

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING
April 28-30, 1995

Omni Chicago Hotel
Chicago, Illinois

MINUTES

I. Call to Order and Opening Remarks

Doctor Rodkey called the meeting to order at 9:05 a.m. The following RUC members were in attendance:

Grant V. Rodkey, MD, Chair	
James J. Dearing, DO*	Douglas Mathisen, MD*
Robert E. Florin, MD	David McCaffree, MD
John O. Gage, MD	James Moorefield, MD
Timothy Gardner, MD	Alan Morris, MD
William F. Gee, MD	L. Charles Novak, MD
Meghan Gerety, MD*	Neil Powe, MD
Tracy Gordy, MD	William Rich, MD
Kay K. Hanley, MD	Peter Sawchuk, MD*
W. Benson Harer, MD	Chester Schmidt, MD
James E. Hayes, MD	Paul Schnur, MD*
Emily Hill, PA-C	Richard Tuck, MD
Charles F. Koopmann, MD*	John Tudor, Jr., MD
George F. Kwass, MD	Richard Whitten, MD*
J. Leonard Lichtenfeld, MD	William L. Winters, MD

(* indicates alternate member)

Grant Bagley, MD, Kay Jewell, MD, and Jesse Levy, PhD, from the Health Care Financing Administration (HCFA) also attended.

The following facilitation committees were appointed by Doctor Rodkey:

Doctor Powe (Chair)
Doctor Dearing
Doctor Florin
Doctor McCaffree
Doctor Rich

Doctor Winters (Chair)
Doctor Gage
Doctor Gerety
Doctor Gee

Doctor Moorefield (Chair)
Doctor Lichtenfeld
Doctor Morris
Doctor Wiener
Doctor Schmidt

Doctor Rodkey made the following opening statement:

"At this meeting we are becoming fully engaged in the five-year review of physician work values. Our objective is to readjust all misvalued codes fairly and accurately so that all codes, from the least to the most complex descriptors of service, fit like the chromatic scale of a grand piano. This is a huge task which, through the RUC, will involve the entire profession of medicine, and it must be completed in six months.

No parallel task of this magnitude or complexity readily comes to mind, but I have been reflecting upon Ulysses's Odyssey. At a certain point, Ulysses was required to sail through the narrow strait separating the huge rock of Scylla with its beautiful maidens singing their siren song from the fearsome whirlpool of Charybdis. He set his rudder straight ahead, stopped up his ears, blindfolded his eyes and lashed himself to the mast until his harrowing ordeal had passed.

The RUC will be surrounded on all sides by cries of pain and anguish and pleas for help during this trying period, but it must keep its course of objectivity and fairness to all. During this stressful cycle we will make continuing efforts to structure the workload and meetings of the RUC so that, unlike poor Ulysses, in the end your Penelope will still be waiting for you."

II. Approval of February 10-11, 1995 Minutes

Doctor Novak noted that the minutes for Electrodiagnostic Medicine [Tab 12] should be corrected to reflect the fact that tracking numbers M9 and M10 passed at the February meeting and were not referred to facilitation. The minutes of the February RUC meeting were approved as amended.

III. Calendar of Meeting Dates

The RUC was informed that the July 27-30 workgroup meetings would be held at the Embassy Suites Hotel in Chicago and that the August 24-27 RUC meeting would be held at the Fairmont Hotel in Chicago. After some discussion of hotel and date options, the RUC decided that the February 8-11, 1996 RUC meeting should still be held on that date and selected the Stouffer Renaissance Cottonwoods Resort in Scottsdale as the meeting site.

Staff discussed the electronic balloting that would be developed for use during the August RUC meeting. Each RUC member will receive a set of ballots that are color coded by topic with their names appearing on each ballot. Since the ballots can be scanned electronically, the results will be reported quickly. It is hoped that, with the number of codes that the RUC will be considering in August, electronic balloting will make the voting process more efficient.

IV. CPT Update

Doctor Gordy reminded the RUC of the moratorium on proposals for CPT coding changes for CPT 1997. Only proposals for new technologies that cannot currently be reported using existing codes and coding changes arising from the five-year review process will be considered for CPT 1997.

