

**AMA/Specialty Society RVS Update Committee  
April 26-27, 1996**

**Marriott Hotel  
Chicago, Illinois**

**MINUTES**

I. Call to Order and Opening Remarks

Doctor Rodkey called the meeting to order at 8:30 am. The following RUC members were in attendance:

Grant V. Rodkey, MD, Chair	John E. Mayer, Jr., MD*
James Fanale, MD	David L. McCaffree, MD
Robert Florin, MD	James Moorefield, MD
John O. Gage, MD	Willard B. Moran, Jr., MD*
William Gee, MD	Alan Morris, MD
Tracy R. Gordy, MD	L. Charles Novak, MD
Larry P. Griffin, MD*	Arvin I. Philippart, MD*
Kay K. Hanley, MD	Neil Powe, MD
James E. Hayes, MD	William Rich, MD
Emily Hill, PA-C	Chester W. Schmidt, Jr., MD
David F. Hitzeman, DO	John Tudor, Jr., MD
James G. Hoehn, MD	Charles Vanchiere, MD
Dudley D. Jones, MD	William L. Winters, MD
J. Leonard Lichtenfeld, MD	Richard W. Whitten, MD*

(\* Indicates alternate member)

Grant Bagley, MD, from the Health Care Financing Administration (HCFA) also attended. Doctor Rodkey welcomed Doctor Vanchiere as the new RUC member representing the American Academy of Pediatrics, replacing Richard Tuck, MD.

The following facilitation committees were appointed:

- Doctors Gordy (Chair), Morris, Philippart, Winters, Vanchiere, and Emily Hill, PA-C.
- Doctors Gee (Chair), Jones, Schmidt, Mayer, Opelka, and Steve Levine, PT.
- Doctors Fanale (Chair), Hannenberg, Florin, McCaffree, Morris, Hitzeman, Mabry, Gee, and Eileen Sullivan-Marx, PhD.

II. Approval of Minutes

In discussing the minutes of the February 1996 RUC meeting, Doctor Powe requested that the language pertaining to establishment of the Practice Cost Subcommittee be clarified to reflect the possibility discussed in February that future actions might include updating the practice cost component of new and revised CPT codes. Several corrections were also noted, indicating that the discussion of the evaluation and management component of global surgical relative values

should reflect that several members expressed opposing views and that the recommendation for code 28002 arose from a comment made by the American Academy of Pediatrics even though it was presented by Doctor Haynes, the Advisor for the American Academy of Orthopaedic Surgeons. The RUC decided not to include the addendum which the Society of Thoracic Surgeons had suggested attaching to the minutes. The minutes were adopted as amended.

The minutes indicated that Doctor Rodkey had provided a guideline at the February meeting that RUC subcommittee meetings would be open only to subcommittee members and other RUC members unless the subcommittee chair decided otherwise. Previously, attendance issues were resolved by subcommittee chairs prior to each subcommittee meeting, but there were no general guidelines. At the April RUC meeting, several members objected to the new policy and the RUC adopted a motion that all subcommittee meetings be open to all staff contacts and Advisory Committee members.

Questions were also raised regarding Doctor Rodkey's mention of a RUC "executive committee" at the February meeting. Staff noted that when the RUC was formed a decision was made not to have an executive committee, and Doctor Rodkey indicated he had not formed an executive committee but had consulted in January with an *ad hoc* committee comprised of Doctors Hanley, Hoehn, Kwass, Rich, and Whitten. Comments were made that any future *ad hoc* committees should better reflect the specialty composition of the RUC, and that the group's membership and decisions should be disseminated to the full RUC.

### III. Calendar of Meeting Dates

Because the Proposed Rule responding to the RUC's recommendations for the five-year review had not be published on schedule and was not available for review prior to the April meeting, the RUC decided to convene a special one-day meeting on June 21, the day before the AMA House of Delegates Annual Meeting begins. The purpose of this meeting is to develop the RUC's comments on the Proposed Rule.

The RUC was informed that the September 1996 meeting would be held in New Orleans, Louisiana.

