American Academy of Pediatrics
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2016 RBRVS

WHAT IS IT
AND
HOW DOES IT AFFECT PEDIATRICS?

The Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule on January 1, 1992. The Medicare RBRVS physician fee schedule replaced the Medicare physician payment system of "customary, prevailing, and reasonable" (CPR) charges under which physicians were paid according to the historical record of the charge for the provision of each service. The current Medicare RBRVS physician fee schedule is derived from the "relative value" of services provided and based on the resources they consume. The relative value of each service is quantifiable and is based on the concept that there are three components of each service: the amount of physician work that goes into the service, the practice expense associated with the service, and the professional liability expense for the provision of the service. The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation is the Medicare payment amount for the provision of a particular service. It is critical to note that 77% of public and private payers, including Medicaid programs, have adopted components of the Medicare RBRVS to pay physicians, while others are exploring its implementation. For more information on RBRVS, go to http://pediatrics.aappublications.org/content/133/6/1158.

ELEMENTS OF THE RBRVS

Physician Work (Work)

The physician work component of the Medicare RBRVS physician fee schedule is maintained and updated by CMS with input from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 31 members, consisting of 21 representatives from major medical specialty societies, as well as representatives from the American Medical Association (AMA), the American Osteopathic Association, the Health Care Professionals Advisory Committee, the Practice Expense Subcommittee, and the CPT Editorial Panel. The American Academy of Pediatrics (AAP) holds one of the 21 seats designated for medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units (RVUs) of physician work and establishes payment policy, which is published in the *Federal Register* (http://www.cms.hhs.gov/PhysicianFeeSched/).

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 2016.

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

2016 Medicare Geographic Practice Cost Indices (GPCIs)

Medicare Locality	Work	Practice Expense (PE)	Professional Liability Insurance (PLI)
Alabama	0.980	0.886	0.611
Alaska**	1.500	1.107	0.712
Arizona	0.986	1.000	0.877
Arkansas	0.966	0.867	0.534
Anaheim/Santa Ana, CA	1.035	1.216	0.908
Los Angeles, CA	1.047	1.161	0.908
Marin/Napa/Solano, CA	1.059	1.286	0.496
Oakland/Berkeley, CA	1.061	1.260	0.457
San Francisco, CA	1.079	1.388	0.457
San Mateo, CA	1.079	1.372	0.416
Santa Clara, CA	1.088	1.347	0.416
Ventura, CA	1.030	1.180	0.834
Rest of California	1.027	1.083	0.658
Colorado	1.000	1.011	1.090
Connecticut	1.024	1.121	1.232
DC + MD/VA Suburbs	1.051	1.205	1.280
Delaware	1.012	1.031	1.083
Fort Lauderdale, FL	0.985	1.030	1.715
Miami, FL	0.991	1.033	2.490
Rest of Florida	0.980	0.960	1.315
Atlanta, GA	0.999	1.005	0.943
Rest of Georgia	0.976	0.899	0.904
Hawaii/Guam	1.003	1.162	0.618
Idaho	0.958	0.898	0.508
Chicago, IL	1.016	1.037	2.019
East St Louis, IL	0.985	0.934	1.885
Suburban Chicago, IL	1.012	1.057	1.636
Rest of Illinois	0.974	0.909	1.253
Indiana	0.971	0.921	0.617
Iowa	0.965	0.896	0.493
Kansas	0.964	0.903	0.662
Kentucky	0.973	0.872	0.795
New Orleans, LA	0.989	0.983	1.390
Rest of Louisiana	0.977	0.887	1.205
Southern Maine	0.982	1.007	0.642
Rest of Maine	0.967	0.918	0.642

