450	3.50	NA	1.30	0.23	NA	5.03	NA	$174.07
36455	2.43	NA	0.69	0.57	NA	3.69	NA	$127.70
36456	2.00	NA	0.74	0.12	NA	2.86	NA	$98.97
Initiation of Neonatal Hypothermia								
99184	4.50	NA	1.55	0.31	NA	6.36	NA	$220.10
Moderate Sedation Provided By The Same Physician Performing The Diagnostic Or Therapeutic Service								
99151	0.50	1.52	0.19	0.04	2.06	0.73	$71.29	$25.26
99152	0.25	1.22	0.08	0.04	1.51	0.37	$52.26	$12.80
99153	0.00	0.30	NA	0.02	0.32	NA	$11.07	NA
Moderate Sedation Provided By A Physician Other Than The Provider Performing The Diagnostic Or Therapeutic Service								
99155	1.90	NA	0.32	0.21	NA	2.43	NA	$84.09
99156	1.65	NA	0.40	0.18	NA	2.23	NA	$77.17
99157	1.25	NA	0.46	0.11	NA	1.82	NA	$62.98
Allergen Immunotherapy								
95115	0.00	0.27	NA	0.01	0.28	NA	$9.69	NA
95117	0.00	0.33	NA	0.01	0.34	NA	$11.77	NA
Orthopedic Procedures								
23500	2.21	4.06	4.20	0.42	6.69	6.83	$231.52	$236.36
24640	1.25	1.77	1.04	0.09	3.11	2.38	$107.63	$82.36
25600	2.78	6.86	6.42	0.55	10.19	9.75	$352.64	$337.41
Otolaryngologic Procedures								
69200	0.77	1.50	0.51	0.11	2.38	1.39	$82.36	$48.10
69209	0.00	0.44	NA	0.01	0.45	NA	$15.57	NA
69210	0.61	0.70	0.27	0.09	1.40	0.97	$48.45	$33.57

				Pulmonary Procedures				
94640	0.00	0.32	NA	0.01	0.33	NA	$11.42	NA
94664	0.00	0.49	NA	0.01	0.50	NA	$17.30	NA
94780	0.48	1.00	0.18	0.04	1.52	0.70	$52.60	$24.22
94781	0.17	0.42	0.06	0.01	0.60	0.24	$20.76	$8.31
				Radiologic Procedures				
76885	0.74	3.34	NA	0.06	4.14	NA	$143.27	NA
76886	0.62	2.36	NA	0.05	3.03	NA	$104.86	NA
				Urologic Procedures				
51701	0.50	0.75	0.18	0.08	1.33	0.76	$46.03	$26.30
54150	1.90	2.27	0.69	0.25	4.42	2.84	$152.96	$98.28
54160	2.53	3.71	1.43	0.29	6.53	4.25	$225.98	$147.08
54161	3.32	NA	2.06	0.40	NA	5.78	NA	$200.02
54162	3.32	3.92	2.15	0.40	7.64	5.87	$264.39	$203.14
				Dermatologic Procedures				
10060	1.22	2.35	1.74	0.12	3.69	3.08	$127.70	$106.59
10120	1.22	3.12	1.70	0.12	4.46	3.04	$154.34	$105.20
17110	0.70	2.59	1.17	0.08	3.37	1.95	$116.62	$67.48
17111	0.97	2.87	1.31	0.10	3.94	2.38	$136.35	$82.36
17250	0.50	2.09	0.51	0.09	2.68	1.10	$92.74	$38.07
				Health & Behavior Assessment/Intervention				
96156	2.10	0.63	0.32	0.09	2.82	2.51	$97.59	$86.86
96158	1.45	0.42	0.20	0.07	1.94	1.72	$67.14	$59.52
96159	0.50	0.14	0.06	0.02	0.66	0.58	$22.84	$20.07
96164	0.21	0.07	0.04	0.01	0.29	0.26	$10.04	$9.00
96165	0.10	0.03	0.02	0.00	0.13	0.12	$4.50	$4.15
96167	1.55	0.44	0.21	0.07	2.06	1.83	$71.29	$63.33
96168	0.55	0.16	0.07	0.02	0.73	0.64	$25.26	$22.15
96170[N]	1.50	0.71	0.58	0.11	2.32	2.19	$80.29	$75.79
96171[N]	0.54	0.26	0.21	0.04	0.84	0.79	$29.07	$27.34
				Medical Nutrition Therapy				
97802	0.53	0.53	0.40	0.02	1.08	0.95	$37.37	$32.88
97803	0.45	0.47	0.34	0.02	0.94	0.81	$32.53	$28.03
97804	0.25	0.24	0.19	0.01	0.50	0.45	$17.30	$15.57
				Education & Training For Patient Self-Management				
98960[B]	0.00	0.81	NA	0.04	0.85	NA	$29.42	NA
98961[B]	0.00	0.39	NA	0.01	0.40	NA	$13.84	NA
98962[B]	0.00	0.29	NA	0.01	0.30	NA	$10.38	NA
				Counseling Risk Factor Reduction & Behavior Change Intervention				
99401[N]	0.48	0.62	0.19	0.04	1.14	0.71	$39.45	$24.57
99402[N]	0.98	0.82	0.38	0.09	1.89	1.45	$65.41	$50.18
99403[N]	1.46	1.00	0.56	0.11	2.57	2.13	$88.94	$73.71
99404[N]	1.95	1.19	0.75	0.17	3.31	2.87	$114.55	$99.32
99406	0.24	0.19	0.09	0.02	0.45	0.35	$15.57	$12.11
99407	0.50	0.29	0.20	0.04	0.83	0.74	$28.72	$25.61
99408[N]	0.65	0.34	0.25	0.05	1.04	0.95	$35.99	$32.88
99409[N]	1.30	0.59	0.50	0.11	2.00	1.91	$69.21	$66.10
				Sleep Medicine Testing				
95782	2.60	25.04	NA	0.32	27.96	NA	$967.59	NA
95783	2.83	26.45	NA	0.33	29.61	NA	$1,024.69	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 MPFS 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 MPFS relative value units for other evaluation and management (E/M) codes, including the new and established office visit codes (99202-99215) 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/Qualified Healthcare Professional (QHP) 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 through the RUC and CMS to have values assigned and published for *all* CPT codes

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