

# 2003 RBRVS

## WHAT IS IT AND HOW DOES IT AFFECT PEDIATRICS?

The Centers for Medicare and Medicaid Services (CMS) implemented the 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 reimbursed 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 physician 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 (see below) and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation, with adjustments under certain circumstances, is the reimbursement a physician receives for the provision of a particular service. It is critical to note that over 74% of public and private payors, including state Medicaid programs, have adopted components of the Medicare RBRVS to reimburse physicians, while many other payers are exploring its implementation.

### **ELEMENTS OF THE RBRVS**

#### **Physician work involved in providing the service**

The physician work component of the Medicare RBRVS physician fee schedule is maintained and updated by the CMS with input from the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 29 members, consisting of 23 representatives from major medical specialty societies, as well as representatives from the American Medical Association, the American Osteopathic Association, the Health Care Professionals Advisory Committee (HCPAC), the Practice Expense Advisory Committee (PEAC), and the CPT Editorial Panel. The American Academy of Pediatrics (AAP) holds one of the 23 seats designated for medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units of physician work and establishes payment policy, which is published in the *Federal Register*. The *Federal Register* can be found at:

1. [www.access.gpo.gov](http://www.access.gpo.gov)
2. Click on "Access to Government Information Products"
3. Under "Quick Links," click on "*Federal Register*," then on "Browse Feature"
4. Under "*Federal Register* Volume," check the box next to "2002 *Federal Register*, Vol. 67." Under "Issue Date," enter "12/31/2002" {Note: It must be in this exact format} in the box next to where it says "On." Finally, in the box under "Search Terms," enter "Medicare physician fee schedule" and click on the "Submit" button.
5. The first listing that appears should be the complete 2003 RBRVS final rule, containing a complete list of RVUs for every CPT code.
6. You can open the final rule in HTML or PDF format. Please note that it can take several minutes for it

to download.

The physician work component (relative value units of physician work) represents approximately 55% of the total relative value units (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 four-year transition to resource-based practice expense RVUs is now completed. CMS uses many sources and methodologies to determine practice expense RVUs. Among these is the Practice Expense Advisory Committee (PEAC), a subcommittee of the RUC. The AAP holds a seat on this committee. 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, doctor's office or patient's home). This policy continues for 2003.

### **Professional Liability Insurance (PLI) Or Malpractice**

Professional liability insurance (malpractice) expense relative values amount to approximately 3% of the physician fee schedule payment. CMS replaced the cost based malpractice expense relative values with resource based malpractice RVUs in 2000. The end result of its computations was to retain the same total malpractice RVUs as they were under the charge based system.

### **Geographic Practice Cost Indices (GPCIs)**

The Geographic Practice Cost Indices (GPCIs) reflect the relative costs associated with physician work, practice, and malpractice expenses 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
- Malpractice GPCI: Applied to professional liability expense relative values

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Geographic Practice Cost Indices By Medicare Carrier and Locality (GPCI)

Locality Name Malpractice	Work	Practice Expense	Malpractice
Alabama	0.978	0.870	0.807
Alaska	1.064	1.172	1.223
Arizona	0.994	0.978	1.111
Arkansas	0.953	0.847	0.340
Anaheim/Santa Ana, CA	1.037	1.184	0.955
Los Angeles, CA	1.056	1.139	0.955
Marin/Napa/Solano, CA	1.015	1.248	0.687
Oakland/Berkeley, CA	1.041	1.235	0.687
San Francisco, CA	1.068	1.458	0.687
San Mateo, CA	1.048	1.432	0.687
Santa Clara, CA	1.063	1.380	0.639
Ventura, CA	1.028	1.125	0.783
Rest of CA	1.007	1.034	0.748
Colorado	0.985	0.992	0.840
Connecticut	1.050	1.156	0.966
Delaware	1.019	1.035	0.712
DC + MD/VA Suburbs	1.050	1.166	0.909
Fort Lauderdale, FL	0.996	1.018	1.877
Miami, FL	1.015	1.052	2.528
Rest of FL	0.975	0.946	1.265
Atlanta, GA	1.006	1.059	0.935
Rest of GA	0.970	0.892	0.935
Hawaii/Guam	0.997	1.124	0.834
Idaho	0.960	0.881	0.497
Chicago, IL	1.028	1.092	1.797
East St. Louis, IL	0.988	0.924	1.691
Suburban, Chicago, IL	1.006	1.071	1.645
Rest of IL	0.964	0.889	1.157
Indiana	0.981	0.922	0.481
Iowa	0.959	0.876	0.596
Kansas	0.963	0.895	0.756
Kentucky	0.970	0.866	0.877
New Orleans, LA	0.998	0.945	1.283
Rest of LA	0.968	0.870	1.073
Southern Maine	0.979	0.999	0.666
Rest of Maine	0.961	0.910	0.666
Baltimore/Surrounding Counties, MD	1.021	1.038	0.916
Rest of MD	0.984	0.972	0.774
Metropolitan Boston	1.041	1.239	0.784
Rest of Massachusetts	1.010	1.129	0.784