Baltimore/Surrounding Counties, MD	1.023	1.097	1.181
Rest of Maryland	1.015	1.036	0.971
Metropolitan Boston, MA	1.017	1.163	0.617
Rest of Massachusetts	1.017	1.066	0.617
Detroit, MI	0.998	0.994	1.328
Rest of Michigan	0.984	0.920	0.954
Minnesota	0.994	1.020	0.319
Mississippi	0.959	0.864	0.613
Metropolitan Kansas City, MO	0.983	0.952	1.025
Metropolitan St Louis, MO	0.987	0.955	1.025
Rest of Missouri	0.952	0.848	0.946
Montana***	0.956	1.000	1.226
Nebraska	0.966	0.908	0.362
Nevada***	1.005	1.051	0.982
New Hampshire	1.000	1.058	0.873
Northern New Jersey	1.040	1.182	1.090
Rest of New Jersey	1.025	1.125	1.090
New Mexico	0.985	0.919	1.161
Manhattan, NY	1.052	1.168	1.764
NYC Suburbs/Long Island, NY	1.046	1.209	2.215
Poughkeepsie/Northern NYC Suburbs, NY	1.010	1.074	1.484
Queens, NY	1.052	1.199	2.181
Rest of New York	0.986	0.945	0.760
North Carolina	0.978	0.930	0.768
North Dakota***	0.965	1.000	0.554
Ohio	0.984	0.918	0.993
Oklahoma	0.960	0.872	0.845
Portland, OR	1.005	1.049	0.708
Rest of Oregon	0.987	0.967	0.708
Metropolitan Philadelphia, PA	1.021	1.087	1.264
Rest of Pennsylvania	0.991	0.929	0.987
Puerto Rico	0.913	0.705	0.293
Rhode Island	1.022	1.053	0.759
South Carolina	0.976	0.912	0.715
South Dakota***	0.954	1.000	0.400
Tennessee	0.970	0.898	0.524
Austin, TX	0.998	1.019	0.766
Beaumont, TX	0.987	0.902	0.955
Brazoria, TX	1.019	0.990	0.955
Dallas, TX	1.018	1.009	0.772
Fort Worth, TX	1.005	0.995	0.772
Galveston, TX	1.019	1.013	0.955
Houston, TX	1.019	1.006	0.955
Rest of Texas	0.990	0.920	0.822
Utah	0.967	0.922	1.169
Vermont	0.981	1.004	0.682
Virginia	0.991	0.983	0.824

Virgin Islands	0.975	0.960	0.996
Seattle (King County), WA	1.025	1.155	0.495
Rest of Washington	0.996	1.015	0.475
West Virginia	0.961	0.836	1.282
Wisconsin	0.984	0.955	0.566
Wyoming***	0.985	1.000	1.219

**** Work GPCI reflects a 1.5 floor for Alaska established by the MIPPA.**

***** PE GPCI reflects a 1.0 floor for frontier states established by the ACA.**

Medicare Conversion Factor (CF)

The Medicare Conversion Factor (CF) is a national value that converts the total RVUs into payment amounts for the purpose of paying physicians for services provided. Since January 1, 1998, there has been one Medicare Conversion Factor, as specified by the Balanced Budget Act of 1997. Anesthesia has a separate conversion factor, but is paid using a different formula. The Medicare Conversion Factor is updated annually. Medicare Conversion Factors in past years have been $36.6137 (2000), $38.2581 (2001), $36.1992 (2002), $36.7856 (2003), $37.3374 (2004), $37.8975 (2005), $37.8975 (2006), $37.8975 (2007), $38.0870 (2008), $36.0666 (2009), $36.0791 (1/1/10-5/31/10), $36.8729 (6/1/10-12/31/10), $33.9764 (2011), $34.0376 (2012), $34.0230 (2013), and $35.8228 (2014 and 2015).

2016 Medicare Conversion Factor = $35.8279

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

- MEI: The allocation of RVUs to pools for physician work, practice expense, and professional liability insurance correspond with the Medicare Economic Index. This is the reason that work is allocated 50.9% of the total RVUs, practice expense is 44.8%, and professional liability insurance is 4.3%.
- HPSA: Incentive payments for physician services provided to patients in Health Professional Shortage Areas (HPSAs), which are medically underserved communities, urban and rural locations that have a documented shortage of medical professionals.
- Nonparticipating Physicians: Reduced payments for physicians, called "nonparticipating" physicians, who do not accept Medicare "assignment." The law sets the payment amount for nonparticipating physicians at 95% of the payment amount for participating physicians (ie, the fee schedule amount).
- Budget Neutrality: Statutory guidelines indicate that revisions to the RVUs for physician services may not alter physician expenditures within the Medicare RBRVS physician fee schedule by more than $20 million from the principal expenditures that would have resulted if the RVU adjustments were never initiated. In 2007 and 2008, the Medicare program applied a separate budget neutrality adjustment factor to the physician work RVUs to ensure Medicare budget neutrality in light of work RVU increases tied to the 2005 Five-Year Review. However, by virtue of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), starting in 2009 CMS is required to maintain Medicare budget neutrality exclusively via annual adjustments to the 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 Marco Island, Florida ("Rest of Florida" Medicare Locality).