V. Report of the Research Subcommittee

Doctor Kwass discussed a written report of the Research Subcommittee of April 27. He reported that the subcommittee met to evaluate the methodologies used in RVS studies conducted by Abt Associates for the American Academy of Orthopaedic Surgeons (AAOS), the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), and the American Society of Anesthesiologists (ASA). He noted that the charge made to the Research Subcommittee by the RUC was to consider whether these studies constitute an appropriate methodology for developing compelling evidence for changing the relative values.

AAOS Study

The Research Subcommittee recommended that the RUC accept the methodology for the 609 orthopaedic codes included in the AAOS Abt study that are provided at least 75% of the time by orthopaedic surgeons for ordinal alignment but not for their proposed relative values. The Research Subcommittee also recommended that the RUC consider a survey of representative codes using RUC methodology to validate the relationship of the Abt-developed relative values to RUC-developed relative values.

The RUC accepted the Research Subcommittee recommendations regarding the AAOS Abt study.

AAO-HNS Study

The Abt study for otolaryngology covered about 800 codes, 417 of which are considered services provided primarily by otolaryngologists. In addition to the Abt report, the AAO-HNS also submitted detailed comments on 100 of the services that are provided by otolaryngologists to HCFA for the five-year review. The Research Subcommittee recommended that the RUC accept the methodology for the 417 otolaryngology codes for their ordinal alignment but not their proposed relative values. The Research Subcommittee recommended further that the RUC consider a survey of representative codes using the RUC methodology to validate the relationship of the Abt-developed relative value units to RUC-developed relative values.

Doctor Kwass expressed his concern during the RUC meeting that the AAO-HNS had not presented data regarding the impact that these changes would have on other services in the manner that AAOS was able to provide. Doctor Koopmann stated that he would provide the RUC with more detailed information.

The RUC accepted the Research Subcommittee recommendations regarding the AAO-HNS Abt study.

ASA Study

The ASA study focused on 15 anesthesia services which represent 45.6% of total Medicare payments for anesthesia services. The periods of anesthesia services were divided into pre-anesthesia, induction, procedure, emergence, and post-anesthesia. A multispecialty panel of 12 physicians assessed the work of these services by estimating the time required for each subcomponent of the service and assigning one of four intensity values to each subcomponent. *The intensity values were defined as the work per minute of four services: established patient office visits, epidural injection, critical care, and a group of very high intensity services such as aortic valve repair.* The intensity values and time estimates were then multiplied and the work of each period was added to produce total work estimates, which were reviewed by the panel.

Doctor Kwass reported that the most of the Research Subcommittee's discussion focused on the use of direct measures of intensity versus measuring physician work. A motion had been made in the subcommittee meeting stating that the construct of developing work values by measuring time and intensity is valid. The motion failed, but the subcommittee adopted a motion that the specialty is not precluded from demonstrating the validity of this construct by other means.

The RUC spent a considerable amount of time discussing the methodology of the ASA Abt study. Several members believe that serious consideration should be given to improving the derivation of work values and suggested a methodology such as that used by the ASA should be considered. Statements were also made that, because the study was a multispecialty process and focused on the dimensions of work other than time, it represented an improvement over the typical RUC methodologies. A number of RUC members expressed concern, however, about the particular choice of services that were used as benchmark levels of intensity, particularly the use of code 99214 as the lowest level of intensity, as well as the general approach of assigning intensity levels rather than measuring physician work. In addition, concern was expressed that an assumption that anesthesiology services are currently undervalued was driving the methodological discussion, whereas the anesthesiologists had not demonstrated the validity of this assumption.

The RUC amended the motion that the Research Subcommittee made to state that: "the specialty is not precluded from demonstrating the validity of this construct though the workgroup process", and the motion was adopted by the RUC as amended.

Doctor Rodkey announced that the anesthesiology codes would be considered by Group 1 (Gordy) during the July workgroup meetings on the five-year review, and that Doctor Mabry, alternate advisor for general surgery, would be added to the membership of the workgroup to facilitate their review process.

