American Academy of Ped

2020 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

2020 Medicare Geographic Practice Cost Indices (GPCIs)

Medicare Locality	Work	Practice Expense (PE)	Professional Liability Insurance (PLI)
ALABAMA	0.985	0.889	0.707
ALASKA*	1.500	1.118	0.661
ARIZONA	0.991	0.961	0.846
ARKANSAS	0.976	0.859	0.521
BAKERSFIELD	1.033	1.084	0.674
CHICO	1.027	1.084	0.571
EL CENTRO	1.027	1.084	0.603
FRESNO	1.027	1.084	0.571
HANFORD-CORCORAN	1.027	1.084	0.571
LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES CNTY)	1.047	1.176	0.725
LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)	1.047	1.176	0.725
MADERA	1.027	1.084	0.571
MERCED	1.027	1.084	0.571
MODESTO	1.027	1.084	0.571
NAPA	1.064	1.284	0.490
SAN FRANCISCO-OAKLAND-HAYWARD (ALAMEDA/CONTRA COSTA CNTY)	1.076	1.327	0.440
OXNARD-THOUSAND OAKS-VENTURA	1.026	1.178	0.700
REDDING	1.027	1.084	0.571
RIVERSIDE-SAN BERNARDINO-ONTARIO	1.027	1.084	0.827
SACRAMENTO--ROSEVILLE--ARDEN-ARCADE	1.034	1.084	0.571
SALINAS	1.052	1.117	0.571
SAN DIEGO-CARLSBAD	1.033	1.135	0.604
SAN FRANCISCO-OAKLAND-HAYWARD (SAN FRANCISCO CNTY)	1.076	1.327	0.440
SAN FRANCISCO-OAKLAND-HAYWARD (MARIN CNTY)	1.072	1.314	0.461
SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY)	1.073	1.284	0.571
SAN LUIS OBISPO-PASO ROBLES-ARROYO GRANDE	1.027	1.087	0.571
SAN FRANCISCO-OAKLAND-HAYWARD (SAN MATEO CNTY)	1.076	1.327	0.440
SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1.089	1.369	0.401
SANTA CRUZ-WATSONVILLE	1.039	1.164	0.571
SANTA MARIA-SANTA BARBARA	1.036	1.145	0.571
SANTA ROSA	1.039	1.146	0.571
STOCKTON-LODI	1.027	1.084	0.571
VALLEJO-FAIRFIELD	1.064	1.284	0.490
VISALIA-PORTERVILLE	1.027	1.084	0.571
YUBA CITY	1.027	1.084	0.571
REST OF CALIFORNIA	1.027	1.084	0.571
COLORADO	1.000	1.033	0.905
CONNECTICUT	1.029	1.113	1.094
DC + MD/VA SUBURBS	1.049	1.221	1.277
DELAWARE	1.006	1.021	1.023
FORT LAUDERDALE	0.990	1.006	1.828
MIAMI	0.992	1.026	2.598