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

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

CPT Code 99213		Location: Marco Island, Florida ("Rest of Florida" Medicare Locality)	
Work RVUs	0.97	Work GPCI	0.980
Non-Facility Practice Expense RVUs	1.01	Practice Expense GPCI	0.960
Professional Liability Insurance RVUs	0.07	Professional Liability Insurance GPCI	1.315

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) + (1.01) + (0.07) = 2.05

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 2016 Medicare Conversion Factor of $35.8279).

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)
(2.05) x (38.00) = $77.90

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

METHOD 2 (GEOGRAPHICALLY ADJUSTED & USING MEDICARE CONVERSION FACTOR)

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

STEP 1

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

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 0.980) + (1.01 x 0.960) + (0.07 x 1.315)
(0.9506) + (0.9696) + (0.09205) = 2.01225

STEP 2

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

2016 Medicare Conversion Factor (CF) = $35.8279

Total Medicare payment for the provision of CPT code 99213 in Marco Island, Florida =
Total geographically adjusted RVUs for CPT code 99213 x 2013 Medicare Conversion Factor
(2.01225 x $35.8279 = $72.09)

In this example, a physician practicing in Marco Island, Florida would receive $72.09 for providing the level 3 established patient office visit for a Medicare beneficiary.

To apply Method 2 using your own GPCIs, access the 2016 RBRVS Conversion Spreadsheet.

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

CONCLUDING REMARKS

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

For further information, please contact the AAP Coding Hotline at aapcodinghotline@aap.org.

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

CPT Code	Work RVUs (wRVUs)	Non-Facility (NF) Practice Expense (PE) RVUs	Facility (F) Practice Expense (PE) RVUs	PLI RVUs	Total NF RVUs	Total F RVUs	100% Medicare (NF)	100% Medicare (F)
Office Or Other Outpatient Services, New Patient								
99201	0.48	0.71	0.23	0.05	1.24	0.76	$44.43	$27.23
99202	0.93	1.10	0.41	0.08	2.11	1.42	$75.60	$50.88
99203	1.42	1.48	0.60	0.15	3.05	2.17	$109.28	$77.75
99204	2.43	1.99	1.02	0.22	4.64	3.67	$166.24	$131.49
99205	3.17	2.36	1.31	0.29	5.82	4.77	$208.52	$170.90
Office Or Other Outpatient Services, Established Patient								
99211	0.18	0.37	0.07	0.01	0.56	0.26	$20.06	$9.32
99212	0.48	0.71	0.20	0.04	1.23	0.72	$44.07	$25.80
99213	0.97	1.01	0.40	0.07	2.05	1.44	$73.45	$51.59
99214	1.50	1.42	0.61	0.10	3.02	2.21	$108.20	$79.18
99215	2.11	1.81	0.86	0.15	4.07	3.12	$145.82	$111.78
Office Or Other Outpatient Consultations*								
99241[I]	0.64	0.66	0.24	0.04	1.34	0.92	$48.01	$32.96
99242[I]	1.34	1.10	0.51	0.08	2.52	1.93	$90.29	$69.15
99243[I]	1.88	1.46	0.71	0.11	3.45	2.70	$123.61	$96.74
99244[I]	3.02	1.96	1.14	0.18	5.16	4.34	$184.87	$155.49
99245[I]	3.77	2.30	1.38	0.22	6.29	5.37	$225.36	$192.40
Prolonged Service With Face-To-Face Patient Contact; Outpatient								
99354	1.77	0.92	0.72	0.13	2.82	2.62	$101.03	$93.87
99355	1.77	0.85	0.65	0.12	2.74	2.54	$98.17	$91.00
Preventive Medicine Services, New Patient								
99381[N]	1.50	1.52	0.57	0.09	$3.11	2.16	$111.42	$77.39
99382[N]	1.60	1.56	0.61	0.09	$3.25	2.30	$116.44	$82.40
99383[N]	1.70	1.58	0.65	0.10	$3.38	2.45	$121.10	$87.78
99384[N]	2.00	1.70	0.77	0.12	$3.82	2.89	$136.86	$103.54
99385[N]	1.92	1.67	0.74	0.11	$3.70	2.77	$132.56	$99.24
Preventive Medicine Services, Established Patient								
99391[N]	1.37	1.34	0.52	0.08	2.79	1.97	$99.96	$70.58
99392[N]	1.50	1.39	0.57	0.09	2.98	2.16	$106.77	$77.39
99393[N]	1.50	1.38	0.57	0.09	2.97	2.16	$106.41	$77.39
99394[N]	1.70	1.46	0.65	0.10	3.26	2.45	$116.80	$87.78
99395[N]	1.75	1.48	0.67	0.10	3.33	2.52	$119.31	$90.29
Immunization Administration Through Age 18 With Counseling								
90460	0.17	0.53	NA	0.01	0.71	NA	$25.44	NA
90461	0.15	0.19	NA	0.01	0.35	NA	$12.54	NA
Immunization Administration								
90471	0.17	0.53	NA	0.01	0.71	NA	$25.44	NA