### IV. CPT Update

Doctor Gordy reported that the RUC will consider 18 issues from the February meeting of the CPT Editorial Panel. He also reported that the RUC will have a light work load for its September meeting. Staff reported that the AMA would continue to monitor the status of the five-year review issues which the RUC referred to CPT and report back to the RUC on any unresolved issues.

### V. Relative Value Recommendations for New or Revised Codes

***Please Note: A copy of the RUC's recommendations for new and revised codes for CPT 1997 is attached to these minutes.***

#### **Multifetal Pregnancy Reduction (Tab 13), Tracking Numbers: Y1**

The RUC recommendation of 4.00 for multifetal pregnancy reduction(s) (MPR) is based on a survey median of obstetricians and comparison to 59012 *Cordocentesis (intrauterine), any method* (work RVU = 3.45). MPR requires more pre-service and intra-service time than 59012,

as well as more physician effort/technical skill because more than one needle stick will typically be required.

### **Debridement of Musculoskeletal Open Injury(s) (Tab 14), Tracking Numbers: L1 - L3**

This issue was referred to the facilitation committee chaired by Doctor Gee. The facilitation committee recommended and the RUC accepted the specialty recommended relative values and a suggested change in the global period for 11010 to 10 days rather than 0 days. The RUC also considered CPT code 20103 *Exploration of penetrating wound (separate procedure); extremity* (work RVU = 4.95) to be an appropriate reference service for this family of codes. 20103 is comparable, but slightly more work, than 11010. The total time for 11010 (125 minutes) is slightly less than CPT code 20103 (130 minutes) and the descriptor of 11010 implies a lesser degree of trauma than the *CPT 1996* introduction to the Wound Exploration codes including 20103. 11011 is equivalent in work to 20103. The total time for 11011 (150 minutes) is greater than 20103, however, the global period for 20103 is longer (010 days). 11013 is more intense and requires more time than 20103 (210 minutes versus 130 minutes).

The RUC proposes that the global period for 11010 *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues* be 010 to minimize the potential for overutilization of this code. The RUC also noted that modifier -51 and the multiple surgery rules would apply when these services were performed on the same day as treatment of the open fracture.

### **Hand Surgery (Tab 15), Tracking Numbers: Q1 - Q10**

The RUC agreed with the recommendations presented for 24149 *Radical resection of capsule, soft tissue, and heterotopic bone, elbow with contracture release (separate procedure)* and 26546 *Repair nonunion, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)* which were based on the survey responses of nearly 50 orthopaedic and hand surgeons.

24149 is more work than 24006 *Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)* (work rvu = 8.70), which *only* includes capsular and soft tissue release and does not address excision of heterotopic bone which requires the careful dissection and preservation of neurovascular structures. 24149 involves a global dissection and capsulectomy rather than only a capsular release as in 24006. 24149 is also more work than 24077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area* (work rvu = 11.18), which is only indicated for neoplasms, and *does not include* resection of bone or contracture release and does not necessarily preserve all neurovascular structures. In addition 24149 requires two separate incisions, while 24077 requires only one. The post-service office time in 24149 is significantly higher than 24077 because of follow-up care required to recover range of motion.

26546 is more work than the combined work of 26615 *Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone* and 20900 *Bone graft, any donor area; minor or small (eg, dowel or button)* [ $7.70=5.18+1/2(5.03)$ ] or 26735 *Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each* and 20900 [ $8.24=5.72+1/2(5.03)$ ]. The intra-operative work of 26546 is greater than both of these combined procedures because achieving alignment and restoring length of the metacarpal or phalanx is more difficult than in a fresh fracture. 26546 also requires more intra-service work than 28322 *Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)* (work rvu = 8.03) because it involves a more critical

alignment and rotational positioning of the metacarpal versus the metatarsal, as well as a more critical attention to the anatomy and function of the extensor tendons in the hand.

**Hand and Arm Surgery (Tab 16), Tracking Numbers: R1 - R6**

The RUC agreed with the recommendations presented for 24341 *Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)* and 26185 *Sesamoidectomy, thumb or finger (separate procedure)* which were based on the survey responses of nearly 50 orthopaedic and hand surgeons.