Detroit, MI	1.043	1.038	2.738
Rest of MI	0.997	0.938	1.571
Minnesota	0.990	0.974	0.452
Mississippi	0.957	0.837	0.779
Metropolitan Kansas City, MO	0.988	0.967	0.846
Metropolitan St. Louis, MO	0.994	0.938	0.846
Rest of MO	0.946	0.825	0.793
Montana	0.950	0.876	0.727
Nebraska	0.948	0.877	0.430
Nevada	1.005	1.039	1.209
New Hampshire	0.986	1.030	0.825
Northern New Jersey	1.058	1.193	0.860
Rest of NJ	1.029	1.110	0.860
New Mexico	0.973	0.900	0.902
Manhattan, NY	1.094	1.351	1.668
NYC Suburbs/Long Island, NY	1.068	1.251	1.952
Poughkeepsie/ Northern NYC Suburbs, NY	1.011	1.075	1.275
Queens, NY	1.058	1.228	1.871
Rest of NY	0.998	0.944	0.764
North Carolina	0.970	0.931	0.595
North Dakota	0.950	0.880	0.657
Ohio	0.988	0.944	0.957
Oklahoma	0.968	0.876	0.444
Portland, OR	0.996	1.049	0.436
Rest of OR	0.961	0.933	0.436
Metropolitan Philadelphia, PA	1.023	1.092	1.413
Rest of PA	0.989	0.929	0.774
Puerto Rico	0.881	0.712	0.275
Rhode Island	1.017	1.065	0.883
South Carolina	0.974	0.904	0.279
South Dakota	0.935	0.878	0.406
Tennessee	0.975	0.900	0.592
Austin, TX	0.986	0.996	0.859
Beaumont, TX	0.992	0.890	1.338
Brazoria, TX	0.992	0.978	1.338
Dallas, TX	1.010	1.065	0.931
Fort Worth, TX	0.987	0.981	0.931
Galveston, TX	0.988	0.969	1.338
Houston, TX	1.020	1.007	1.336
Rest of TX	0.966	0.880	0.956
Utah	0.976	0.941	0.644
Vermont	0.973	0.986	0.539
Virgin Islands	0.965	1.023	1.002
Virginia	0.984	0.938	0.500
Seattle (King County), WA	1.005	1.100	0.788
Rest of WA	0.981	0.972	0.788

West Virginia	0.963	0.850	1.378
Wisconsin	0.981	0.929	0.939
Wyoming	0.967	0.895	1.005

### 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 reimbursing 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 CF is updated annually. Medicare Conversion Factors in past years have been \$36.6137 (2000), \$38.2581 (2001), and \$36.1992 (2002).

**2003 Medicare Conversion Factor = ~~\$34.5920~~ \$36.7856 {NOTE: On 2/28/03, CMS released an update to the 12/31/02 final rule, indicating that the 2003 conversion factor will be revised effective 3/1/03.}**

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

- MEI: The allocation of RVUs to pools for physician work, practice expense, and malpractice, have been revised to correspond with the Medicare Economic Index. Work is now allocated 55% of the total RVU, practice expense is 42%, and malpractice is 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.
- Non-Par Physician: Reduced payments for physicians, called “nonparticipating” physicians, who do not accept “assignment,” the Medicare approved amount that consists of the 80% Medicare payment and the 20% patient copayment, as payment in full for services rendered to Medicare recipients.
- Budget Neutrality: Statutory guidelines indicating 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.