At the conclusion of this discussion, Doctor Florin made a motion that the Research Subcommittee examine the history, development, application, and prospective application of "intensity" and "complexity" in development relative work values. The motion passed.

Doctor Powe noted that the Research Subcommittee's process of reviewing the Abt studies had benefited substantially from the assistance of an independent consultant, Doctor Dunn. Several members agreed, but others commented that the AMA should work with other consultants besides Doctor Dunn. Staff replied that on several occasions other consultants had been asked for advice, including Monica Noether, PhD, Allen Dobson, PhD, and James Kahan, PhD, but that it is difficult to identify knowledgeable consultants in this area who are not working for particular specialty societies.

The full report of the Research Subcommittee is attached.

VI. Report of the Subcommittee on the Five-Year Review

Doctor Tudor reported to the RUC that the Subcommittee on the Five-Year Review met in Chicago on March 24-25, 1995. A report of this meeting (dated April 7, 1995) was distributed to the RUC and included in the agenda book for the April RUC meeting.

The major focus of the meeting was the discussion of options for the disposition of each comment that was received by the RUC. Doctor Tudor explained the action keys and the "consent calendar" developed for consideration at the April RUC meeting.

Action Key:

- 1 = Survey/Rationale developed by specialty societies
- 2 = Refer to RUC for approval in April (Accept lower value)
- 3 = Refer to RUC for approval in April (No change from published value)
- 4 = Refer to CPT Editorial Panel
- 5 = Not a work issue (eg, practice cost or payment policy issue)

Even though a code is assigned a "1", this does not necessarily mean that a survey is necessary; however, it is necessary for the specialty to at least develop a more complete rationale either supporting the change or defending the current value, and to compile whatever objective data might be available to them to support this rationale. Actions keyed as "2" or "3" involve services for which the subcommittee believes no further in-depth review or survey is required.

Services which are assigned a 2 are those which have been identified as overvalued. By assigning a 2 to these codes, the subcommittee is recommending that the recommended reduction in value be accepted.

Services which are assigned a 3 are services which have been identified as undervalued currently, but for which the subcommittee believed no survey should be conducted. By assigning a 3 to these codes, the subcommittee is recommending that the current published value be maintained, and thus that the recommended increase not be adopted.





Codes assigned a "4" are these codes which the subcommittee believes require review by the CPT Editorial Panel before they can be considered by the RUC.

In addition to the Action Key, the subcommittee developed a Rationale Key for all codes assigned either a 2 or 3. This key provides a shorthand way of indicating why the subcommittee believes no survey or further in-depth review is required.

Rationale Key For Action Key #2 or #3:

- 1 = Frequency is less than 1000 per 1994 BMAD data
- 2 = Overall impact is less than +/-10%
- 3 = No request to Survey
- 4 = Service has recently been reviewed by the RUC
- 5 = Not a work issue (eg, Practice Cost issue; code incorrectly included in process)

The subcommittee directed staff to review all the public and CMD codes that were not discussed separately by the subcommittee and to assign a 2 or 3 to codes in the following categories:

-  Medicare claims frequency of 1,000 or less in 1994;
-  Recommended RVU change of +/- 10% or less;
-  Codes for which a RUC survey has already been completed since 1992; and
-  Codes that no society wishes to survey.

All codes that were assigned a 2 or 3 are part of the consent calendar that was developed for this meeting. The recommendation of the subcommittee for each of these codes is that the lower of the recommended value or the current value be adopted. If a RUC members or specialty believes any of these codes should

be increased, they will need to extract the code from the consent calendar and either make a motion to that effect or present more detailed rationale and data in July.

Identification of Potentially Overvalued Services

Doctor Tudor indicated to the RUC that the subcommittee was disappointed in the quality of the comments made by the carrier medical directors and that Dan Dunn was asked to review an additional list of codes identified through various means as potentially overvalued to determine if a more in depth review was warranted, and to assess whether other means exist for systematically identifying potentially overvalued codes. Doctor Dunn was also asked to assist the Research Subcommittee in reviewing the three Abt studies, which meant his analysis of the potentially overvalued services was not completed in time for the April RUC meeting.