24341 is similar to 25260/25263 *Repair, tendon or muscle, flexor, forearm and/or wrist; primary/secondary, single, each tendon or muscle* (work rvu = 7.33/7.37) in total physician work. 24341 is less work than 24342 *Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft* (work rvu = 10.13) which may require two incisions and dissection in the antecubital fossa with necessary identification and protection of neurovascular structures.

26185 is slightly more work to 28315 *Sesamoidectomy, first toe (separate procedure)* (work rvu = 4.60) because more intra-service work is required to protect the digital nerves and arteries which are directly over the sesamoid. The function of the digit (thumb or finger) would be significantly comprised if these digital nerves were injured.

**Excision of Epiphyseal Bar (Tab 17), Tracking Numbers: P1**

The RUC agreed with the recommendations presented for 20150 *Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision* which was based on the survey responses of more than 60 pediatric orthopaedic surgeons.

20150 is comparable to 27365 *Radical resection of tumor, bone, femur or knee* (NPRM proposed work rvu = 15.00) as both services require identification of abnormal tissue and resection without damage to surrounding tissues. There is risk of tumor recurrence in 27365, however, risk of further epiphyseal damage (i.e., growth plate injury resulting in further or different deformity) is present with 20150. 20150 is more technically demanding than 27479 *Epiphyseal arrest by epiphysiodesis or stapling; combined distal femur, proximal tibia and fibula* (work rvu = 12.18) due to difficulty in localizing and removing the epiphyseal bar.

**Release of Hip Flexor Deformity (Tab 18), Tracking Numbers: S1**

The RUC agreed with the recommendations presented for 27036 *Capsulectomy or capsulotomy of hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)* which was based on the survey responses of more than 60 pediatric orthopaedic surgeons.

The intra-service and post-service intensity of work of 27036 is greater than 27025 *Fasciotomy, hip or thigh, any type* (work rvu = 10.19). 27025 does not include the additional intra-service work of releasing the rectus femoris, gluteus medius, gluteus minimus, or sartorius, or excision of heterotopic ossification which is a part of 27036. The intra-service intensity of 27036 is more similar to 27165 *Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast* (work rvu - 16.20).

**Pediatric Cystourethroscopy (Tab 19), Tracking Numbers: V1 - V5**

A comment from a CMD during the five-year review process suggested that the relative value for 52340 *Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)* (1996 work rvu = 7.76) be reduced to be similar to 52277 *Cystourethroscopy, with resection of external sphincter*

(*sphincterotomy*) (work rvu = 6.17). The RUC review this comment and determined that confusion exists between 52340, which is utilized to treat pediatric patients, and 52500 *Transurethral resection of bladder neck (separate procedure)* (work rvu = 7.82). The RUC referred this issue to CPT and the Editorial Panel revised the language of 52340 to identify it as a pediatric service.

A survey was conducted of pediatric urologists after the CPT change to determine the appropriate work relative value for this very rare procedure (less than 300 performed annually). The RUC agreed that the time and intensity of 52340 is similar to 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work rvu = 11.51) and 52500.

CPT code 52300 *Cystourethroscopy; with resection of ureterocele(s), unilateral or bilateral* (1996 work rvu = 5.35) was split into two codes to differentiate between orthotopic and ectopic ureterocele(s). Only 20% of all these procedures include the resection or fulguration of the more difficult ectopic ureterocele(s). A budget neutral recommendation of 5.31 for 52300 orthotopic and 5.51 for 52301 ectopic is recommended.

