Work Intensity and IWPUT

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PRACTICE **POINTS**

- Intraservice work per unit of time (IWPUT) examines skin-to-skin work of a procedure.
- The removal of global period visits will cause changes in the IWPUT of codes.

After reading the July 2016 column on global periods and *Current Procedural Terminology* (*CPT*) code 99024,[1] you may be wondering why you get paid what you do and how the procedure and visits all link together, which is associated with work intensity.

When *CPT* codes are given a value, the determination of the value of the work is performed via a survey process carried out by specialties for presentation to the American Medical Association/Specialty Society Relative Value Scale Update Committee, which is used by the Centers for Medicare & Medicaid Services (CMS) to help determine relative value units (RVUs) that determine payment. The work RVU (wRVU) is typically around half of the total RVU for each *CPT* code. The value is based on multiple factors including the time to perform the service, the technical skill needed, the physical effort involved, mental effort and judgment, and stress under which the physician works due to the potential risks to the patient.[2] A series of instruments and calculations have been used to determine a value called intraservice work per unit of time (IWPUT), which is used to examine the intraservice (skin-to-skin) work of a procedure relative to similar procedures.

Calculating the IWPUT

To determine the IWPUT value of a procedure, a formula is used to subtract all the preservice and postservice work and look at what is left based on the total RVUs for the procedure, which can be mathematically presented using the following construct: total wRVUs (the complete work you provide in performing the service) is the sum of preservice work (eg, evaluation and management [E&M] services, preparatory work [eg, scrub, dress, wait]), intraservice (skin-to-skin) work, immediate postservice work (eg, dressings, prescriptions, instructions given by the physician), and postoperative work at E&M visits (eg, hospital days, discharge day, global follow-up visits).

All of these activities defined as E&M services are simply subtracted from the total wRVU, while wRVUs for preservice and postservice work that is not linked to a *CPT* global period are calculated by simply subtracting the product of each specified time by their intensity (eg, day prior evaluation, same day evaluation, and immediate post have an intensity of 0.0224, while scrub/preparation has an intensity of 0.0081),[3] leaving you with intraservice (skin-to-skin) work. This intraservice work is divided by the intraservice time to give you IWPUT. For more information on the concept as well as the process and controversies, an excellent review is available from the CMS.[4]

Understanding the IWPUT

The procedure with the highest IWPUT value in all of medicine is an emergency endotracheal intubation (*CPT* code 31500), which has a value of 0.4061.[5] The procedure is short and intense, and if it fails, the patient is dead. All other procedures have lower IWPUT values. For example, a small malignant excision on the trunk, arms, or legs (*CPT* code 11600) has an IWPUT of 0.0324, while a laparoscopic cholecystectomy with exploration of the common duct

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(*CPT* code 47564) has an IWPUT of 0.0737.[5] These small values have been the drivers behind much of the Relative Value Scale Update Committee's valuation process for more than a decade. Some specialists who perform mostly 90-day global procedures wanted IWPUT to be the critical validation factor in the process, which led to problems for the first few years of this century. It may seem obvious that if there are 2 ways to fix a broken leg, the more complex one would likely have a higher IWPUT. Because IWPUT is a pure number with no values attached, this assumption would seem reasonable. If we compare a malignant excision to a benign one, we would expect higher intensity for the malignant one, as we are going deeper and have more concerns about clear margins and recurrences. Within a group of similar procedures, these pure numbers can be useful to validate a proposed value. More wRVUs in a shorter time period would result in a higher IWPUT; however, anomalies arise. There are eleven 000 global period *CPT* codes, ten 010 codes, and one hundred ninety 090 codes with negative IWPUTs, implying the skin-to-skin work has a value less than 0, which is an illogical conclusion. The more logical conclusion is that the codes are overloaded with preservice and postservice times. The real travesty is when one begins to compare apples to oranges—glaucoma surgery to belly surgery, endoscopy to skin surgery, or any other comparison you can come up with—taking a number that can be used to evaluate intensity between similar procedures and generalizing across all procedures, a concept that has never been validated. The wRVUs themselves define the relativity, but in many instances the IWPUT has been used in the process to justify forcing values lower based on cross-specialty comparisons, which may lead some to think we need better measures, as has been reported in the literature.[6-8] Reform likely will happen, but for now we must work within the constraints of this tiny number, the IWPUT.

Obtaining the IWPUT

You are probably wondering, "How can I learn the IWPUT for the codes I use?" You probably do not want or need to other than to gain an understanding of how they have been misused. Purchase a subscription to the Resource-Based Relative Value Scale (RBRVS) DataManager Online or access the data for free through the CMS website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-P.html) by downloading the CY 2017 PFS Proposed Rule Addenda, which gives you total RVUs for all *CPT* codes, and the CY 2017 PFS Proposed Rule Physician Time, which gives you the preservice, intraservice, and postservice times for all *CPT* codes.

Using *CPT* code 11600 as an example, the total wRVU is 1.63, while preservice evaluation time is 10 minutes, intraservice time is 10 minutes, and immediate postservice time is 5 minutes. There is also 1 global follow-up visit, a *CPT* 99213, built in with a wRVU of 0.97 that determines the total value of the code. Using the IWPUT formula, we have the following: $\{1.63 - [(10 \times 0.0224) + (5 \times 0.0224) + 0.97]\} / 10 = 0.0324$.

These data also are useful if you are negotiating a contract based on RVUs, so learn a bit more about why you get paid what you are paid.

The Importance of IWPUT

Those interested in the academic discourse behind IWPUT should consult the literature,[3,9] which is open source and freely available, but for now we will concentrate on why IWPUT is an important concept. As global periods are reevaluated under the Medicare Access and CHIP Reauthorization Act of 2015,[10] the removal of global period visits will cause changes in the IWPUT value of codes, which will make them outliers and therefore targeted for resurvey and revaluation. The intent of the CMS is to cut reimbursement under our fee-for-service system, so there will be pain for physicians who have flourished under the current policy. To avoid inappropriate decreases in reimbursement, we should all keep accurate records of which global postoperative services are indeed provided, which leads us back to *CPT* code 99024. If it is not tracked, then it may not be seen as having been done. So be sure to use it.

Remember that if you do what you document, document what you do, and report medically necessary *CPT* codes, you should have nothing to worry about for now.

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