90472	0.15	0.19	NA	0.01	0.35	NA	$12.54	NA
90473[R]	0.17	0.53	NA	0.01	0.71	NA	$25.44	NA
90474[R]	0.15	0.19	NA	0.01	0.35	NA	$12.54	NA
Hydration, Therapeutic, Prophylactic, & Diagnostic Injections & Infusions, & Chemotherapy & Other Highly Complex Drug Or Highly Complex Biologic Agent Administration								
96360	0.17	1.42	NA	0.03	1.62	NA	$58.04	NA
96361	0.09	0.33	NA	0.01	0.43	NA	$15.41	NA
96365	0.21	1.70	NA	0.04	1.95	NA	$69.86	NA
96366	0.18	0.34	NA	0.01	0.53	NA	$18.99	NA
96374	0.18	1.38	NA	0.03	1.59	NA	$56.97	NA
Vision & Hearing Screening								
99173[N]	0.00	0.08	NA	0.01	0.09	NA	$3.22	NA
99174[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	NA
99177[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	NA
92551[N]	0.00	0.33	NA	0.01	0.34	NA	$12.18	NA
92552	0.00	0.87	NA	0.01	0.88	NA	$31.53	NA
Developmental Screening & Testing								
96110[N]	0.00	0.26	NA	0.01	0.27	NA	$9.67	NA
96111	2.60	0.92	0.74	0.13	3.65	3.47	$130.77	$124.32
Emotional/Behavioral Assessment								
96127	0.00	0.14	NA	0.01	0.15	NA	$5.37	NA
Topical Application of Fluoride Varnish								
99188[N]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
Care Plan Oversight								
99339[B]	1.25	0.86	NA	0.07	2.18	NA	$78.10	NA
99340[B]	1.80	1.15	NA	0.11	3.06	NA	$109.63	NA
Chronic Care Management								
99487[B]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
99489[B]	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
99490	0.61	0.49	0.23	0.04	1.14	0.88	$40.84	$31.53
Transitional Care Management								
99495	2.11	2.36	0.87	0.13	4.60	3.11	$164.81	$111.42
99496	3.05	3.25	1.26	0.19	6.49	4.50	$232.52	$161.23
Physician Telephone & Online E/M Services								
99441[N]	0.25	0.13	0.10	0.01	0.39	0.36	$13.97	$12.90
99442[N]	0.50	0.23	0.19	0.03	0.76	0.72	$27.23	$25.80
99443[N]	0.75	0.33	0.29	0.04	1.12	1.08	$40.13	$38.69
Codes 99444-99449 are bundled by Medicare and have no published RVUs.								
Physician Medical Team Conference								
99367[B]	1.10	NA	0.42	0.07	NA	1.59	NA	$56.97
Newborn Care Services								
99460	1.92	NA	0.68	0.12	NA	2.72	NA	$97.45
99461	1.26	1.45	0.52	0.08	2.79	1.86	$99.96	$66.64
99462	0.84	NA	0.29	0.05	NA	1.18	NA	$42.28
99463	2.13	NA	1.09	0.14	NA	3.36	NA	$120.38
99464	1.50	NA	0.41	0.11	NA	2.02	NA	$72.37