#### **Clitoroplasty and Vaginoplasty for Intersex State (Tab 19), Codes 56805 and 57335**

The clitoroplasty and vaginoplasty codes were sent to the facilitation committee chaired by Doctor Gordy. The facilitation committee recommended and the RUC accepted the specialty recommended values, increasing 56805 *Clitoroplasty for intersex state* (1996 work rvu= 15.49) and 57335 *Vaginoplasty for intersex state* (1996 work rvu = 9.11) to 18.00 to correct the current rank order anomaly and to appropriately value these services that are performed on children less than one year of age. 56805 is similar in time and intensity to 54336 *One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap* (work rvu = 18.95) and is more work than 54125 *Amputation of penis; complete* (work rvu = 12.80), a destructive procedure to treat carcinoma of the penis. 57335 has a substantially longer intra-service time and is more intense than 57292 *Construction of artificial vagina; with graft* (work rvu = 12.34) and is more work than 45123 *Proctectomy, partial, without anastomosis, perineal approach* (work rvu = 13.27), which describes a destructive procedure. 57335 also includes the endocrine management of the urogenital syndrome

#### **Pediatric Echocardiography (Tab 20), Tracking Numbers: LL1 - LL5**

The RUC agreed to a request from the American Academy of Pediatrics and the American College of Cardiology to defer this issue until after further consideration by the CPT Editorial Panel and a resurvey.

#### **Echocardiography (Tab 21), Tracking Numbers: KK1 - KK15**

The RUC agreed to a request from the American College of Cardiology to defer this issue until after further consideration by the CPT Editorial Panel.

#### **Pacemaker (Tab 22), Tracking Numbers: T1 & T2**

The CPT Editorial Panel accepted a revision to the Pacemaker section to allow physicians to report the removal of a pacemaker lead system while leaving the pulse generator in place. The RUC recommendations for 33234 *Removal of transvenous pacemaker electrodes; single lead system, atrial or ventricular* and 33235 *dual lead system* are calculated by reducing the current work relative values by 2.97 to "back out" the removal of permanent pacemaker pulse generator which is no longer included in the descriptor for these codes.

**Nuclear Cardiology (Tab 23), Tracking Numbers: CC1 - CC12**

The RUC recommends that the current work relative values be maintained for these nuclear cardiology codes and notes the American College of Nuclear Physicians and the Society of Nuclear Medicine will be requesting that the CPT Editorial Panel reconsider this issue.

**Microvascular Anastomosis (Tab 24), Tracking Numbers: N1 - N21**

The microvascular anastomosis codes were examined by the facilitation committee chaired by Doctor Fanale. The facilitation committee recommended and the RUC accepted revised relative value recommendation based on a comparison of time and intensity to code 20955 *Bone graft with microvascular anastomosis; fibula*. The RUC recommendations for codes 15756-15758, 20956 and 20957 are based on HCFA's assumption (Federal Register, 12/8/94) that the intraoperative intensity of CPT code 20955 Bone graft with microvascular anastomosis; fibula (work rvu = 37.58) is 3.80 work RVUs per hour. The recommendations for 26551-26556 were also calculated based on HCFA's assumption that the intraoperative intensity of CPT code 20970 Free osteocutaneous flap with microvascular anastomosis; iliac crest (work RVU = 41.22) is 4.00 work RVUs per hour.

The RUC did not agree with the survey results that indicated ICU visits by the microsurgeon occurred with these services and, therefore, calculated all hospital time (both ICU and other hospital) at the Harvard intensity factor of 3.00 per hour. The survey data from the previously valued microvascular anastomosis codes did include a breakdown of ICU versus hospital time and, therefore, the RUC was unable to determine if HCFA had incorporated the appropriate amount of postoperative intensity when assigning the relative values for these services.

The RUC referred CPT codes 43496 *Free jejunum transfer with microvascular anastomosis* and 49906 *Free omental flap with microvascular anastomosis* back to the specialty societies to resurvey based on vignettes that clearly indicate what services are included in these codes. For example, a laparotomy may be performed by a general surgeon during the same operative session but should *not* be included in the work relative for this code.

**Nasopharyngeal Lesion Resection/Excision (Tab 25), Tracking Numbers: Z1 & Z2**

The RUC accepted the recommendation presented for a new skull base surgery code, 61586 *Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft* based on the survey responses of more than 35 otolaryngologists. 61586 is very similar to 21433 *Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches* (work rvu = 23.69) because of the multiple approaches [LeFort I with removal of the zygomatic arch (occasionally with part of the orbital wall and/or floor), degloving the maxilla, and medial maxillectomy). It requires careful planning of the bone cuts to preserve vision, the blood supply to the palate, and careful reapproximation of the bones with plating. 61586 is more complicated than 21433 because the osteotomies must avoid incision of the vascular tumor because a life threatening hemorrhage may occur. The preservice work of 61586 is more complex than 21433, however, the post-service work is similar.