REST OF FLORIDA	0.985	0.946	1.396
ATLANTA	1.000	0.998	0.996
REST OF GEORGIA	0.987	0.889	0.989
HAWAII, GUAM	1.006	1.144	0.644
IDAHO	0.977	0.890	0.464
CHICAGO	1.009	1.039	1.898
EAST ST. LOUIS	0.993	0.939	1.723
SUBURBAN CHICAGO	1.008	1.057	1.535
REST OF ILLINOIS	0.987	0.916	1.195
INDIANA	0.982	0.910	0.422
IOWA	0.984	0.907	0.424
KANSAS	0.982	0.910	0.536
KENTUCKY	0.985	0.874	0.823
NEW ORLEANS	0.989	0.947	1.400
REST OF LOUISIANA	0.981	0.879	1.253
SOUTHERN MAINE	0.995	1.002	0.661
REST OF MAINE	0.982	0.910	0.661
BALTIMORE/SURR. CNTYS	1.026	1.095	1.304
REST OF MARYLAND	1.010	1.035	1.076
METROPOLITAN BOSTON	1.041	1.191	0.952
REST OF MASSACHUSETTS	1.023	1.064	0.952
DETROIT	0.995	0.993	1.657
REST OF MICHIGAN	0.986	0.915	0.999
MINNESOTA	1.000	1.012	0.357
MISSISSIPPI	0.978	0.856	0.521
METROPOLITAN KANSAS CITY	0.991	0.959	0.982
METROPOLITAN ST. LOUIS	0.994	0.968	0.971
REST OF MISSOURI	0.977	0.857	0.910
MONTANA**	0.975	1.000	1.304
NEBRASKA	0.986	0.909	0.277
NEVADA**	1.004	1.000	1.130
NEW HAMPSHIRE	0.999	1.042	0.984
NORTHERN NJ	1.045	1.190	0.949
REST OF NEW JERSEY	1.030	1.132	0.949
NEW MEXICO	0.990	0.908	1.207
MANHATTAN	1.054	1.192	1.823
NYC SUBURBS/LONG ISLAND	1.044	1.214	2.425
POUGHKPSIE/N NYC SUBURBS	1.022	1.087	1.479
QUEENS	1.054	1.214	2.391
REST OF NEW YORK	0.995	0.952	0.673
NORTH CAROLINA	0.989	0.930	0.757
NORTH DAKOTA**	0.985	1.000	0.485
OHIO	0.992	0.915	1.049
OKLAHOMA	0.979	0.886	0.868
PORTLAND	1.016	1.059	0.659
REST OF OREGON	0.992	0.957	0.659

METROPOLITAN PHILADELPHIA	1.022	1.079	1.289
REST OF PENNSYLVANIA	0.993	0.937	0.960
PUERTO RICO	0.999	1.008	0.988
RHODE ISLAND	1.024	1.049	0.990
SOUTH CAROLINA	0.985	0.907	0.624
SOUTH DAKOTA**	0.975	1.000	0.368
TENNESSEE	0.986	0.897	0.509
AUSTIN	1.000	1.040	0.643
BEAUMONT	0.994	0.934	0.695
BRAZORIA	1.026	1.010	0.695
DALLAS	1.018	1.020	0.657
FORT WORTH	1.011	0.991	0.643
GALVESTON	1.026	1.019	0.695
HOUSTON	1.026	1.020	0.918
REST OF TEXAS	0.996	0.947	0.690
UTAH	0.985	0.923	0.982
VERMONT	0.991	1.008	0.582
VIRGINIA	0.999	0.991	0.903
VIRGIN ISLANDS	0.999	1.008	0.988
SEATTLE (KING CNTY)	1.031	1.170	0.854
REST OF WASHINGTON	1.000	1.012	0.823
WEST VIRGINIA	0.980	0.857	1.247
WISCONSIN	0.990	0.949	0.322
WYOMING**	0.985	1.000	0.860

2020 GPCIs reflect the first year of a two-year update transition.

*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						
2020	**$36.0896**	**0.0014**						

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.

2020: With the budget neutrality adjustment to account for changes in RVUs, the finalized CY 2020 Medicare Conversion Factor is $36.0896, a slight increase of $0.05 above the CY 2019 Medicare Conversion Factor.

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	0.990
Non-Facility Practice Expense RVUs	1.06	Practice Expense GPCI	0.949
Professional Liability Insurance RVUs	0.08	Professional Liability Insurance GPCI	0.322

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) + (1.06) + (0.08) = 2.11

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 2020 Medicare conversion factor of $36.0896).

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)
(2.11) x (38.00) = $80.18

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 0.990) + (1.06 x 0.949) + (0.08 x 0.322)
(0.9603) + (1.00594) + (0.02576) = 1.992

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

2020 Medicare conversion factor (CF) = $36.0896

Total Medicare payment for the provision of CPT code 99213 in Green Bay, Wisconsin =
Total geographically adjusted RVUs for CPT code 99213 x 2020 Medicare conversion factor
(1.992 x $36.0896 = $71.89)

In this example, a physician practicing in Green Bay, Wisconsin will receive $71.89 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, please access the 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 (E/M) REVISIONS: 2019 AND 2021

Implemented in **2019** (effective date 1/1/19): Physicians must continue to utilize either the 1995 or 1997 Documentation Guidelines. However, there is 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** (effective date 1/1/21), CMS finalized its policy to utilize the CPT framework and RUC recommendations for Office Visit E/M codes.