There was considerable discussion among the RUC regarding the subcommittee's report on this issue. Citing the lack of rationale provided for examining the radiation oncology codes, concern was expressed that the approach proposed by the Five-Year Review Subcommittee would mean that the RUC was making the same type of baseless comments as the CMDs had made. Several RUC members also felt that the RUC should be able to tell HCFA that no rationale was provided to back up many of the CMD comments. Staff noted that it might be possible to obtain more information from HCFA about the rationale underlying the CMD comments. Doctor Bagley stated that HCFA must respond to all of the public comments it received, including the CMD comments, and they will, therefore, need a response from the RUC to all the comments.

In addition to concern about the subcommittee's proposal for identifying additional potentially overvalued services, concern was also expressed that the list of such codes was not yet available for review by the specialties or the RUC. A motion was made that:

- (1) Doctor Dunn's analysis be completed in time to inform the specialty societies about any additional codes identified for review on or before June 1;
- (2) radiation oncology services not be particularly singled out in the analysis; and,
- (3) following the June 1 notification, specialties should have a minimum of 8 weeks to prepare their recommendations to the RUC.

The motion passed, and the RUC accepted Doctor Tudor's report..

Other Five-Year Review Issues

In response to a question regarding the impact that the five-year review would have on practice expense relative values, Doctor Jewell reported that since practice expense values were derived from 1991 charge data, they would not change if physician work values were changed.

Emily Hill noted a discrepancy between the current plans for non-MD/DO providers participation in the five-year review survey process and the April 25 letter to Doctor Tudor from Tom Ault of HCFA, which states:

"There are instances where some providers, such as psychologists performing medical psychotherapy, are not reimbursed under the RVS fee schedule. Nevertheless, the exclusion of these groups from a survey of the codes which they perform could seriously impair the validity and quality of the data. HCFA has expressed an intention to

ultimately include all professional services within the fee schedule and incomplete survey data could hamper that process. We therefore urge the RUC-HCPAC to involve all practitioners in the review process whether or not they are currently reimbursed under the RVS fee schedule."

Doctor Schmidt expressed his concern with this letter, stating that he could not understand how providers that do not specifically perform a service could survey that service. After considerable discussion, Doctor Rodkey suggested that Ms. Hill, Doctor Schmidt, Doctor Tudor, and other interested attendees discuss the issue further on their own. Later, Doctor Schmidt reported that a decision had been reached that the psychiatrists would share the vignettes they had developed with the other interested organizations and jointly survey these services for the five-year review.

VII. Pediatrics Committee

In October 1994, Congress adopted legislation requiring HCFA to complete the RBRVS for pediatric services and to study whether the work involved in services that are provided to pediatric and adult populations differ according to patient age. In the December Final Rule, HCFA stated that the RBRVS was already complete for pediatric services but that the issue of the differences in work of providing services to the adult vs. pediatric patients should be addressed during the five-year review. *In their comments on this Rule, the American Academy of Pediatrics identified 480 codes for which they believe physician work is significantly different when the services are provided to pediatric patients than to adult patients.* This comment letter was referred to the RUC.

At the March 24-25 Five-Year Review Subcommittee meeting, Doctor Tuck outlined the major factors contributing to these differences in work:

1. Physiological and anatomic differences;
2. Psychological differences;
3. Increased use of conscious sedation;
4. Increased time spent counseling patient family members;
5. Age specific diseases.

A motion was then adopted that an ad hoc committee be formed, including members of the CPT Editorial Panel, to consider the AAP's comments and develop a recommendation to the RUC on how to address them. The members of this new committee are Doctors Tuck (Chair), Fanale, Florin, Harer, Wiener, Mayer, DeHart, and Wood.

At the RUC meeting, Doctor Gerety stated that she found it interesting that differences in the RBRVS originally developed for Medicare would recognize differences in work for children but not the frail elderly population. Doctor Moorefield suggested that the Pediatrics Committee limit their discussion to tangible or clear differences in the physician work of procedures.