**Computerized Dynamic Posturography (Tab 26), Tracking Numbers: GG1**

The RUC did not accept the work relative value recommendation of 1.30 presented for 92548 *Computerized dynamic posturography*. The RUC recommends that this service be assigned a relative value similar to 92585 *Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system* (work rvu = .50) because both services are tests that require

physician interpretation, but may be reported in addition to an evaluation and management service.

**Vital Capacity Test (Tab 27), Tracking Numbers: OO1 & OO2**

The RUC agrees with the CMD comment for the five-year review that 94150 *Vital capacity, total (separate procedure)* (1996 work rvu = .11) is overvalued and should be assigned the same work relative value as 94690 *Oxygen uptake, expired gas analysis; rest, individual (separate procedure)* (work rvu = .07). A survey conducted during the five-year review by the pulmonologists indicates an intra-service time of only 4 minutes and the technical skill for this service is minimal.

**Autonomic Testing (Tab 28), Tracking Numbers: PP1 - PP3**

The RUC accepted the recommendations presented by the American Academy of Neurology and the American Association of Electrodiagnostic Medicine which are based on the survey median of nearly 50 respondents. Autonomic testing requires similar time and intensity than 95860 *Needle electromyography, one extremity and related paraspinal area* (work rvu = 0.96). 95860 involves 40 minutes of total time compared to 35 minutes for 95921 and 95923 and 45 minutes for 95922. The RUC also clarified that the physician is performing these tests, as well as generating a report based on the findings of the test.

**Drainage of Abscess (Tab 29), Tracking Numbers: U9 & U10**

The RUC reviewed 49020 *Drainage of peritoneal abscess of localized peritonitis, exclusive of appendiceal abscess, transabdominal* (work rvu = 9.06) during the five-year review and determined that the code should be split into two codes, one describing an open procedure and another describing percutaneous drainage. After a great deal of discussion, the RUC agreed that code 49020, now clarified as an open procedure, is undervalued and recommends an increase to 14.25 based on the 25th percentile of the survey responses of 50 general surgeons. Only the most complex patients with extensive non-localized peritonitis require surgical drainage rather than percutaneous drainage. The intraoperative work involves draining the abscesses, as well as meticulously dissecting numerous adhesions. These patients usually are admitted to the ICU following the operation, are difficult to manage postoperatively, and require a great deal of care and attention by the surgeon. In addition, the survey conducted for the five-year review indicates a dramatic increase in length of hospital stay for 49020. The Harvard data includes a length of stay of 7 days, with no ICU time. The RUC survey the length of stay is 14 days, with 2 ICU visits by the surgeon.

The RUC was unable to develop a recommendation for 49021 *Drainage of peritoneal abscess of localized peritonitis, percutaneous* at this time. The Society of Cardiovascular and Interventional Radiology will be seeking reconsideration of CPT changes for percutaneous abscess drainage and will survey these codes for a future RUC meeting.

**Nasolacrimal Duct Probe (Tab 30), Tracking Numbers: C1 - C8**

Codes 68800-68830 for *dilation of lacrimal punctum* and *probing of a nasolacrimal duct* have been deleted and replaced with new codes 68801 - 68815 to indicate that these codes should be used to report unilateral procedures. Bilateral procedures will be reported using the code with the -50 modifier. The RUC accepted the relative value recommendations presented by ophthalmology and optometry which were based on budget neutral calculations assuming that 50% of 68801 *Dilation of lacrimal punctum, with or without irrigation* and 31% of 68810 *Probing of nasolacrimal duct, with or without irrigation* are performed bilaterally and would be subject to the multiple surgery reduction.

The RUC also accepted the specialty recommendation to increase the relative value for 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* from 1.53 to 2.25. Sixty-two percent of these procedures are performed unilaterally. The pre-, intra-, and post-service work of this service are also comparable to 67345 *Chemodenervation of extraocular muscle* (work rvu = 2.91).