The following changes will be implemented on January 1, 2021 to allow time for extensive education for use of the new guidelines and revised codes:

- CMS will adopt the CPT guidelines to report Office Visits based on either medical decision making or physician time
- CMS accepted the RUC work recommendations for the Office Visit codes
- CMS adopted the RUC physician time recommendations for the Office Visit codes

CMS departed from the CPT and RUC recommendations in two ways:

1) CMS will implement an add-on payment for office visits for primary care and patients with serious or complex conditions (code GPCIX; ~$18 per visit)
CMS states that although it has no specialty restrictions on reporting new code GPC1X, CMS assumes that the following specialties will report this add-on code with 100% of their Office Visits, essentially making this a bonus payment for: family medicine, general practice, internal medicine, pediatrics, geriatrics, nurse practitioners, physician assistants, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease.

2) Although the surgical specialties participated in the RUC survey and their data and vignettes were incorporated into the RUC recommendations, CMS will not to apply the Office Visit increases to the global surgery packages. CMS offers to continue to review data to address the its concern that the follow up visits are not typically performed.

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	0.76	0.22	0.05	1.29	0.75	$46.56	$27.07
99202	0.93	1.12	0.41	0.09	2.14	1.43	$77.23	$51.61
99203	1.42	1.48	0.59	0.13	3.03	2.14	$109.35	$77.23
99204	2.43	1.98	1.01	0.22	4.63	3.66	$167.09	$132.09
99205	3.17	2.40	1.33	0.28	5.85	4.78	$211.12	$172.51
Office Or Other Outpatient Services, Established Patient								
99211	0.18	0.46	0.07	0.01	0.65	0.26	$23.46	$9.38
99212	0.48	0.75	0.20	0.05	1.28	0.73	$46.19	$26.35
99213	0.97	1.06	0.40	0.08	2.11	1.45	$76.15	$52.33
99214	1.50	1.45	0.62	0.11	3.06	2.23	$110.43	$80.48
99215	2.11	1.85	0.89	0.15	4.11	3.15	$148.33	$113.68
Office Or Other Outpatient Consultations*								
99241[I]	0.64	0.66	0.24	0.05	1.35	0.93	$48.72	$33.56
99242[I]	1.34	1.10	0.51	0.11	2.55	1.96	$92.03	$70.74
99243[I]	1.88	1.46	0.71	0.15	3.49	2.74	$125.95	$98.89
99244[I]	3.02	1.96	1.14	0.25	5.23	4.41	$188.75	$159.16
99245[I]	3.77	2.30	1.38	0.30	6.37	5.45	$229.89	$196.69
Prolonged Service With Face-To-Face Patient Contact; Outpatient								
99354	2.33	1.18	0.96	0.15	3.66	3.44	$132.09	$124.15
99355	1.77	0.90	0.71	0.11	2.78	2.59	$100.33	$93.47
Preventive Medicine Services, New Patient								
99381[N]	1.50	1.52	0.58	0.11	3.13	2.19	$112.96	$79.04
99382[N]	1.60	1.56	0.62	0.12	3.28	2.34	$118.37	$84.45
99383[N]	1.70	1.59	0.65	0.13	3.42	2.48	$123.43	$89.50
99384[N]	2.00	1.71	0.77	0.16	3.87	2.93	$139.67	$105.74
99385[N]	1.92	1.68	0.74	0.15	3.75	2.81	$135.34	$101.41
Preventive Medicine Services, Established Patient								
99391[N]	1.37	1.35	0.53	0.11	2.83	2.01	$102.13	$72.54
99392[N]	1.50	1.40	0.58	0.11	3.01	2.19	$108.63	$79.04
99393[N]	1.50	1.39	0.58	0.11	3.00	2.19	$108.27	$79.04
99394[N]	1.70	1.47	0.65	0.13	3.30	2.48	$119.10	$89.50
99395[N]	1.75	1.50	0.67	0.13	3.38	2.55	$121.98	$92.03
Immunization Administration Through Age 18 With Counseling								
90460	0.17	0.22	NA	0.01	0.40	NA	$14.44	NA
90461	0.15	0.20	NA	0.01	0.36	NA	$12.99	NA
Immunization Administration								

