AMA/Specialty RVS Update Committee
Meeting Minutes
April 22 - 25, 2004

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, April 22, 2004 at 1:00 pm. The following RUC Members were in attendance:

William Rich, MD (Chair)
Dennis M. Beck, MD*
Michael D. Bishop, MD
James Blankenship, MD
James P. Borgstede, MD
Neil H. Brooks, MD
Ronald Burd, MD*
Norman A. Cohen, MD
James Denneny, MD*
John Derr, Jr., MD
Mary Foto, OT
John O. Gage, MD
William F. Gee, MD
Meghan Gerety, MD
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
James D Maloney, MD*
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Chester W. Schmidt, Jr., MD
Daniel Mark Siegel, MD
J. Baldwin Smith, III, MD
Peter Smith, MD*
Holly Stanley, MD*
Susan M. Strate, MD
Trexler Topping, MD
Arthur Traugott, MD*
Richard Tuck, MD
James C. Waldorf, MD*
Richard W. Whitten, MD
Maurits J. Wiersema, MD
Robert M. Zwolak, MD

* Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich requested a moment of silence for two long serving RUC volunteers who contributed greatly to this organization, Ronald Shellow, MD and James E. Hayes, MD who both passed away in February.

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1

Greg Przybylski, MD* (Chair)
Neil Brooks, MD
Richard Dickey, MD*
Eddy Fraifeld, MD
Mary Foto, OTR*
Meghan Gerety, MD
Charles Koopmann, Jr, MD
Scott Manaker, MD*
John Mayer, MD
Robert Fifer, PhD
Charles Shoemaker, MD*
J. Baldwin Smith, III, MD
Trexler Topping, MD
Richard Tuck, MD

Facilitation Committee #2

Barbara Levy, MD (Chair)
Michael Bishop, MD
James Borgstede, MD*
Norman Cohen, MD
John Gage, MD
Anthony Hamm, DC
David Hitzeman, DO
Ronald Kaufman, MD, MB*
Peter McCreight, MD*
William Moran, MD*
Tye Ouzounian, MD*
Chester Schmidt, MD
Maurits Wiersema, MD
Robert Zwolak, MD

Facilitation Committee #3

J. Leonard Lichtenfeld, MD (Chair)
James Anthony, MD*
James Blankenship, MD
Joel Brill, MD*
John Derr, MD
William Gee, MD
Emily Hill, PA-C
Peter Hollmann, MD
Gregory Kwasny, MD*
Charles Mick, MD
Julia Pillsbury, MD*
Bernard Pfeifer, MD
Daniel Siegel, MD*
Susan Strate, MD
Richard Whitten, MD

**Current or former Practice Expense Advisory Committee (PEAC) member*

- CMS Staff attending the meeting include:
  - Edith Hambrick, MD, CMS Medical Officer
  - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, PT, CMS Health Insurance Specialist
  - Kenvin Ivory-Kennedy-Observer (Chicago CMS Regional Office)

- The following individuals were observers at the April 2004 meeting:

Debra	Abel	American Academy of Audiology
Sanford	Baim, MD	American College of Radiology
John	Barr, MD	American Society of Neuroradiology
William	Beach, MD	American Academy of Orthopaedic Surgeons
James	Boxall, MD	American College of Cardiology
Kenneth	Brin, MD	American College of Cardiology
Roger	Brooks	American Association of Oriental Medicine
Chris	Cates, MD	American College of Cardiology
Alice	Church	American Academy of Dermatology
Jeff	Cozzens, MD	American Association of Neurological Surgeons
Jeffery	Dann, MD	American Urological Association
Bruce	Deitchman, MD	American Academy of Dermatology
Jane	Dillion, MD	American Academy of Otolaryngology – Head and Neck
Ted	Feldman, MD	American College of Cardiology
James	Fletcher, MD	Society of Nuclear Medicine
Ronald	Green, MD	American Academy of Ophthalmology
Pamela	Kirby	American Association of Nurse Anesthestists
Kathy	Krol, MD	Society of Interventional Radiology
Edward	Martin, MD	American College of Cardiology
Najeeb	Mohideen, MD	American Society for Therapeutic Radiology and Oncology
Bill	Putnam, MD	Society of Thoracic Surgeons
Thomas	Rees, PhD	American Speech and Language Hearing Association
Michael	Rezak, MD	American Academy of Neurology
Marshall	Sager, DO	American Academy of Medical Acupuncture
Craig	Sobolewski, MD	American College of Obstetricians and Gynecologists
Scott	Trerotola, MD	Society of Interventional Radiology
Sandra	Tunajek	American Association of Nurse Anesthestists
Tamara	Vokes, MD	American College of Radiology
Frank	West, MD	American Association for Vascular Surgery

- Doctor Rich welcomed PEAC members in attendance so the RUC can incorporate their practice expense expertise into the valuation of fee inputs of new and revised codes. The PEAC members in attendance for this meeting are:

James Anthony, MD
Joel Brill, MD
Richard Dickey, MD
Ronald Kaufman, MD, MBA
Gregory Kwasny, MD
Scott Manaker, MD
Peter McCreight, MD
Bill Moran, MD
Tye Ouzounian, MD
Julia Pillsbury, MD
Charles Shoemaker, MD

- Doctor Rich stated that AMA staff have a list of those who have submitted Financial Disclosure Statements. Those that have not submitted Financial Disclosure Statements by the end of the chairman's report will not be allowed to present.

- Doctor Rich recognized Meghan Gerety, MD for her service on the RUC. She will be rotating off of the RUC but will continue to Chair the Five-Year Review Workgroup. The RUC presented Doctor Gerety with a gift to acknowledge her years of service.

- Doctor Rich made a presentation about Maintaining Medicare Physician Payment Schedule Viability – The role of the "House of Medicine", Specialty Societies and the RUC, which outlines the impact of the RUC and the external environment. **The full presentation is attached at the end of these minutes.**

III. Director's Report

Patrick Gallagher made the following announcements:

- Introduced Susan Dombrowski as new AMA staff, she will be the primary staff person for HCPAC meetings and will be staffing all of the RUC meetings as well.
- Introduced Kathy Kuntzman as the new vice president for the Health Policy Group at the AMA. She previously was the Vice President of Federation Relations and has worked extensively with all the specialty and state societies.

Sherry Smith made the following announcements:

- The following RUC members have been re-appointed for an additional three-year term:

James Blankenship, MD	American College of Cardiology
James P. Borgstede, MD	American College of Radiology
Neil H. Brooks, MD	American Academy of Family Physicians
John Derr, Jr, MD	American Society of Plastic Surgeons
Bernard Pfeifer, MD	American Academy of Orthopaedic Surgeons
Gregory Przybylski, MD	American Association of Neurological Surgeons
Chester W. Schmidt, MD	American Psychiatric Association
Richard H. Tuck, MD	American Academy of Pediatrics

- CPT is considering convening for three meetings a year rather than four. Given the adjustment in the CPT meeting dates, at the September 2004 RUC meeting, the Administrative Subcommittee will determine whether there needs to be any adjustment in the RUC meetings. The CPT meeting schedule change would begin in 2005.