68812 *Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent* is performed when 68811 has failed. The RUC agreed that the relative value for this service should be increased from 2.12 to 3.00 to maintain relativity with 68810 and 68811. This increase is merited by degree of pre-, intra-, and post-service work involved in this procedure; complications of intra-nasal bleeding; the possibility of aspirating blood intra- or post-operatively; and the morbidity associated with drawing metallic probes through the nasolacrimal system.

## VI. Facilitation Committee Reports

### **Home and Emergency Visits (Tab 5)**

At the February meeting, a facilitation committee chaired by Doctor Hanley was appointed to reconsider the established patient home visit codes and the emergency visit codes. There was considerable discussion in February regarding the use of the *home visit codes*; that is, podiatrists are coding the vast majority of the new patient home visit claims to Medicare and many of the lowest level established patient visits to describe situations when they are called in by the patient's primary care physician to treat foot problems that arise. On the other hand, geriatricians and other primary care physicians rarely see these patients for the first time in the home. When the patients are new to them they may be seen in the hospital, nursing home, or office, so they are more likely to code the home visit service as an established patient visit. At the February meeting, the RUC adopted the facilitation committee's recommendations for the new patient home visits but did not adopt the recommendations for the established patient visits, some of which were higher than the comparable new visits. At this meeting, the facilitation committee decided and the RUC agreed that the new versus established problem is not one that can really be "fixed" by the relative values assigned to the codes, but that some reworking of the CPT codes should be done. The RUC is recommending, therefore, that the whole family of home visit codes be referred to CPT, with particular attention to the following issues:

1. the need for a higher level code(s) for the most complex services;
2. changing the definition of new patients to encompass annual home care visits by a physician; and
3. the need for either the home visit codes or the care plan oversight code to address the need for extensive case management involving the patient's family.

In reviewing the relative values for the codes, the RUC concluded that the principal problem with the previous recommendations was the perception of an anomalous relationship between new and established patient visits. The RUC discussed the differences between home visits and other visits, including the severe and multiple disabilities of the patients, the need to assess patients' functional and mental status, to train both patients and untrained caregivers, and the need to manage problems related to patient dementia, other psychiatric problems, and the caregiver pathologies. The facilitation committee concluded and the RUC agreed that the AAFP survey median recommended in February for code 99353 was an appropriate value for the highest level established patient visit and that the relationship between the level 3 new service at 2.40 and the established visit at the recommended level of 2.25 was correct, with the established patient code being 93% of the new patient code. A proportional relationship between new and established



visits was calculated for the level 1 and 2 established patient codes, producing the following recommendations:

CPT Code	1996 RVUs	Feb 96 Rec	April 96 Rec
New			
99341	1.12	1.12	1.12
99342	1.58	1.76	1.76
99343	2.09	2.40	2.40
Established			
99351	.83	1.18	1.05
99352	1.12	1.71	1.65
99353	1.48	2.25	2.25

Doctors Hayes and Sawchuk made a very detailed, graphical and compelling presentation to the facilitation committee of the need to revisit the *emergency visit codes* and increase them to be more in line with the other evaluation and management services. The facilitation committee recommended and the RUC accepted the American College of Emergency Physicians recommendation to increase the relative values of the first three levels of Emergency Department codes (99281, 99282, and 99283) to a level comparable to the office visit services (99201, 99202, and 99203). The fourth and fifth level of Emergency Department services (99284 and 99285) are typically of greater intensity than that of the office visits at the same level (99204 and 99205). The RUC adopted recommended work relative values of 2.00 for 99284 and 2.90 for 99285, which are consistent with the 25th percentile survey results and were calculated using regression analysis.