90471	0.17	0.22	NA	0.01	0.40	NA	$14.44	NA
90472	0.15	0.20	NA	0.01	0.36	NA	$12.99	NA
90473[R]	0.17	0.22	NA	0.01	0.40	NA	$14.44	NA
90474[R]	0.15	0.20	NA	0.01	0.36	NA	$12.99	NA
Hydration, Therapeutic, Prophylactic, & Diagnostic Injections & Infusions, & Chemotherapy & Other Highly Complex Drug Or Highly Complex Biologic Agent Administration								
96360	0.17	0.77	NA	0.02	0.96	NA	$34.65	NA
96361	0.09	0.28	NA	0.01	0.38	NA	$13.71	NA
96365	0.21	1.74	NA	0.05	2.00	NA	$72.18	NA
96366	0.18	0.42	NA	0.01	0.61	NA	$22.01	NA
96374	0.18	0.91	NA	0.02	1.11	NA	$40.06	NA
Vision & Hearing Screening								
99173[N]	0.00	0.07	NA	0.01	0.08	NA	$2.89	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	$11.91	NA
92552	0.00	0.88	NA	0.01	0.89	NA	$32.12	NA
Developmental Screening & Testing								
96110[N]	0.00	0.27	NA	0.01	0.28	NA	$10.11	NA
96112	2.56	1.20	0.95	0.13	3.89	3.64	$140.39	$131.37
96113	1.16	0.52	0.43	0.06	1.74	1.65	$62.80	$59.55
Emotional/Behavioral Assessment								
96127	0.00	0.13	NA	0.01	0.14	NA	$5.05	NA
Health Risk Assessment								
96160	0.00	0.07	NA	0.00	0.07	NA	$2.53	NA
96161	0.00	0.07	NA	0.00	0.07	NA	$2.53	NA
Topical Application of Fluoride Varnish								
99188[N]	0.20	0.13	0.08	0.02	0.35	0.30	$12.63	$10.83
Care Plan Oversight								
99339[B]	1.25	0.85	NA	0.09	2.19	NA	$79.04	NA
99340[B]	1.80	1.12	NA	0.13	3.05	NA	$110.07	NA
Behavioral/Psychiatric Collaborative Care Management								
99484	0.61	0.67	0.25	0.05	1.33	0.91	$48.00	$32.84
99492	1.70	2.54	0.69	0.11	4.35	2.50	$156.99	$90.22
99493	1.53	1.88	0.63	0.09	3.50	2.25	$126.31	$81.20
99494	0.82	0.90	0.33	0.05	1.77	1.20	$63.88	$43.31
Chronic Care Management								
99487	1.00	1.50	0.42	0.06	2.56	1.48	$92.39	$53.41
99489	0.50	0.71	0.20	0.03	1.24	0.73	$44.75	$26.35
99490	0.61	0.51	0.25	0.05	1.17	0.91	$42.22	$32.84
99491	1.45	0.79	0.79	0.09	2.33	2.33	$84.09	$84.09
Transitional Care Management								
99495	2.36	2.71	0.99	0.13	5.20	3.48	$187.67	$125.59
99496	3.10	3.58	1.30	0.19	6.87	4.59	$247.94	$165.65
Physician Telephone/Interprofessional Internet Consultation/Online E/M Services								
99421	0.25	0.16	0.10	0.02	0.43	0.37	$15.52	$13.35