- Specialty societies should review the document on Specialty Society Contact Information for Medicare Coverage Issues which was shared with the coverage area at CMS and will be distributed to CMD's in May. If any changes are needed, contact AMA staff by May 1st.

IV. Approval of Minutes of the January 29-31, 2004

- Doctor Whitten had several editorial changes to the minutes, which have been incorporated.

  With the exception of one, Page 40 of the January Minutes includes a section pertaining to conscious sedation and a new question on the survey instrument. Doctor Whitten had some concerns on whether the RUC should revise the language. Background for questions 6, the last sentence should read:

  > For purposes of the following question, sedation and analgesia delivered <u>separately</u> by an anesthesiologist or other anesthesia provider <u>not performing the primary procedure</u> is not considered conscious sedation.

  The minutes were reviewed by the RUC and all changes were accepted as editorial.

V. CPT Update

Doctor Peter Hollmann and Michael Beebe briefed the RUC on the following issues:

- Infusion Therapy
  - A Drug Infusion Work Group has been formed by the Editorial Panel to review drug infusion codes to determine if this section of CPT should be modified in accordance with the Medicare Moderization Act (MMA) provisions. The workgroup, which includes members of CMS and all of the appropriate societies, will convene a conference call in May 2004. This issue will be presented before the panel in August.

- Conscious Sedation
    - The task force of CPT and RUC members has completed its review of conscious sedation. The May 2004 CPT meeting will present the introductory language regarding the conscious sedation information and the list of codes that include conscious sedation.

- Evaluation and Management Clinical Examples Development
    - For the past three years CPT has been working to change the E/M code descriptors to make them easier to understand, apply and review and to diminish the need for documentation guidelines.
    - In November 2002, the CPT Editorial Panel provisionally passed new E/M code descriptors. This was provisional because a large portion of the new descriptors relied on clinical examples for implementation, since physicians needed to choose the level based on magnitude estimation.
    - The Editorial Panel appointed a Clinical Example task force, composed of CPT, RUC and CMS members.
    - The task force reviewed how best to develop clinical examples; how clinical examples can be tested to ensure intra specialty and cross specialty comparability; and the ability of contractor medical directors to use examples for review purposes.
    - The task force created a multi-pronged approach to allow several different tests to occur on the clinical examples and also developed detailed comprehensive instructions to go out to specialties which developed the examples to achieve consistency within the specialties and across specialties.
    - The task force conducted an intra-specialty pilot study in which physicians of the same specialty coded the clinical examples that were designed by that specialty. A submission of 330 clinical examples from 11 specialties was evaluated in early 2004. Results were startlingly poor. The pilot did not demonstrate that coding from clinical examples would be an improvement over the current E/M system. Specialty physicians were only able to correctly assign appropriate E/M codes from clinical examples with a maximum specialty accuracy of 44% and a minimum specialty accuracy of 26%. On a code level basis clinical examples from 99213 were the most accurate with 54% correct and clinical examples from 99215 were the least accurate with 18% correct. The clinical example task force concluded that this was not a viable approach. As a result, the task force made six recommendations to the Editorial Panel to review at the 2004 May CPT meeting. The Editorial Panel will review, but prior

to any action this issue must go to the Specialty Advisory committee.

The following recommendations will be made to the CPT Panel:

1. The CPT Editorial Panel should rescind its November 2002 action to accept the new E/M descriptors based on the use of Clinical Examples to guide code selection.
2. The CPT Editorial Panel should reconsider and resubmit to the CPT/HCPAC Advisors the Panel's actions on several of the codes that the workgroup thought were still viable ideas which involved changes to follow-up inpatient consultations, confirmatory consultations and nursing facility services in order to determine if these are still viable.
3. The CPT Editorial Panel should revise CPT code descriptors and appropriate guidelines for family of E/M codes to specify that two out of three key criteria are required on those codes instead of three out of three key criteria required.
4. The CPT Editorial Panel should consider replacing or supplementing the E/M clinical examples with new, more detailed, clinical examples.
5. The CPT Editorial Panel should consider adopting broad principles of medical record documentation which are less specific but consistent with 1995-1997 E/M documentation guidelines.
6. The CPT Editorial Panel should consider developing a new E/M educational resource that contains specialty specific illustrations of appropriate medical record notes that would match with the clinical examples, a new publication to help physicians applying the E/M codes.

Staff Note: The Panel, at the 2004 May meeting, accepted Issue #1. The Panel accepted with modification the recommendation for Issue #2 to reconsider and resubmit to the CPT/HCPAC Advisors the Panel's November 2002 actions on the changes to the codes, descriptors and guidelines for the Follow-up Inpatient Consultations (99261 – 99263), the Confirmatory Consultations (99271 – 99275), and the Nursing Facility Services (99301 – 99316). The Panel modified this recommendation by excluding the Nursing Facility Services codes, as the American Geriatric Society, in conjunction with other specialty societies, is interested in revising the Nursing Facility Services codes to incorporate the concepts of the 2002 action while not relying upon the reference code method of selection. The Panel rejected Issue #3, #4, and #6 and postponed Issue #5.

VI. CMS Update

Doctor Ken Simon and Carolyn Mullen briefed the RUC on the following:

- Mark McClellan, MD, former FDA Commissioner, joined CMS in the capacity as the CMS Administrator. Over the last month he has become acclimated to the challenge that is before him. One thing that he has made clear is that the direction of the agency will continue to be focused on quality initiatives and finding ways to provide incentives to clinicians to link quality with payment. For the future, anticipate more creative methods on linking improved care with increased payment.

- Herb Kuhn was also hired to replace Tom Grissom (who now works for Boston Scientific in Washington) as the Director for the Center for Medicare Management which is the Medicare Fee-For-Service section of the Agency.

- Recently CMS has been interpreting the MMA and determining how to operationalize and implement the different provisions contained within the law. Over the next couple months, CMS will be engaged in sorting out how to facilitate and operationalize that part of the law regarding oncology issues, which is the center of controversy for many specialties. At the 2004 September RUC meeting we will have a better idea on how drugs will be priced and will have a better forecast for the upcoming year.

- A RUC member questioned what CMS will do about the Five-Year review for PE and what will they do with the zero work pool. Carolyn Mullen replied that the Five-Year review is still in refinement for PE and any comments are welcome. Also, regarding the zero work pool, CMS actions depend on the fact that three of the specialties that make up the bulk of the zero work pool have completed PE cost surveys, which have not been processed by Lewin to date. Ms. Mullen indicated that she thinks the specialties may feel that the main problem causing the zero work pool to be a necessity lies with the specialty's practice expense per hour. Hopefully the surveys will be acceptable which will enable CMS to move most procedures out of the zero work pool. However, if there are any drastic effects on any one specialty, it will not occur this year.