#### **Intravascular Ultrasound Services (Tab 6), Tracking Numbers: A1 - A6**

These codes were first considered by the RUC at the February meeting and were assigned to a facilitation committee chaired by Doctor Powe, which recommended as follows:

CPT Code	CPT Descriptor	RUC Recommendation	Global Period	IWPUT
37250	Intravascular ultrasound (non-coronary vessel) during therapeutic intervention; initial vessel	2.10	ZZZ	.09
37251	each additional vessel	1.60	ZZZ	.08
75945	Intravascular ultrasound (non-coronary vessel) radiological supervision and interpretation, initial vessel	0.40	XXX	.02
75946	Intravascular ultrasound each additional non-coronary vessel, radiological supervision and interpretation	0.40	XXX	.02
92978	Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel	2.50	ZZZ	.10
92979	each additional vessel	2.00	ZZZ	.08

The RUC based the above recommended values for intravascular ultrasound on the ultrasound portion of 43259 *Upper gastrointestinal endoscopy with endoscopic ultrasound examination* (work rvu = 4.89). If the relative value for 43235 *Upper gastrointestinal endoscopy without ultrasound* (work rvu = 2.39) is subtracted from the 43259 the result is 2.50 RVUs (4.89 - 2.39 = 2.50). The RUC suggests that the value of 92978 should be set equal to the ultrasound portion of 43259. The calculated IWPUT for the ultrasound component of 43259 is 0.08. which is similar to the RUC recommendation of 0.10.

The RUC did not accept the specialty recommendations, which were based on survey results. The amount of pre-service time and work involved in placing and positioning an ultrasound catheter after other catheters had already been introduced led to inappropriately high work relative values.

The facilitation committee also based its recommendations on 93503 *Insertion and placement of flow directed catheter (eg. Swan-Ganz)* for monitoring purposes (work rvu = 2.43). The work involved in providing this service is similar to the intravascular ultrasound codes. The IWPUT for 93503 is 0.08. which is comparable to the IWPUT for 92978.

Once the committee arrived at a value for the most difficult of the intravascular ultrasound service, the remainder of the codes were reduced so as to maintain a rank order that it felt was appropriate. The RUC adopted the facilitation committee's recommendations.

## VII. Five-Year Review of the RBRVS

The Notice of Proposed Rulemaking scheduled for publishing in March had not been published as of the April RUC meeting, but it was released to the Federal Register the following week. Doctor Bagley provided a brief overview of HCFA's response to the RUC's recommendations for the five-year review. He stated that 93% of the RUC's recommendations were accepted. He also explained that HCFA agreed with the RUC that the evaluation and management (E/M) services were undervalued, but believed that the arguments offered by the RUC applied equally to all E/M services, not just the ones that the RUC had recommended be increased. HCFA also thought that

the RUC's methodology had produced some errors in the specific values recommended, so instead HCFA used a mathematical approach and increased the intrawork and postwork of each code while maintaining original relationships between E/M services within a family and between families. HCFA did not propose to increase the E/M component of global surgical services and indicated that they would only change their view on this if the RUC submitted a recommendation accompanied by compelling evidence. For many families of services reviewed by the RUC, HCFA accepted all the RUC's recommendations. For some, they accepted all but one or two codes. The major exceptions were the RUC-recommended increases for psychotherapy codes.

Doctor Gage reported on a meeting of the workgroup on global surgical packages which was formed at the February meeting. He indicated that the surgeons had compiled some preliminary information on the current visit services provided as part of the global surgical package and they will continue to work on this issue and report again at the September RUC meeting.

#### VIII. RUC HCPAC Review Board Report

Doctor Hanley reported that the RUC HCPAC Review Board met on Thursday, April 25 and relative value recommendations for several issues:

- The Review Board agreed that the relative values for Chiropractic Manipulative Treatment should be equivalent for the established relative values for Osteopathic Manipulative Treatment codes 98925-98927. It also adopted a motion to request that the chairs and co-chairs of the CPT and RUC HCPAC Review Boards appoint a Manual Manipulative Technique Workgroup including CPT and RUC representatives from the American Osteopathic Association, American Physical Therapy Association, American Academy of Physical Medicine and Rehabilitation, the American Chiropractic Association, and other interested or appropriate parties, to discuss the codes and relative values for the various manipulation procedures.
- The Review Board accepted recommendations from the American Podiatric Medical Association for *Debridement of nail(s) by any method(s); one to five* and *six or more* which were based on survey medians and comparison to key reference services 11040 Debridement, skin, partial thickness (0.50) and 11050 Paring or curettage of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (e.g., callus or wart) with or without anesthesia; single lesion (0.43).
- The Review Board adopted an interim recommendation that the current relative values for biofeedback training be reduced from .89 to .45 pending a new survey to be conducted by the American Psychological Association.
- Recommendations were adopted from the American Physical Therapy and American Occupational Therapy Associations for a new code for *Orthotics fitting and training, upper and/or lower extremities, each 15 minutes* and a revised code 97520 for *Prosthetic training, upper and/or lower extremities; each 15 minutes* to each be assigned 0.45 RVU.