99422	0.50	0.31	0.21	0.05	0.86	0.76	$31.04	$27.43
99423	0.80	0.51	0.33	0.08	1.39	1.21	$50.16	$43.67
99441[N]	0.25	0.13	0.10	0.02	0.40	0.37	$14.44	$13.35
99442[N]	0.50	0.23	0.19	0.05	0.78	0.74	$28.15	$26.71
99443[N]	0.75	0.33	0.29	0.06	1.14	1.10	$41.14	$39.70
99446	0.35	0.13	0.13	0.03	0.51	0.51	NA	$18.41
99447	0.70	0.27	0.27	0.06	1.03	1.03	NA	$37.17
99448	1.05	0.40	0.40	0.09	1.54	1.54	NA	$55.58
99449	1.40	0.54	0.54	0.11	2.05	2.05	NA	$73.98
99451	0.70	0.29	0.29	0.05	1.04	1.04	$37.53	$37.53
99452	0.70	0.29	0.29	0.05	1.04	1.04	$37.53	$37.53
Medicare Virtual Communication Technology-Based Services								
G2010	0.18	0.15	0.07	0.01	0.34	0.26	$12.27	$9.38
G2012	0.25	0.14	0.10	0.02	0.41	0.37	$14.80	$13.35
Prolonged Service Before/After Direct Patient Care								
99358	2.10	0.92	0.92	0.13	3.15	3.15	$113.68	$113.68
99359	1.00	0.46	0.46	0.08	1.54	1.54	$55.58	$55.58
Physician Medical Team Conference								
99367[B]	1.10	NA	0.42	0.09	NA	1.61	NA	$58.10
Newborn Care Services								
99460	1.92	NA	0.66	0.12	NA	2.70	NA	$97.44
99461	1.26	1.22	0.43	0.09	2.57	1.78	$92.75	$64.24
99462	0.84	NA	0.29	0.06	NA	1.19	NA	$42.95
99463	2.13	NA	0.86	0.13	NA	3.12	NA	$112.60
99464	1.50	NA	0.52	0.09	NA	2.11	NA	$76.15
99465	2.93	NA	1.01	0.19	NA	4.13	NA	$149.05
Initial Hospital Care								
99221	1.92	NA	0.77	0.19	NA	2.88	NA	$103.94
99222	2.61	NA	1.06	0.22	NA	3.89	NA	$140.39
99223	3.86	NA	1.57	0.28	NA	5.71	NA	$206.07
Subsequent Hospital Care								
99231	0.76	NA	0.29	0.06	NA	1.11	NA	$40.06
99232	1.39	NA	0.56	0.09	NA	2.04	NA	$73.62
99233	2.00	NA	0.81	0.13	NA	2.94	NA	$106.10
Discharge Day Management								
99238	1.28	NA	0.69	0.09	NA	2.06	NA	$74.34
99239	1.90	NA	1.00	0.12	NA	3.02	NA	$108.99
Initial Observation Care								
99217	1.28	NA	0.68	0.09	NA	2.05	NA	$73.98
99218	1.92	NA	0.74	0.16	NA	2.82	NA	$101.77
99219	2.60	NA	1.05	0.18	NA	3.83	NA	$138.22
99220	3.56	NA	1.40	0.26	NA	5.22	NA	$188.39
Subsequent Observation Care								
99224	0.76	NA	0.30	0.06	NA	1.12	NA	$40.42
99225	1.39	NA	0.57	0.09	NA	2.05	NA	$73.98
99226	2.00	NA	0.82	0.13	NA	2.95	NA	$106.46
Emergency Department Services								
99281	0.48	NA	0.11	0.05	NA	0.64	NA	$23.10