- A RUC member asked CMS what will occur if there is a difference in the SMS versus the PEAC practice expense. Ms. Mullen responded that if there is a problem with the SMS data, which could indicate that a new survey needs to be done (eg, separately billable supply costs may be included). The main action would be to analyze what is causing this discrepancy. CMS would like to work with the specialties to address this because they may have an idea on what is causing this discrepancy. Ideally, CMS would prefer scaling factors that are close to one.

- A RUC member questioned CMS about the SGR issue and specifically removing drugs from the SGR. Doctor Simon responded that it is premature at this point to know how the agency will deal with this issue. CMS continues to review this issue in a comprehensive manner.

- A RUC member asked if CMS had any new information on the GAO request to analyze the issue of assistants present at surgery. Doctor Simon responded that there was not any new information at this time and that it is under review.

- A RUC member questioned if there is an established end point for the refinement of the PE RVUs. If so, will established PE RVUs at that time be fixed over some number of years? And as we introduce new services with disposables will those be cross-walked to existing services or will PE RVUs be calculated every year? Ms. Mullen indicated that no decision has been made on the refinement of PE RVUs yet. Ms. Mullen indicated that CMS would like to come to a point to have only five-year reviews, not to have it refined every year. CMS is aware of the need to put some stability into the practice expense. Perhaps, using the conversion factor to normalize rather than change RVUs in order to keep them steady may be an appropriate method.

VII. CMD Update

Doctor William Mangold, Contractor Medical Director (CMD) for Arizona and Nevada, addressed the RUC and indicated that there will be a CMD/CMS meeting in Baltimore on May 20, 2004. One of the topics will include discussion of CMDs' role in the five-year review process. Doctors Rich, Schmidt and Sherry Smith will present to the CMDs at this meeting.

VIII. Washington Update

Sharon McIlrath addressed the following issues:

- *Medical Liability Reform:* Senate leadership has continued to pursue a "carve-out" bill. In February 2004, forty-eight votes were received on the obstetrical bill and on April 7, 2004, forty-nine votes were received for the obstetrics plus trauma bill, both of which were not enough votes to bring it to the floor. AMA supported Senator Frist and other Senate leaders on both carve-out bills. In the future there may be additional parts to the carve-out approach, adding rural and underserved and Good Samaritan portions to the bill. However, due to the short amount of time left in this session, these issues may not come forth. Meanwhile Senators Durbin and Graham are developing a bi-partisan bill that would provide tax credits to help cover the cost of liability premiums and set up mandatory pre-trial screening panels. This may be attractive as an interim measure to some

states and physicians. However, the problem is that screening panels are not admissible in court and are not binding. AMA is continuing to discuss the issues of the liability bill which would cover hospitals, physicians and other practitioners. AMA is working with other medical groups to try to develop a liability bill that would only cover hospitals, physicians and other practictioners.

- *Patient Safety:* The Senate did not manage to pass its bill on patient safety last year, despite the fact that it was unanimously approved in the Senate Committee. Senator Gregg is trying to bring this issue to the floor for a vote but has been unsuccessful. The AMA is participating in a broad-based coalition with the state, specialty medical societies and AHA.

- *Medicare Physician Update:* The focus is currently on administrative changes. The Medicare Trustees Report stated that there will be cuts of 5% a year from 2006 through 2012, followed by a cut of about 2% in 2013. This is unsustainable and is unlikely to happen. AMA has a work group comprised of medical specialties and other health professionals paid under the payment schedule. All prefer the MedPAC solution, though there is a difference of opinion on whether we should provide an alternative and what the alternative would look like. AMA is working with the CMS administrator, Mark McClellan, MD, regarding the administrative changes. Most of the proposed fixes are not new, most have been presented since 2001. Proposed changes include:

    - Take drugs out of the SGR formula
    - Include an allowance in the target for coverage decisions
    - Allow for indirect impact of screening benefits
    - Revise the MEI so it better reflects the cost of modern medical practice
    - Make sure that the target is adjusted for the impact of a new drug benefit on the use of physician services (New proposed change)

  Doctor McClellan made it clear in his remarks, that the price of support for help on the SGR is physician support for quality initiatives and measures to improve efficiency

- *Medicare Modernization Improvement and Prescription Drug Act (MMA) Aftermath:* Democrats are continuing to try to reopen and amend this act. However, no Medicare legislation is expected this year.

- *MMA Regulatory Aftermath:*
    - *AWP:* There is a concern that much steeper reductions in drug prices when a new average sales price methodology kicks in next year, could lead to access problems before any of the studies to monitor the impact of the changes are due. As a result, the three Congressional Medicare Committees asked GAO to provide an earlier analysis. The GAO may have some data on the impact of

this year's cuts by August and a report on the expected impact of the 2005 payment rates by early fall. In the meantime, affected groups are moving to collect their own data. AMA is working with these specialties to develop a survey.

- *Chronic Care Demonstration:* CMS recently released an RFP for the Chronic Care Demonstration which will cover 150,000 – 300,000 seniors with chronic conditions. The demonstration focused on congestive heart failure, complex diabetes and COPD. One requirement is that it has to cover 10% of beneficiaries in an area. The disease management entity is at risk for any spending over what Medicare would otherwise have spent. It is unlikely then, that even large physician groups will bid on these contracts. Physician groups hope to see some type of management fee for caring for these patients.
- *Drug Discount Cards:* Twenty-eight companies with 49 cards have been selected to date. Marketing will start soon. There will be a lot of questions to physicians from beneficiaries regarding what card they should chose. AMA has worked with AARP and others to convince CMS to require all the companies to use the same enrollment form. CMS recently announced that there will be one enrollment form and all companies will have to use it.

Questions

- A RUC member posed a question regarding the Chronic Care Demonstration. The RUC member indicated that the demonstration appeared to be a disadvantage for family practice and general internal medicine. The RUC member asked if this demonstration project will increase reporting requirements for people covered under this demonstration project. Also, if new money was not used to fund this project, how will it affect the SGR? Ms. McIlrath responded that in theory, it can not have any impact on the SGR because if there are not savings then the companies are at risk. The downside is that it is hard to see how they will provide the management fee that the physicians feel would be justified for the work that they are going to have to do. In addition, chronic care demonstrations may encourage more physician care in order to reduce hospitalizations so even if the demonstrations meet the savings criteria, there could be an increase in physician care which would have implications for the SGR.