99465	2.93	NA	1.19	0.19	NA	4.31	NA	$154.42
Initial Hospital Care								
99221	1.92	NA	0.75	0.19	NA	2.86	NA	$102.47
99222	2.61	NA	1.04	0.21	NA	3.86	NA	$138.30
99223	3.86	NA	1.55	0.29	NA	5.70	NA	$204.22
Subsequent Hospital Care								
99231	0.76	NA	0.29	0.06	NA	1.11	NA	$39.77
99232	1.39	NA	0.55	0.09	NA	2.03	NA	$72.73
99233	2.00	NA	0.79	0.14	NA	2.93	NA	$104.98
Discharge Day Management								
99238	1.28	NA	0.68	0.08	NA	2.04	NA	$73.09
99239	1.90	NA	1.00	0.12	NA	3.02	NA	$108.20
Initial Observation Care								
99217	1.28	NA	0.68	0.09	NA	2.05	NA	$73.45
99218	1.92	NA	0.74	0.15	NA	2.81	NA	$100.68
99219	2.60	NA	1.03	0.18	NA	3.81	NA	$136.50
99220	3.56	NA	1.42	0.24	NA	5.22	NA	$187.02
Subsequent Observation Care								
99224	0.76	NA	0.30	0.06	NA	1.12	NA	$40.13
99225	1.39	NA	0.57	0.09	NA	2.05	NA	$73.45
99226	2.00	NA	0.82	0.13	NA	2.95	NA	$105.69
Emergency Department Services								
99281	0.45	NA	0.11	0.04	NA	0.60	NA	$21.50
99282	0.88	NA	0.21	0.08	NA	1.17	NA	$41.92
99283	1.34	NA	0.29	0.12	NA	1.75	NA	$62.70
99284	2.56	NA	0.53	0.23	NA	3.32	NA	$118.95
99285	3.80	NA	0.75	0.35	NA	4.90	NA	$175.56
Prolonged Service With Face-To-Face Patient Contact; Inpatient								
99356	1.71	NA	0.76	0.11	NA	2.58	NA	$92.44
99357	1.71	NA	0.75	0.11	NA	2.57	NA	$92.08
Physician Standby Services								
99360[X]	1.20	NA	0.46	0.07	NA	1.73	NA	$61.98
Critical Care Services								
99291	4.50	2.85	1.42	0.39	7.74	6.31	$277.31	$226.07
99292	2.25	1.02	0.72	0.19	3.46	3.16	$123.96	$113.22
Pediatric Critical Care Patient Transport								
99466	4.79	NA	1.36	0.34	NA	6.49	NA	$232.52
99467	2.40	NA	0.75	0.13	NA	3.28	NA	$117.52
99485[B]	1.50	NA	0.57	0.09	NA	2.16	NA	$77.39
99486[B]	1.30	NA	0.50	0.08	NA	1.88	NA	$67.36
Inpatient Pediatric & Neonatal Critical Care								
99468	18.46	NA	7.06	1.11	NA	26.63	NA	$954.10
99469	7.99	NA	2.72	0.51	NA	11.22	NA	$401.99
99471	15.98	NA	7.09	1.69	NA	24.76	NA	$887.10
99472	7.99	NA	2.96	0.61	NA	11.56	NA	$414.17
99475	11.25	NA	4.16	0.87	NA	16.28	NA	$583.28
99476	6.75	NA	2.5	0.53	NA	9.78	NA	$350.40
Initial & Continuing Intensive Care Services								
99477	7.00	NA	2.67	0.41	NA	10.08	NA	$361.15
99478	2.75	NA	0.93	0.18	NA	3.86	NA	$138.30