### HOW TO USE THE RBRVS

CMS publishes RVUs for CPT codes in the *Federal Register*. To calculate the Medicare physician reimbursement for a service, the relative value units 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 in the final reimbursement 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 reimbursement. For example, they may use their own CF 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, in order for the physician to code 99213, the appropriate patient history, medical examination, and physician decision-making process must be documented.

The following RVUs, GPCIs, and CF are based on the information provided by the CMS in the *Federal Register* on December 31, 2002.

<u>CPT Code: 99213</u>		Location: Marco Island, Florida ("Rest of Florida" Medicare Locality)	
Work RVU	0.67	Work GPCI	0.975
Non-Facility Practice Expense RVU	0.69	Practice Expense GPCI	0.946
Malpractice RVU	0.03	Malpractice GPCI	1.265

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

This is an example of a physician reimbursement mechanism in a non-facility setting that takes into consideration the total RVU from the Medicare RBRVS but excludes all other components of the physician fee schedule. Often the total RVU is multiplied by a payer-specific conversion factor that is not associated with the Medicare established CF.

**STEP 1**

Add together the physician work, practice expense, and malpractice expense RVUs to obtain the total RVU for the office visit.

$$\begin{aligned} \text{Total RVU for CPT Code 99213} &= \\ \text{Work RVU} + \text{Practice Expense RVU} + \text{Malpractice RVU} \\ (0.67) + (0.69) + (0.03) &= 1.39 \end{aligned}$$

**STEP 2**

Multiply the total Medicare RVU for CPT Code 99213 by a non-Medicare, payer-specific primary care services conversion factor (which may or may not be different than the Medicare conversion factor of \$36.7856).

For example: Payer-specific primary care conversion factor = \$38.00

$$\begin{aligned} \text{Total physician reimbursement for the provision of CPT code 99213 by this third-party payer} &= \\ (\text{Total Medicare RVU}) \times (\text{Payer CF}) \\ (1.39) \times (38.00) &= \$52.82 \end{aligned}$$

*Note: In some cases, payers will not use the Medicare total RVU for a service in their calculation of physician reimbursement. 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 reimbursement 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 Work, Practice Expense, and Malpractice RVUs by the appropriate GCIs; add the figures thus obtained to get the total geographically adjusted RVU for the office visit.

$$\begin{aligned} \text{Total RVU for CPT Code 99213 (geographically adjusted)} &= \\ (\text{Work RVU} \times \text{Work GCI}) &+ (\text{Practice Expense RVU} \times \text{Practice Expense GCI}) + (\text{Malpractice RVU} \times \text{Malpractice GCI}) \\ &= (0.67 \times 0.975) + (0.69 \times 0.946) + (0.03 \times 1.265) \\ &= (0.65325) + (0.65274) + (0.03795) = 1.34394 \sim 1.34 \end{aligned}$$

## STEP 2

Multiply the total geographically adjusted RVU by the Medicare CF to obtain the physician reimbursement for the office visit.

$$2003 \text{ Medicare Conversion Factor (CF)} = \$36.7856$$

Total Medicare payment for the provision of CPT Code 99213 in Marco Island, Florida =

$$\begin{aligned} &\text{Total geographically adjusted RVU for CPT Code 99213} \times 2003 \text{ CF} \\ &= (1.34 \times \$36.7856) = \$49.29 \end{aligned}$$

In this example, a physician practicing in Marco Island, Florida would receive \$49.29 for providing the Level 3 physician office visit to a Medicare recipient.

*A table that provides RVUs for a series of CPT codes commonly used by pediatricians has been included for further clarification and interpretation. Please refer to this table to determine other Medicare physician reimbursement for 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 state Medicaid programs, Blue Cross Blue Shield carriers, and managed care organizations are utilizing variations of the Medicare RBRVS to determine physician reimbursement and even capitation 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, malpractice 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 (PMPM) estimates.