- A RUC member speculated that a SGR fix will be difficult as there currently appears to be a political impediment where the administration wants to drive many people into Medicare Advantage. Ms. McIlrath responded that some individuals in the administration want to see the use of the private plans expanded. Currently, the way the risk adjustor is being implemented favors the managed care plans. However, with the

current Federal budget situation, there may be countervailing pressure to reduce the subsidies the managed care plans are receiving.

IX. Election of Internal Medicine Rotating Seat

The specialty societies and individuals listed below were nominated for the internal medicine rotating seat election. The term for the internal medicine rotating seat is for two years, beginning with the September 2004 RUC meeting and ending in May 2006, with the provision of final recommendations to the Centers for Medicare and Medicaid Services (CMS).

American Association of Clinical Endocrinologists	Sethu K. Reddy, MD, FACE
American College of Chest Physicians American Thoracic Society	Scott Manaker, MD, PhD, FCCP
American Society of Hematology	Samuel M. Silver, MD, PhD
Renal Physicians Association	Emil P. Paganini, MD, FACP, FRCP
The Endocrine Society	Richard A. Dickey, MD

Scott Manaker, MD, PhD, FCCP, was elected to serve as the internal medicine rotating seat.

X. Relative Value Recommendations for CPT 2005

Tissue Debridement of Genitalia for Gangrene (Tab 5)
Jeffery A. Dann, MD, American Urological Association (AUA)
Facilitation Committee #2

The CPT Editorial Panel in February 2004 created four new codes for performing a debridement for Fournier's Gangrene. Existing excision and debridement codes were not specific to the urogenital system where debridements are extensive and involve removal/transplantation of the genital organs such as the penis or testes. In addition, these procedures are usually performed emergently in high risk patients with over 50% mortality rates. Two of the four codes were brought forth by specialties and the other two codes are recommended as carrier priced for 2005, and will be reviewed by the RUC in September 2004.

11004 and 11006
The RUC reviewed the typical patient scenario for these two codes and understood that the new codes would never be performed in the physician's

office due to fact that these patients were at high risk and emergent. The RUC also reviewed and compared the work of 000 day global codes 11012 *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone* (RUC Surveyed, MPC listed, Work RVU=6.87) and 43242 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)* (RUC Surveyed, Work RVU = 7.30). Both codes have an intra-service work time of 90 minutes which is identical to new code 11004. The RUC believed that code 11004 is significantly more intense than code 11012 and at a higher risk. It was explained that for these new codes the physician is actually filleting the skin. In addition, the RUC believed the intensity of code 43242 was similar for this emergency room procedure. The RUC then used the intra-service work intensity of 43242 to establish a work RVU for code 11004. The RUC believed that the pre-service time associated with these codes should reflect the existence of an extensive E/M code prior to the service, and recommended decreasing the pre-service evaluation time by 15 minutes. The pre and immediate post service time for 11004 and 11006 was justified to the RUC as being longer and more involved than the time needed for code 43242. The RUC used the building block approach using the intensity of 43242, with the understanding that the work of 11004 is more involved. **The RUC used an intra-service work per unit of time (IWPUT) of .077 to establish a work RVU for 11004 of 8.80.**

The RUC used the same building block approach to develop a work RVU for code 11006. **The RUC used the IWPUT of code 43242 (0.077) to establish a work RVU of 11.10 for 11006.** In addition, the RUC also believed the intra-time associated with these procedures was not sufficiently reflected in the specialty's survey results. The RUC understood that the intra-service physician time for 11006 had to be more than the intra-service time for code 11004 and accepted the specialty's recommendation for the 75th percentile surveyed results of 120 minutes. The RUC also reviewed 000 day global code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording* (RUC Surveyed, MPC listed, Work RVU =11.57) for its complexity and work in relation to this new service. Code 93620 has a RUC surveyed pre-service time of 60 minutes, intra-service time of 120 minutes, and 60 minutes of post service time.

The RUC recommends the following physician time and relative work values:

CPT Code	Pre-Service Evaluation Time	Pre-Service Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	Recommended RVU
11004	30	15	20	90	30	8.80
11006	30	15	20	120	30	11.10

The RUC recommends that codes 11005 and 11008 be carrier priced for the year 2005.

Practice Expense for 11004 and 11006
The RUC agreed that these procedures are performed on an emergent basis in the facility setting only, and would not have any practice expense. The RUC recommends no practice expense inputs for these codes.

Renal Pelvic – Ureter Therapeutic Agents Instillation (Tab 6)
Jeffery A. Dann, MD, American Urological Association (AUA)
Facilitation Committee #2

The CPT Editorial Panel in February 2004 created a new code for the service of instillation of therapeutic agents into the renal pelvis or ureter to treat either an urothelial tumor or fungal infections of the upper tracts. No other code had previously described this service.

The RUC reviewed the specialty societies' initial recommendations and determined that the pre-service time for this code was inappropriate. The society agreed and explained that the pre-service time should be reduced by 10 minutes to 20.5 minutes, as the physician does not need to scrub prior to performing this procedure, only sterile gloves are necessary. The RUC then reviewed the intra-service time and due to the hazardous material being handled, recommends that the intra-service time should be increased to 30 minutes to reflect the physician constant attention to ensure the safety of the patient and staff. In addition, these 30 minutes are necessary to comply with the recommended infusion time. The society agreed with this recommendation and explained that in a similar CPT code 51720 *Bladder instillation of anticarcinogenic agent (including detention time)* (Work RVU=1.96), which has 27 minutes of intra-service time and an IWPUT of 0.058, the physician does monitor the patient for the entire intra-service period. The RUC was comfortable with this intra-service time comparison and recommended 30 minutes of intra-service time for 50391 *Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelstomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)*. The RUC believed that the work value of 51720 could be applied to new code 50391 with adjustments in physician time. **The RUC recommendations for code 50391 are summarized below:**

CPT Code	Pre-Service Time	Intra-Service Time	Post-Service Time	Work RVU

50391	**20.5**	**30**	**10**	**1.96**

The RUC also used a building block methodology to establish the 1.96 Work RVUs for 50391, as shown below.