99479	2.50	NA	0.85	0.16	NA	3.51	NA	$125.76
99480	2.40	NA	0.82	0.15	NA	3.37	NA	$120.74
Initiation of Neonatal Hypothermia								
99184	4.50	NA	1.72	0.27	NA	6.49	NA	$232.52
Moderate Sedation Provided By The Same Physician Performing The Diagnostic Or Therapeutic Service								
Codes 99143-99145 are carrier-priced by Medicare and have no published RVUs.								
Moderate Sedation Provided By A Physician Other Than The Health Care Professional Performing The Diagnostic Or Therapeutic Service								
Codes 99148-99150 are carrier-priced by Medicare and have no published RVUs.								
Allergen Immunotherapy								
95115	0.00	0.24	NA	0.01	0.25	NA	$8.96	NA
95117	0.00	0.28	NA	0.01	0.29	NA	$10.39	NA
Orthopedic Procedures								
23500	2.21	3.68	3.78	0.4	6.29	6.39	$225.36	$228.94
24640	1.25	2.41	1.20	0.2	3.86	2.65	$138.30	$94.94
25600	2.78	6.12	5.63	0.51	9.41	8.92	$337.14	$319.58
Otolaryngologic Procedures								
69200	0.77	1.96	0.49	0.10	2.83	1.36	$101.39	$48.73
69209	0.00	0.35	NA	0.01	0.36	NA	$12.90	NA
69210	0.61	0.72	0.26	0.07	1.40	0.94	$50.16	$33.68
Pulmonary Procedures								
94640	0.00	0.51	NA	0.01	0.52	NA	$18.63	NA
94664	0.00	0.48	NA	0.01	0.49	NA	$17.56	NA
94780	0.48	1.07	0.13	0.04	1.59	0.65	$56.97	$23.29
94781	0.17	0.47	0.07	0.01	0.65	0.25	$23.29	$8.96
Radiologic Procedures								
76885	0.74	3.33	NA	0.05	4.12	NA	$147.61	NA
76886	0.62	2.34	NA	0.04	3.00	NA	$107.48	NA
Urologic Procedures								
51701	0.50	0.99	0.24	0.06	1.55	0.80	$55.53	$28.66
54150	1.90	2.25	0.68	0.23	4.38	2.81	$156.93	$100.68
54160	2.53	3.50	1.36	0.30	6.33	4.19	$226.79	$150.12
54161	3.32	NA	1.95	0.38	NA	5.65	NA	$202.43
54162	3.32	3.61	2.02	0.38	7.31	5.72	$261.90	$204.94
Dermatologic Procedures								
10060	1.22	1.97	1.42	0.13	3.32	2.77	$118.95	$99.24
10120	1.22	2.94	1.59	0.14	4.30	2.95	$154.06	$105.69
17110	0.70	2.35	1.21	0.09	3.14	2.00	$112.50	$71.66
17111	0.97	2.62	1.36	0.13	3.72	2.46	$133.28	$88.14
17250	0.50	1.68	0.49	0.07	2.25	1.06	$80.61	$37.98
Health & Behavior Assessment/Intervention								
96150	0.50	0.09	0.08	0.02	0.61	0.60	$21.86	$21.50
96151	0.48	0.08	0.07	0.02	0.58	0.57	$20.78	$20.42
96152	0.46	0.08	0.07	0.02	0.56	0.55	$20.06	$19.71
96153	0.10	0.02	0.02	0.01	0.13	0.13	$4.66	$4.66
96154	0.45	0.08	0.07	0.02	0.55	0.54	$19.71	$19.35
96155	0.44	0.17	0.17	0.03	0.64	0.64	$22.93	$22.93
Medical Nutrition Therapy								
97802	0.53	0.43	0.37	0.02	0.98	0.92	$35.11	$32.96

97803	0.45	0.38	0.31	0.02	0.85	0.78	$30.45	$27.95
97804	0.25	0.18	0.17	0.01	0.44	0.43	$15.76	$15.41
Education & Training For Patient Self-Management								
98960[B]	0.00	0.77	NA	0.02	0.79	NA	$28.30	NA
98961[B]	0.00	0.37	NA	0.01	0.38	NA	$13.61	NA
98962[B]	0.00	0.27	NA	0.01	0.28	NA	$10.03	NA
Counseling Risk Factor Reduction & Behavior Change Intervention								
99401[N]	0.48	0.51	0.18	0.03	1.02	0.69	$36.54	$24.72
99402[N]	0.98	0.70	0.38	0.06	1.74	1.42	$62.34	$50.88
99403[N]	1.46	0.89	0.56	0.09	2.44	2.11	$87.42	$75.60
99404[N]	1.95	1.07	0.75	0.12	3.14	2.82	$112.50	$101.03
99406	0.24	0.14	0.09	0.02	0.40	0.35	$14.33	$12.54
99407	0.50	0.24	0.19	0.04	0.78	0.73	$27.95	$26.15
99408[N]	0.65	0.30	0.25	0.04	0.99	0.94	$35.47	$33.68
99409[N]	1.30	0.55	0.50	0.08	1.93	1.88	$69.15	$67.36
Sleep Medicine Testing								
95782	2.60	26.09	NA	0.29	28.98	NA	$1,038.29	NA
95783	2.83	27.36	NA	0.27	30.46	NA	$1,091.32	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 Policy.

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))

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

[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