99282	0.93	NA	0.21	0.09	NA	1.23	NA	$44.39
99283	1.42	NA	0.29	0.13	NA	1.84	NA	$66.40
99284	2.60	NA	0.51	0.27	NA	3.38	NA	$121.98
99285	3.80	NA	0.71	0.40	NA	4.91	NA	$177.20
Prolonged Service With Face-To-Face Patient Contact; Inpatient								
99356	1.71	NA	0.79	0.11	NA	2.61	NA	$94.19
99357	1.71	NA	0.81	0.11	NA	2.63	NA	$94.92
Physician Standby Services								
99360[X]	1.20	NA	0.46	0.09	NA	1.75	NA	$63.16
Critical Care Services								
99291	4.50	2.99	1.38	0.40	7.89	6.28	$284.75	$226.64
99292	2.25	1.03	0.70	0.21	3.49	3.16	$125.95	$114.04
Pediatric Critical Care Patient Transport								
99466	4.79	NA	1.64	0.31	NA	6.74	NA	$243.24
99467	2.40	NA	0.83	0.15	NA	3.38	NA	$121.98
99485[B]	1.50	NA	0.58	0.11	NA	2.19	NA	$79.04
99486[B]	1.30	NA	0.50	0.11	NA	1.91	NA	$68.93
Inpatient Pediatric & Neonatal Critical Care								
99468	18.46	NA	6.34	1.18	NA	25.98	NA	$937.61
99469	7.99	NA	2.75	0.51	NA	11.25	NA	$406.01
99471	15.98	NA	5.48	1.03	NA	22.49	NA	$811.66
99472	7.99	NA	2.84	0.54	NA	11.37	NA	$410.34
99475	11.25	NA	3.86	0.72	NA	15.83	NA	$571.30
99476	6.75	NA	2.56	0.49	NA	9.80	NA	$353.68
Initial & Continuing Intensive Care Services								
99477	7.00	NA	2.41	0.46	NA	9.87	NA	$356.20
99478	2.75	NA	0.95	0.18	NA	3.88	NA	$140.03
99479	2.50	NA	0.86	0.16	NA	3.52	NA	$127.04
99480	2.40	NA	0.83	0.15	NA	3.38	NA	$121.98
Neonatal & Pediatric Transfusion								
36440	1.03	NA	0.36	0.08	NA	1.47	NA	$53.05
36450	3.50	NA	1.20	0.23	NA	4.93	NA	$177.92
36455	2.43	NA	0.69	0.56	NA	3.68	NA	$132.81
36456	2.00	NA	0.77	0.16	NA	2.93	NA	$105.74
Initiation of Neonatal Hypothermia								
99184	4.50	NA	1.53	0.30	NA	6.33	NA	$228.45
Moderate Sedation Provided By The Same Physician Performing The Diagnostic Or Therapeutic Service								
99151	0.50	1.55	0.12	0.05	2.10	0.67	$75.79	$24.18
99152	0.25	1.16	0.08	0.02	1.43	0.35	$51.61	$12.63
99153	0.00	0.29	NA	0.01	0.30	NA	$10.83	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	$87.70
99156	1.65	NA	0.42	0.15	NA	2.22	NA	$80.12
99157	1.25	NA	0.47	0.09	NA	1.81	NA	$65.32
Allergen Immunotherapy								
95115	0.00	0.25	NA	0.01	0.26	NA	$9.38	NA
95117	0.00	0.29	NA	0.01	0.30	NA	$10.83	NA