50391			**RVW**
Global = 000		**Rec RVW**	**1.96**
	Survey Data	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	20.5	0.0224	0.459
Pre-service scrub, dress, wait		0.0081	0
Pre-service total			**0.459**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	10	0.0224	0.224
Post-service total			**0.224**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	30	**0.043**	**1.28**

Practice Expense Inputs for 50391

The RUC then reviewed the practice expense inputs for 50391. The society proposed, and the RUC agreed, that the pre-service time for the facility-setting should have zero time because all of the clinical labor time is being provided by the hospital staff for this typically inpatient stay patient. In addition, the society recommended, and the RUC agreed, that in the non-facility setting, the pre-service time should be cross-walked to PEAC reviewed code 51720 resulting in 8 minutes of total pre-service time. In addition, the RUC recommended, and the specialty agreed, that the assist physician time should go to zero minutes because the physician is monitoring the patient for the entire service and therefore does not require additional staff to assist him/her. It was also recommended that the time for preparing and positioning the patient should go to zero because in the description of the intra-service time, the physician is positioning the patient. The supplies and equipment were then reviewed and modified to ensure no duplication. **The modified practice expense inputs for 50391 were approved by the Facilitation Committee.**

TMJ Manipulation Under Anesthesia (Tab 7)

Jeffery B. Carter, DMD, MD, American Association of Oral and Maxillofacial Surgeons (AAO)

CPT Code 21298 *Manipulation of temporomandibular joint (TMJ) under general anesthesia* has been rescinded by the CPT Editorial Panel for 2005 at the specialty's request. The RUC, therefore, did not take any action on this issue.

Osteochondral Procedures (Tab 8)
Dale Blasier, MD, American Academy of Orthopaedic Surgery (AAOS)
William Beach, MD, Arthroscopy Association of North America (AANA)
Facilitation Committee #1

CPT transferred three category III codes (0012T, 0013T, and 0014T) and two associated codes, to category I status due to the fact that these procedures are performed often and with sufficient clinical follow-up and efficacy to warrant a category I CPT code. These codes describe various osteochondral allograph implantations and transplantation procedures of the knee

29866, 29867, 29868, 27412 & 27415

The RUC reviewed the survey results for 29866 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft)*, 29867 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft) osteochondral allograft (eg, mosaicplasty),* and 29868 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft) meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral,* 27412 *Autologous chondrocyte implantation, knee* and 27415 *Osteochondral allograft, knee, open* and agreed that the pre-service time for entire family of codes should be consistent. The RUC reviewed codes 29873 *Arthroscopy, knee, surgical; with lateral release* and 29883 *Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)* to validate the pre-service time. Both of these codes (29873 and 29883) have RUC survey data and the pre-service times are both 75 minutes total. **After extensive discussion the RUC felt that the pre-service time should total 75 minutes each for the family of codes (evaluation = 45 minutes, positioning = 15 minutes and scrub/dress/wait = 15 minutes).**

The RUC agreed that the post-service time for 29866, 29867, and 29868 were appropriate as surveyed. However, 27412 and 27415 were modified to include two 99212 and three 99213 office visits. Reference code 29883 includes two 99212 and two 99213 office visits and the RUC agreed that an additional 99213 for these services is warranted.

The RUC recommends a work RVU of 13.88 for 29866 (25th percentile survey value) and a work RVU of 17.00 for 29867 (median survey value). The RUC recommends a work RVU of 23.59 for 29868, which reflects only the adjustment in pre-service time.

The RUC recommends a work RVU of 23.23 for 27412 and 18.49 for 27415. The RUC notes that these values are similar to the specialty's survey 25th percentile. The RUC agreed with the specialty society that CPT codes 27227 *Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation* (Work RVU=23.41), (90 minutes pre-service, 180 minutes intra-service, 6 hospital visits and 4 office visits) and 27284 *Arthrodesis, hip joint (including obtaining graft);* (Work RVU=23.41), (80 minutes pre-service, 180 minutes intra-service, 4 hospital visits and 3 office visits) are appropriate reference services for 27412. The RUC also considered the following reference services for 27415: 28705 *Arthrodesis; pantalar* (Work RVU=18.77), (75 minutes pre-service, 180 minutes intra-service, 2 hospital visits and 4 office visits) and 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (Work RVU=18.46), (60 minutes pre-service, 150 minutes intra-service, 2 hospital visits and 5 office visits).

The RUC agreed that the survey median intra-time and the original IWPUT were appropriate. Additionally, the RUC believed the specialties survey results did not fully account for the physicians pre-service and post-service work levels. The RUC modified the physician time and recommends the following:

CPT Code	Pre-Service Time			Intra-Service	IWPUT	Post-Office Visits	Recommended RVU
	Evaluation	Positioning	Scrub/Dress/ Wait				
29866	45	15	15	100 minutes	.087	99212 x 3, 99213 x 2	13.88
29867	45	15	15	120 minutes	.081	99212 x 2, 99213 x 3	17.00
29868	45	15	15	180 minutes	.087	99212 x 2, 99213 x 3	23.59
27412	45	15	15	180 minutes	.085	99212 x 2, 99213 x 3	23.23
27415	45	15	15	120 minutes	.088	99212 x 2, 99213 x 3	18.49

Practice Expense Inputs

The standard practice expense inputs for 090 day global period codes were used and adjusted for the new office visit level as described above.

Bronchoscopy Stent Revisions, Endobrachial Ultrasound (Tab 9)
Alan Plummer, MD, FCCP, American Thoracic Surgery (ATS)
Scott Manaker, MD, PhD, FCCP American College of Chest Physicians (ACCP)
Facilitation Committee #1

The CPT Editorial Panel in November 2003 revised two bronchoscopy procedures and created four new codes, in order to create more specific bronchial and tracheal stent placement techniques. Some procedures involve dilation and placement of one or more stents, while others may involve a revision of an existing stent and therapeutic intervention.

The RUC reviewed the survey data separately for each of the new and revised codes. The RUC believed that the reference codes used in the surveys were appropriate for the services. The physician work for the new codes was believed by the RUC to be more intense and time consuming than the reference codes, and the specialty society's recommended work values seemed appropriate. In addition, RUC understood that these new and revised procedures typically required general anesthesia in a facility setting, and therefore should not be on the conscious sedation list.

31630 and 31631

The specialty society's survey results for the two existing revised codes, 31630 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal or bronchial dilation or closed reduction of fracture* (Work RVU = 3.81) and 31631 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)* (Work RVU = 4.36) supported their current values and recommended no change in the work values. The RUC reviewed the physician time for each of the codes and recommended that the surveyed times be used, replacing the existing Harvard time, with one modification. The RUC believed that the intra-service time for 31630 should be 45 minutes instead of the surveyed 60 minutes, as the newly created family should reflect consistent time amongst its similar codes. **The RUC recommends that the specialty's physician surveyed time replace the existing Harvard time, and the intra-service time of 31630 be 45 minutes. The RUC also recommends no change in the existing physician work relative values for codes 31630 and 31631.**

31636

The RUC reviewed the physician work of new code 31636 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial* in relation to its reference codes 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80). The RUC believed that the work of the new code was more difficult and required more time and physician work than either of the reference codes and supported the specialty society's median surveyed work value. **The RUC recommends a 4.30 work relative value for code 31636.**