The Review Board adopted the final report and recommendations of a multidisciplinary workgroup comprised of Review Board and RUC members charged with responding to a request from HCFA to reconsider the relative values for physical and occupational therapy codes. There was a follow-up discussion on HCFA's policy regarding the definition of "physician services" and

which services should have assigned "work" relative values. Finally, the Review Board discussed the expanded workgroup process recommended to the RUC by the Research Subcommittee and voiced their support of such a process with appropriate representation of HCPAC members.

#### IX. Research Subcommittee Report

A Research Subcommittee meeting was held on April 13. A revised survey instrument was presented to the RUC and was accepted with several revisions. It was agreed that proportionally more emphasis needed to be placed on mental effort, judgment and skill as opposed to time. The RUC also agreed to supply the subcommittee with raw data from the surveys conducted for one meeting. The RUC did not adopt the subcommittee's recommendation for a workgroup process for considering new and revised codes, believing it was better to have the full RUC deliberate on all issues. It was felt that workgroups should continue to be an option when particular issues warrant "pre-facilitation." A copy of the Research Subcommittee report is attached to these minutes.

#### X. Practice Cost Subcommittee Report

A meeting of the Practice Cost Subcommittee meeting was held on Thursday, April 25. Jesse Levy, PhD, the project director at HCFA for the Abt Associates study explained the plan and timetable for the development of practice cost relative values. He explained that HCFA is committed to having final values ready to meet the statutory requirement for resource-based practice cost relative values by January 1998. There was some discussion of HCFA's plan to use proxy data and a formula approach to develop relative values in lieu of survey data. Problems arising from the perceived overlap between physician work and practice costs were also discussed, as well as the need for clinical expertise to distinguish the two. The subcommittee will continue to review the RUC's role in this process and maintain a dialogue with HCFA on this issue. A copy of the subcommittee's report is attached to these minutes.

#### XI. Correct Coding Initiative

Doctor McKusick and Kristen Morris reviewed the efforts of the Correct Coding Policy Committee and concerns that arose during its evaluation of the 951 disputed code pairs. The second phase of new committee's efforts will focus on proposed new edits involving separate procedure codes and revisions to CPT. Input from specialty societies is essential. The impact of "black box" edits was also discussed. These are of concern because the policies underlying these systems are proprietary and there is no input from organized medicine. The fraud and abuse provisions of the pending Kennedy-Kassebaum legislation were also discussed and the need for physicians to oppose the current language pertaining to "knowing" but not necessarily "willful" violations of the law.

#### IX. Other Issues

The RUC considered three other issues: a request from the American Academy of Neurology for a permanent seat on the RUC; changing the RUC HCPAC Review Board Co-Chair seat to a voting rather than nonvoting seat; and the election process for the two rotating seats. It took the following actions:

- The RUC adopted a motion that, based upon a reexamination of original RUC membership criteria and data, the specialty of neurology, represented by the American Academy of Neurology, be granted a permanent seat.

- The RUC adopted a motion to grant a voting seat to the RUC HCPAC Review Board Co-Chair, currently Emily Hill, PA-C.
- To review and provide oversight to the nomination and September 1996 election process for the two RUC rotating seats, Doctor Rodkey appointed an *ad hoc* Nominating Subcommittee comprised of Doctors Novak (Chair), Hitzeman, Jones, Lichtenfeld, and Morris.

The meeting was adjourned at 4:30 pm on Saturday, April 27.