*For further information, please contact the Division of Health Care Finance and Practice at 800/433-9016, extension 7931.*

*Developed by the Committee on Coding and Nomenclature, with contributions by Linda Walsh and Teri Salus.*

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**2003 RELATIVE VALUE UNITS (RVUs)\***

CPT CODE	DESCRIPTION	WORK RVU	TOTAL			TOTAL NON- FACILITY RVU	TOTAL FACILITY RVU
			NON-FACILITY PRACTICE EXPENSE RVU	FACILITY PRACTICE RVU	MALPRACTICE RVU		
<b>Office Or Other Outpatient Visits/New Patient</b>							
99201	Problem focused history and exam/ straightforward	0.45	0.48	0.16	0.02	0.95	0.63
99202	Expanded problem focused history and exam/ straightforward	0.88	0.77	0.32	0.05	1.70	1.25
99203	Detailed history and exam/ low complexity	1.34	1.10	0.49	0.08	2.52	1.91
99204	Comprehensive history and exam moderate complexity	2.00	1.49	0.72	0.10	3.59	2.82
99205	Comprehensive his tory and exam/ high complexity	2.67	1.79	0.95	0.12	4.58	3.74
<b>Office Or Other Outpatient Visits/Established Patient</b>							
99211	May or may not require physician presence; minimal	0.17	0.38	0.06	0.01	0.56	0.24
99212	Problem focused history and exam/ straightforward	0.45	0.52	0.16	0.02	0.99	0.63
99213	Expanded problem focused history and exam/low complexity	0.67	0.69	0.24	0.03	1.39	0.94
99214	Detailed history and exam/ moderate complexity	1.10	1.03	0.40	0.04	2.17	1.54
99215	Comprehensive history and exam/ high complexity	1.77	1.34	0.64	0.07	3.18	2.48
<b>Initial Hospital Care</b>							
99221	Detailed history and exam	1.28	N/A	0.46	0.05	N/A	1.79
99222	Comprehensive history & exam /moderate complexity	2.14	N/A	0.75	0.08	N/A	2.97
99223	Detailed history and exam/high complexity	2.99	N/A	1.04	0.10	N/A	4.13
99231	Problem focused history and exam/ low complexity	0.64	N/A	0.23	0.02	N/A	0.89
99232	Expanded problem focused history and exam/moderate complexity	1.06	N/A	0.38	0.03	N/A	1.47
99233	Detailed history and exam/ high complexity	1.51	N/A	0.53	0.05	N/A	2.09
<b>Hospital Discharge</b>							
99238	30 minutes or less	1.28	N/A	0.56	0.04	N/A	1.88
99239	More than 30 minutes	1.75	N/A	0.75	0.05	N/A	2.55
<b>Office or Other Outpatient Consultations</b>							
99241	Problem focused	0.64	0.61	0.22	0.04	1.29	0.90
99242	Expanded problem-focused	1.29	1.02	0.47	0.09	2.40	1.85
99243	Detailed	1.72	1.35	0.64	0.10	3.17	2.46
99244	Comprehensive/mod complexity	2.58	1.80	0.94	0.13	4.51	3.65
99245	Comprehensive/high complexity	3.43	2.26	1.24	0.16	5.85	4.83

**Immunization Administration**

90471	One vaccine	0.00	0.20	NA	0.01	0.21	NA
90472	Each additional vaccine	0.00	0.14	NA	0.01	0.15	NA

**Critical Care Services**

99291	First hour	4.00	1.57	1.30	0.14	5.71	5.44
99292	Each additional 30 minutes	2.00	0.86	0.65	0.07	2.93	2.72

**Pediatric Critical Care Patient Transport**

99289	First hour	4.80	N/A	1.87	0.14	N/A	6.81
99290	Each additional 30 minutes	2.40	N/A	0.94	0.07	N/A	3.41

**Neonatal and Pediatric Critical Care Services**

99293	Pediatric (31 days through 24 months of age) initial day	16.00	N/A	5.13	0.70	N/A	21.83
99294	Pediatric (31 days through 24 months of age) subsequent	8.00	N/A	2.57	0.23	N/A	10.80
99295	Neonatal (30 days or under) initial day	18.49	N/A	5.48	0.70	N/A	24.67
99296	Neonatal (30 days or under) subsequent	8.00	N/A	2.61	0.23	N/A	10.84

**Intensive (Non-Critical) Low Birth Weight Services**

99298	VLBW (less than 1500 grams) subsequent intensive care	2.75	N/A	0.96	0.10	N/A	3.81
99298	LBW (1500-2500 grams) subsequent intensive care	2.50	N/A	0.98	0.10	N/A	3.58