31637

The RUC reviewed the physician work of the new code 31637, *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure*) in relation to its reference code 31636 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent (includes tracheal/bronchial dilation as required), initial* (RUC recommended Work RVU=4.30). The RUC believed that because the reference code has pre and post service time associated with it, 15 and 25 minutes, respectively, and the reference code has a longer intra-service time than the surveyed code 45 minutes and 30 minutes, respectively, that the surveyed code should have less work than the work associated with the reference code. The RUC believed that this work value should be similar to the difference between the basic bronchoscopy code, 31622 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)* (RVU=2.78) and 31636. **Therefore, the RUC recommends a work relative value of 1.58 for 31637.**

31638

The RUC reviewed the work and physician time of new code 31638 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of a tracheal or bronchial stent inserted at a previous session (includes tracheal/bronchial dilation as required*) in relation to its reference codes 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80). The RUC believed the specialty's survey results were appropriate for the entire service, and understood that the additional intra-service time for this code was appropriate considering the family of codes and the reference codes. The RUC agreed with the specialty's recommended work value for 31638. **The RUC recommends a work relative value of 4.88 for new code 31638.**

31620

The RUC reviewed the procedure in great detail and provided justification for the intensity of the code. The RUC reviewed code 92979 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (ZZZ global, RUC Surveyed, Work RVU = 1.44) and the specialty society's reference code 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (000 global, RUC Surveyed, Work RVU = 3.80). The RUC did not believe that the work of 31628 was comparable to 31620, but believed it was closer to

the work of code 92979. The RUC then reviewed the differences in intra service work of two other codes to capture the ultrasound work component and make its recommendation. The RUC reviewed the difference between codes 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) and 43231 Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination (RUC Surveyed, Work RVU = 3.19). The RUC extracted the pre-service and post-service work from both codes 43200 and 43231 resulting in 0.91 and 2.31 respectively. The RUC then recommended subtracting the intra-service work of 43200 from 43231 to capture only the ultrasound portion of work, resulting in a work RVU of 1.40. **The RUC recommends a Work RVU of 31620 of 1.40. In addition, the RUC recommends that this could be added to the Conscious Sedation List.**

Practice Expense:
<u>31630, 31631, 31636 and 31638</u>
The RUC understood that these procedures would only be safely performed in the facility setting and therefore did not recommend practice expense inputs in the non-facility setting. The RUC reviewed the specialty society recommended practice expense inputs for the facility setting carefully, and altered the clinical labor staff type and lowered the time, to be consistent to similar practice expense inputs of 000 day global bronchoscopy procedures that have been through the RUC process. The revised practice expense inputs were attached to the CMS submission.

<u>31637 and 31620</u>
The RUC understood that 31637 would only be performed in addition to its base code 31636 and therefore did not recommend practice expense inputs. As for 31620, RUC agreed that the cleaning of the ultrasound probe clinical labor time would be reduced to 5 minutes, and supplies and equipment were altered to account for the any duplication in the base code 31622 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure).* The revised practice expense inputs for 31620 were attached to the CMS submission.

<u>Chronic Indwelling Pleural Catheter (Tab 10)</u>
Bill Putnam, MD, Society of Thoracic Surgeons
Facilitation Committee #1

The CPT Editorial Panel created one new code to represent a new technology and technique for management of pleural effusions. The technique of insertion, and management of a chronic indwelling pleural catheter with cuff into the pleural space, and perioperative management had not been represented in existing CPT codes.

The RUC began its review of 32019 *Insertion of indwelling tunneled pleural catheter with cuff* by assessing 000 day global codes, including 32020 *Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)* (RUC Surveyed, MPC listed, 000 day global Work RVU = 3.97), 61107 *Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device* (Work RVU = 4.99) and 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (RUC Surveyed, MPC List, Work RVU = 4.43) in relation to this new code. The RUC believed that the new code does not require the same amount of work associated with code 61107 and 45380, and the RUC felt that the work associated with 32020 was the best reference. In relation to code 32020, the RUC felt that because of the additional tunneling and counter incision of the placement of the cuff associated with the new code warranted a 5% higher work RVU. In addition, the RUC and the presenters understood that the discharge day time reported on the summary of recommendation form was in error and should be deleted. **The RUC recommends a relative work value of 4.17 for code 32019, and there should be no physician time for discharge day management.**

The RUC also recommends that code 32019 be placed on the conscious sedation list.

Practice Expense for 32019

The RUC reviewed the revised recommended practice expense inputs in detail and agreed to reduce the clinical labor time in the pre-service time period, and in the intra-service time periods, in both clinical settings. **The revised practice expense inputs were attached to the CMS submission and are recommended by the RUC.**

Lung Transplantation (Tab 11)

Abraham Sahked, MD, American Society of Transplant Surgeons
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 32850 *Donor pneumonectomy(ies) (including cold preservation), from cadaver donor ~~with preparation and maintenance of allograft (cadaver)~~;* 32855 and 32856 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the pulmonary venous/atrial cuff, pulmonary artery, and bronchus-; unilateral and bilateral,* respectively are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time the **RUC does not submit any recommendations for codes 32850, 32855 and 32856.**

Heart-Lung, Heart Transplantation (Tab 12)
Abraham Sahked, MD, American Society of Transplant Surgeons
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 33930 *Donor cardiectomy-pneumonectomy (including cold preservation) ~~with preparation and maintenance of allograft~~;* 33933 *Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, and trachea for implantation*; 33940 Donor cardiectomy (including cold preservation)~~with preparation and maintenance of allograft~~; and 33944 *Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 33930, 33933, 33940, and 33944.**

Intestine Transplantation (Tab 13)
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 44132 *Donor enterectomy (including cold preservation), open, ~~with preparation and maintenance of allograft~~; from cadaver donor*; 44133 *Donor enterectomy (including cold preservation, open, ~~with preparation and maintenance of allograft~~; partial, from living donor*; 44135 *Intestinal allotransplantation; from cadaver donor*; 44136 *Intestinal allotransplantation; from living donor*; and 44715 *Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at the time

the **RUC does not submit any recommendations for codes 44132; 44133; 44135; 44136; and 44715**.

The CPT Editorial Panel created a new code 44137 *Removal of transplanted intestinal allograft; complete*. The specialty society informed the RUC that this service is infrequently performed (approximately 10 times annually) and is performed by a limited number of transplant surgeons in the country. A survey was attempted, but was not successful. **The RUC, therefore, recommends that CPT code 44137 be carrier priced in 2005.**

Backbench Reconstruction Codes (44720 and 44721)
The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 44720 *Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each* and 441721 *Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation;arterial anastomosis, each.* These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect. In addition, the specialty clarified that although venous anastomoses are often viewed as more work than arterial anastomoses, the opposite is true for this backbench reconstruction. The veins are typically easier than the artery as these anastomoses are in the arterial branches and are smaller than the vein.