Orthopedic Procedures								
23500	2.21	3.68	3.81	0.43	6.32	6.45	$228.09	$232.78
24640	1.25	1.55	0.92	0.09	2.89	2.26	$104.30	$81.56
25600	2.78	6.21	5.76	0.52	9.51	9.06	$343.21	$326.97
Otolaryngologic Procedures								
69200	0.77	1.43	0.47	0.11	2.31	1.35	$83.37	$48.72
69209	0.00	0.39	NA	0.01	0.40	NA	$14.44	NA
69210	0.61	0.66	0.26	0.09	1.36	0.96	$49.08	$34.65
Pulmonary Procedures								
94640	0.00	0.49	NA	0.01	0.50	NA	$18.04	NA
94664	0.00	0.46	NA	0.01	0.47	NA	$16.96	NA
94780	0.48	0.92	0.17	0.03	1.43	0.68	$51.61	$24.54
94781	0.17	0.38	0.06	0.01	0.56	0.24	$20.21	$8.66
Radiologic Procedures								
76885	0.74	3.27	NA	0.04	4.05	NA	$146.16	NA
76886	0.62	2.31	NA	0.04	2.97	NA	$107.19	NA
Urologic Procedures								
51701	0.50	0.70	0.18	0.08	1.28	0.76	$46.19	$27.43
54150	1.90	2.25	0.69	0.25	4.40	2.84	$158.79	$102.49
54160	2.53	3.48	1.36	0.28	6.29	4.17	$227.00	$150.49
54161	3.32	NA	1.97	0.39	NA	5.68	NA	$204.99
54162	3.32	3.68	2.04	0.39	7.39	5.75	$266.70	$207.52
Dermatologic Procedures								
10060	1.22	2.09	1.52	0.13	3.44	2.87	$124.15	$103.58
10120	1.22	2.96	1.59	0.13	4.31	2.94	$155.55	$106.10
17110	0.70	2.39	1.13	0.08	3.17	1.91	$114.40	$68.93
17111	0.97	2.66	1.28	0.09	3.72	2.34	$134.25	$84.45
17250	0.50	1.83	0.48	0.09	2.42	1.07	$87.34	$38.62
Health & Behavior Assessment/Intervention								
96156	2.10	0.58	0.32	0.09	2.77	2.51	$99.97	$90.58
96158	1.45	0.39	0.21	0.05	1.89	1.71	$68.21	$61.71
96159	0.50	0.14	0.07	0.02	0.66	0.59	$23.82	$21.29
96164	0.21	0.06	0.03	0.01	0.28	0.25	$10.11	$9.02
96165	0.10	0.03	0.01	0.00	0.13	0.11	$4.69	$3.97
96167	1.55	0.42	0.22	0.06	2.03	1.83	$73.26	$66.04
96168	0.55	0.15	0.08	0.02	0.72	0.65	$25.98	$23.46
96170[N]	1.50	0.69	0.58	0.11	2.30	2.19	$83.01	$79.04
96171[N]	0.54	0.25	0.21	0.05	0.84	0.80	$30.32	$28.87
Medical Nutrition Therapy								
97802	0.53	0.51	0.41	0.02	1.06	0.96	$38.25	$34.65
97803	0.45	0.45	0.34	0.02	0.92	0.81	$33.20	$29.23
97804	0.25	0.22	0.19	0.01	0.48	0.45	$17.32	$16.24
Education & Training For Patient Self-Management								
98960[B]	0.00	0.75	NA	0.02	0.77	NA	$27.79	NA
98961[B]	0.00	0.36	NA	0.01	0.37	NA	$13.35	NA
98962[B]	0.00	0.26	NA	0.01	0.27	NA	$9.74	NA
Counseling Risk Factor Reduction & Behavior Change Intervention								

99401[N]	0.48	0.59	0.18	0.05	1.12	0.71	$40.42	$25.62
99402[N]	0.98	0.78	0.38	0.09	1.85	1.45	$66.77	$52.33
99403[N]	1.46	0.96	0.56	0.11	2.53	2.13	$91.31	$76.87
99404[N]	1.95	1.14	0.75	0.15	3.24	2.85	$116.93	$102.86
99406	0.24	0.17	0.09	0.02	0.43	0.35	$15.52	$12.63
99407	0.50	0.27	0.19	0.05	0.82	0.74	$29.59	$26.71
99408[N]	0.65	0.32	0.25	0.05	1.02	0.95	$36.81	$34.29
99409[N]	1.30	0.57	0.50	0.11	1.98	1.91	$71.46	$68.93
Sleep Medicine Testing								
95782	2.60	22.61	NA	0.28	25.49	NA	$919.92	NA
95783	2.83	23.96	NA	0.31	27.10	NA	$978.03	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