**Preventive Medicine Services**

99381	Preventive visit, new, infant	+1.19	1.52	0.46	0.04	2.75	1.69
99382	Preventive visit, new, age 1-4	+1.36	1.56	0.53	0.04	2.96	1.93
99383	Preventive visit, new, age 5-11	+1.36	1.50	0.53	0.04	2.90	1.93
99384	Preventive visit, new, age 12-17	+1.53	1.57	0.60	0.05	3.15	2.18
99385	Preventive visit, new, age 18-39	+1.53	1.57	0.60	0.05	3.15	2.18
99391	Preventive visit, est, infant	+1.02	1.03	0.40	0.03	2.08	1.45
99392	Preventive visit, est, age 1-4	+1.19	1.10	0.46	0.04	2.33	1.69
99393	Preventive visit, est, age 5-11	+1.19	1.07	0.46	0.04	2.30	1.69
99394	Preventive visit, est, age 12-17	+1.36	1.15	0.53	0.04	2.55	1.93
99395	Preventive visit, est, age 18-39	+1.36	1.18	0.53	0.04	2.58	1.93

**Pulmonary**

94640	Airway inhalation treatment	0.00	0.70	N/A	0.02	0.72	N/A
94664	Demonstration/evaluation	0.00	0.52	N/A	0.03	0.55	N/A

**Sedation/Analgesia**

99141	Conscious sedation, IV/IM/inhalant	+0.80	2.15	0.39	0.04	2.99	1.23
99142	Conscious sedation, oral/rectal/nasal	+0.60	1.25	0.31	0.03	1.88	0.94

**Newborn Care**

99431	Initial care, normal newborn	1.17	N/A	0.39	0.04	N/A	1.60
99432	Newborn care not in hospital	1.26	0.84	0.41	0.06	2.16	1.73
99433	Subsequent normal newborn care	0.62	N/A	0.20	0.02	N/A	0.84
99435	NB admit/discharge same day	1.50	N/A	0.51	0.05	N/A	2.06
99436	Attendance at delivery	1.50	0.49	0.48	0.05	2.04	2.03
99440	Newborn resuscitation	2.93	N/A	0.95	0.11	N/A	3.99

**Musculoskeletal/Orthopedics**

20150	Excise epiphyseal bar	13.69	N/A	8.96	0.96	N/A	23.61
20664	Halo brace application	8.06	N/A	8.62	1.49	N/A	18.17
24640	Nursemaid elbow	1.20	3.54	1.84	0.11	4.85	3.15
23500	Clavicle fracture	2.08	4.08	2.60	0.26	6.42	4.94
27036	Excision of hip joint/muscle	12.88	N/A	14.25	1.80	N/A	28.93

**Cardiovascular**

93530	Right heart catheterization, congenital	4.23	18.37	N/A	1.11	23.71	N/A
93531	Right and left heart catheterization, congenital	8.35	51.30	N/A	2.96	62.61	N/A
93532	Right and left heart catheterization, congenital	10.00	50.70	N/A	2.95	63.65	N/A
93533	Right and left heart catheterization, congenital	6.70	49.24	N/A	2.86	58.80	N/A

**Digestive**

43235	Upper GI endoscopy, diagnosis	2.39	5.85	1.06	0.13	8.37	3.58
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**Medicine/Echocardiography**

76885	Echo exam, infant hips	0.74	1.76	N/A	0.11	2.61	N/A
76886	Echo exam, infant hips	0.62	1.62	N/A	0.10	2.34	N/A
93303	Echo transthoracic	1.30	4.33	N/A	0.23	5.86	N/A
93315	Echo transesophageal	2.78	4.79	N/A	0.34	7.91	N/A

\*Note: Information for table extracted from the *Federal Register*, December 31, 2002

Work RVU = Physician work RVU

Non-facility practice expense RVU = Practice expense RVU for services provided in a non-facility (eg, physician's office or patient's home) setting  
Facility practice expense RVU = Practice expense RVU for services provided in a facility (eg, hospital or ambulatory surgical center) setting.

Malpractice RVU = Malpractice expense (professional liability insurance) RVU

Total non-facility RVU = The sum of the work, non-facility practice expense, and malpractice liability RVUs

Total facility RVU = The sum of the work, facility practice expense, and malpractice liability RVUs

+Indicates RVUs are not used for Medicare Payment

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