VIII. RBRVS Practice Cost Component

Jesse Levy, PhD, from HCFA's Office of Research and Demonstrations, provided an overview of HCFA's plans for responding to legislation enacted in October 1994 requiring the Secretary of HHS to conduct a study of physicians' practice expenses and to develop "resource-based" practice expense relative values for implementation in 1998. Based on work to date on this issue, HCFA believes a variety of methods could be used to develop new practice cost relative values, and Doctor Levy noted that researchers have




estimated indirect costs at from 30-88% of total costs depending on their choice of methodology. In its Request for Proposals for the national study, therefore, HCFA is seeking development of a database that would be adaptable to a variety of methodological assumptions.

In early April, HCFA awarded the contract for this study to Abt Associates, Inc., of Cambridge, Massachusetts. The Abt study will have three phases: a mail survey to be completed by 3,000 physician practices which will solicit information on the resources used by the practice; a series of "clinical practice expert panels" which will develop specific resource cost profiles for each code on the RBRVS; and, collection of price information from suppliers and purchasing managers. A Technical Expert Group (TEG) comprised of researchers in this field and representatives from the American College of Physicians and American College of Surgeons is being established to oversee the study. The AMA and RUC will be invited to appoint several individuals as observers to the TEG.

Doctor Levy also noted that HCFA has awarded contracts to the Cambridge Health Economics Group and Health Economics Research to develop alternative methods for calculating resource-based practice expense relative values should the Abt study fail to produce useful results. There was some discussion regarding the size and composition of the TEG. Doctor Morris suggested HCFA convene a public meeting to obtain input from all specialties on the study, not just those represented on the TEG.

IX. Relative Value Recommendations

Relative value recommendations for CPT 1996 that were adopted at this meeting are attached to the minutes as Appendix A. In addition to the discussion reported in the recommendations:

-  tracking numbers A11, A14, and A15 for speech pathology services, and tracking numbers K1 and K2 for transperineal radioactive substance insertion of the prostate were referred to the Facilitation Committee chaired by Doctor Powe;
-  tracking numbers W31, W32, W43, and W44 for spinal procedures were referred to the Facilitation Committee chaired by Doctor Winters; and,
-  tracking numbers L2, L4, L6, L7, and L8 for infusion therapy, tracking number AB1 for the Maze procedure, and tracking number AC1 for systemic-to-pulmonary artery shunt were referred to the Facilitation Committee chaired by Doctor Moorefield.

All of the Facilitation Committee recommendations passed and are reflected in the recommendations submitted to HCFA.

[Note: Since copies of all the RUC recommendations for the 1996 RBRVS have already been provided to all RUC participants, Appendix A is not included in this copy of the minutes.]

X. Consent Calendars for the Five-Year Review

In accordance with the recommendations of the Subcommittee on the Five-Year Review as discussed in its April 7, 1995 report, approximately 350 codes were placed on a consent calendar for discussion at the April RUC meeting, with recommendations to retain the existing value, accept the proposed reduction in value, or refer to the CPT Editorial Panel.

During the discussion of the consent calendar, RUC members, advisors, and staff were given the opportunity to extract codes for any reason. Codes that were extracted were then added to the list of codes undergoing in-depth review over the Summer. After extractions and other amendments to the consent calendar were made, the RUC adopted the recommendations of the Subcommittee on the Five-Year Review for the amended consent calendar. This revised consent calendar is appended to the minutes as Appendix B. The recommendations adopted on the consent calendar were also reflected in the RUC recommendations submitted to HCFA for the five-year review of the RBRVS, which are Appendix C..

[Note: Since copies of the revised consent calendar were distributed to all RUC participants in June 1995 and copies of the RUC's recommendations for the five-year review were distributed to all RUC participants in October 1995, Appendices B and C are not included in this copy of the minutes.]

XI. Other Issues

Medical Liability Reform

Sandy Sherman discussed a "Dear Senator" sample letter that the AMA has been encouraging its members to send to their Senators.

RUC Meeting Agendas

It was announced that for all future RUC meetings, no ad hoc requests for changes in the order of agenda items will be accepted. If a presenter can only be available on one day of the RUC meeting, then the needs of the presenter must be communicated to AMA staff at least three weeks prior to the RUC meeting so that the agenda book can be arranged in the appropriate order for the meeting.