The RUC reviewed survey data from more than twenty transplant surgeons for these two services. The RUC understands that these are essentially add-on

codes and only include intra-service work. These services should be modifier -51 exempt. CPT code 44720 requires 50 minutes of intra-service time and 44721 requires 70 minutes of intra-service time. The RUC agreed that the survey medians of 5.00 for 44720 and 7.00 for 44721 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these new codes were more intense than the reference services, as indicated by the survey results. **The RUC recommends 5.00 for CPT code 44720 and 7.00 for CPT code 44721.**

Practice Expense
CPT codes 44720 and 44721 essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Liver Transplantation (Tab 14)
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 47133 *Donor hepatectomy (including cold preservation), ~~with preparation and maintenance of allograft,~~ from cadaver donor*; *47143 Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment;* 47144 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation;* with trisegment *split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII))*; and 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 47133, 47143, 47144, and 47145.**

Backbench Reconstruction Codes (47146and 47147)
The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 47146 *Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each* and 47147 *Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each*. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect. In addition, the specialty clarified that although venous anastomoses are often viewed as more work than arterial anastomoses, the opposite is true for this backbench reconstruction. The veins are typically easier than the artery as these anastomoses are in the arterial branches and are smaller than the vein.

The RUC reviewed survey data from more than forty transplant surgeons for these two services. The RUC understands that these are essentially add-on codes and only include intra-service work. These services should be modifier -51 exempt. CPT code 47146 requires 60 minutes of intra-service time and 47147 requires 65 minutes of intra-service time. The RUC agreed that the survey medians of 6.00 for 47146 and 7.00 for 47147 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these new codes were more intense than the reference services, as indicated by

the survey results. **The RUC recommends 6.00 for CPT code 47146 and 7.00 for CPT code 47147.**

Practice Expense
Codes 47146 and 47147 are essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Pancreas Transplantation (Tab 15)
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes *48550 Donor pancreatectomy (including cold preservation), ~~with preparation and maintenance of allograft from cadaver donor,~~ with or without duodenal segment for transplantation* and *48551 Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from the iliac artery to the superior mesenteric artery and to the splenic artery* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 48550 and 48551.**

Backbench Reconstruction Codes 48552
The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT code 48552 *Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation; venous anastomosis, each*. This code describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient. The specialty has indicated that typically only one anastomosis is performed

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect.

The RUC reviewed survey data from more than thirty transplant surgeons for this service. The RUC understands that this is essentially an add-on codes and only includes intra-service work. This service should be modifier -51 exempt. CPT code 48552 requires 40 minutes of intra-service time. The RUC agreed that the survey median of 4.30 is appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that this new service is more intense than the reference services, as indicated by the survey results. **The RUC recommends 4.30 for CPT code 48552..**

Practice Expense
CPT Code 48552 is essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Kidney Transplantation (Tab 16)
Michael Abecassis, MD, FACS, American Society of Transplant Surgeons

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 50300 *Donor nephrectomy (including cold preservation); ~~with preparation and maintenance of allograft,~~ from cadaver donor, unilateral or bilateral*;50323 *Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic, and retroperitoneal attachments, excision of adrenal gland, and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary*; and 50325 *Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 50300, 50323, and 50325.**

Backbench Reconstruction Codes (50327, 50328, and 50329)
The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 50327 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each;* 50328 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each;* and 50329 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each.*. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect.

The RUC reviewed survey data from more than thirty-five transplant surgeons for these two services. The RUC understands that these are essentially add-on codes and only include intra-service work. These services should be modifier -51 exempt. CPT code The RUC expressed concern regarding the median survey time of 60 minutes for these codes as the vessels are larger than in the organs discussed in the other backbench reconstruction work (intestine, liver, and pancreas). After extensive discussion, the RUC agreed to modify the physician time. Accordingly, 50327, 50328, and 50329 will be modified to be approximately 45 minutes of intra-service time. The RUC agreed that the survey 25th percentile of 4.00 for 50327, 3.50 for 50328, and 3.34 for 50329 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two*

locations (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these services differ slightly in intensity, but are very similar in intensity and time as 35686. **The RUC recommends 4.00 for CPT code 50327, 3.50 for CPT code 50328, and 3.34 for CPT code 50329.**

Practice Expense
CPT codes 50327, 50328, and 50329 are essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Upper Arm Cephalic Vein Transposition (Tab 17)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)

The CPT Editorial Panel created a code 36818 *Arteriovenous anastomosis, open; by upper arm cephalic vein transposition* to report a new method of arteriovenous anastomosis for hemodialysis patients. This new procedure is a cephalic vein transposition that requires two upper arm incisions, one medial over the brachial artery, the other lateral to expose the vein.

The RUC reviewed survey data from 30 vascular surgeons and the presenters explained that the reference code selected by the survey respondents, 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU= 13.98) may have contributed to an overestimation of the work involved in this procedure because the reference code has 30 minutes more of intra-service work and the survey respondents rated it with a higher intensity than the new code, but the median survey value was the same as the reference service. The presenters stated that this value overstated the value of the new code given the differences in time and intensity and the median survey value was not used in developing the RUC recommendation. Instead the code was valued by comparing it to other codes in the family as well as by examining the intra-service intensity of the intra-service work. The presenters used a building block analysis that is explained as follows:

The major driver of this code is the intra-service work. Respondents rated intensity and complexity of intra-service work as essentially equal to that of reference code CPT 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU= 13.98) Intra-service time of the new code is 90-minutes compared to 120-minutes for the reference service. According to building block analysis, intra-service work of the reference code is 10.08 RVUs. Based on a linear relationship, the intra-service work of the new code should be 90/120*10.08 = 7.56 RVUs.

Pre-service work of the new code is 70-minutes compared to 25 minutes for the reference code. In both services 15-minutes may be assumed for scrub, prep, wait, since all of that work is essentially same for similar services. This leaves 55-minutes of the new code for pre-op evaluation, compared to 10-minutes for the reference code. The presenters stated that the difference is primarily due to new JCAHO requirements for performing history and physical update. According to building block analysis, the pre-service work of the reference code 36819 is 0.56 RVUs. In order to determine the pre-service work of the new code, 55 incremental minutes x 0.0224 RVUs per minute (=1.23 RVUs) should be added to the pre-service work of reference code, or pre-service work = 1.79.

Next, the post-service work of the new code can be built from reference code 36819 by subtracting the work of the hospital visits since the office visits are exactly the same. Total post-service work of the reference service is 3.34 RVUs. To obtain total post service work the work associated with one in-patient visit and 1/2 a discharge day should be subtracted. However, the new code has 15 additional minutes of immediate post-service work that should be added back at an intensity of .0224. The post-service calculation is as follows: 3.34 (total post service for 36819) minus 1x99231 minus 0.5 x 99238 plus 15 x 0.0224 = 2.40 RVUs

3.34
-.64 99231 visit
-.64 half of 99238
+.34 15 minutes x.0224
2.40 post service work

The RVW for new service, built from clinically close reference service, is the sum of intra-service (7.56), plus pre-service (1.79), plus post-service (2.40) = 11.75.

The RUC agreed with the above analysis but disagreed with the pre-service time used to calculate the recommended RVU. The RUC specifically recommends changing the pre-service evaluation time from 45 minutes to 35 minutes. Therefore the total RVU should reflect the reduction of 10 minutes of pre-service time or (10 minutes X .022=.22 RVUs). This results in a final work RVU of (11.75-.22) 11.52. The RUC then compared this value of 11.52 with intra time of 90 minutes to other codes in the family and felt it was in proper rank order with codes 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU=8.92, intra time of 75 minutes), and code 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU = 13.98, intra time of 120 minutes) **The RUC recommends a work relative value of 11.52 for code 36818.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

Endovascular Graft for Abdominal Aortic Aneurysm (Tab 18)
Gary Seabrook, MD, Society of Vascular Surgery (SVS)
Bibb Allen, MD, American College of Radiology (ACR)
Bob Vogelzang, MD, Society of Interventional Radiology (SIR)

The CPT Editorial Panel transferred a category III code (0001T) to category I status due to the FDA approval of a modular endovascular prothesis which is the device used in new code 348X1 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection;using modular bifurcated prosthesis (two docking limbs).* The RUC reviewed the survey data for this code, especially the comparison with the reference service 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)* (work RVU = 22.97). The survey median value of 24.00 RVUs was based on survey results from 63 vascular surgeons. The presenters explained that code 348X1 is very similar to the reference service and while there are some subtleties in terms of which endograft fits best in which patient, the overall spectrum of patients is the same. Deployment of the modular three-piece endograft used in 348X1 is very similar to the reference service two-piece endograft, except that 348X1 has one additional component that must be precisely deployed inside the patient. Maneuvering and deployment of this additional piece requires about 15 minutes of extra intra-service time. The intra-service intensity and complexity 348X1 is slighly higher than the reference service. The survey respondents reported a pre-sevice time of 25 minutes less for the new procedure as compared to the reference service but the presenters attributed this difference to random survey variation rather than clinical reality. Length of hospital stay, number and level of in-hospital visits, discharge day management, and the number and level of office visits is identical to the reference service. Therefore, the main difference between the two codes is an additional 15-minutes of intra-service time in the new service. The RUC agreed that this additional time and slightly higher intensity justifies a one RVU difference with the reference service and recommends the survey median of 24.00 RVUs.

The RUC recommends a work RVU of 24.00 for code 348X1.

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

Carotid Stenting (Tab 19)
Chris Cates MD, American College of Cardiology (ACC)
Ken Brin MD, American College of Cardiology (ACC)
Joseph Babb, MD, American College of Cardiology (ACC)
Bob Vogelzang, MD, Society of Interventional Radiology (SIR)
Kathy Krol, MD, Society of Interventional Radiology (SIR)
Bibb Allen, MD, American College of Radiology (ACR)
Gary Seabrook, MD, Society of Vascular Surgery (SVS)
John Barr, MD, American Society of Interventional & Therapeutic Neuroradiology (ASITN)
John Wilson, MD, American Academy of Neurological Surgeons (AANS)
Jim Anthony, MD, American Academy of Neurology (AAN)
Pre-Facilitation Committee #3
Facilitation Committee #3

The CPT Editorial Panel created two new codes to report percutaneous stent placement in the cervical portion of the extracranial carotid artery, with and without use of an embolic protection system including all associated radiological supervision and interpretation. The RUC and the presenters agreed that both codes will be added to the conscious sedation list.

37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection*
The committee reviewed the survey data and supporting additional rationale. The presenters clarified that the typical patient would not have had a diagnostic angiography, but would have carotid duplex type studies as screening tests prior to this procedure. The presenters concluded that the survey median RVW of 21.78 is too high and recommended the 25th percentile work relative value of 18.86 based on the comparison with three similarly complex and intense percutaneous interventional procedures, all of which have been RUC-surveyed. The RUC examined this rationale but first revised the pre-service time resulting in a reduction in the RVU to 18.71 due to a reallocation and reduction in pre-service time. The pre-service RVUs were reduced from 1.95 to 1.80. The presenters explained the physician work involved focusing on the high level of intensity that is maintained throughout the intra-service period. The survey intensity results reflected the high

intensity and patient risk associated with the procedure and also corresponded with the vignette. The RUC was concerned that the typical patient may change in the future but the committee agreed that for now the intensity measures and vignette were accurate. Due to ongoing trials, future applications may not be known for at least 5 years.

The RUC compared code 37215 to the reference service 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (work RVU = 14.82, RUC surveyed, 000 day global) Although the intra-service time is lower for the new code (103 minutes vs 120 minutes) all of the intensity measures supported a higher intensity. The IWPUT for the new code and the reference code are .112 and .102 respectively. The committee felt that the differences in intensity was supported by the data and the vignette.

In addition, the RUC reviewed a variety of building block calculations that also supported the recommended value and placed the code in proper rank order and the RUC agreed that the adjusted 25th percentile survey work RVU of 18.71 is the most accurate relative value. **The RUC recommends a work RVU of 18.71 for code 37215.**

37216

The RUC reviewed the survey data and rationale for 37216 and concluded than the originally proposed value needed to be adjusted for the 8 minute reduction in pre-service time and a .15 RVU reduction in work to be consistent with the reduction in work for 37215. This resulted in a total RVU of 17.98. The committee was comfortable that this value reflected the difference of 6 minutes intra-service time between the two codes to reflect the value and time of deploying and removing the embolic protection device. This value maintains the incremental difference of .73 RVUs. **The RUC recommends a work RVU of 17.98 for code 37216.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

Complex Deep Brain Neurostimulator Generator – Transmitter Electronic Analysis (Tab 20)

James Anthony, MD, American Academy of Neurology (AAN)
Michael Rezak, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Frederick Boop, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)

John Wilson, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Pre-Facilitation Committee #3

Codes 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* and 95979 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)* describe initial or subsequent electronic analysis of an implanted brain neurostimulator pulse generator system, with programming. The RUC concluded that these codes represent new technology that was not available when the other neurostimulator codes (95971-95973) were developed and therefore complex deep brain stimulation was not included in the original valuation or vignette. **The RUC therefore recommends that the changes to codes 95971-95973 do not change the physician work and recommends 0.78 work RVUs for code 95971, 1.50 RVUs for 95972, and 0.92 RVUs for 95973.**

The presenters provided a rationale for a value of 3.50 RVUs, which is between the median and 75th percentile survey values. The most frequent reference code listed by survey respondents was 95974, *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU =3.00). This reference code and code 95978 are for the first 60 minutes of service. Survey respondents evaluated the 95978 as more complex and more intense than the reference code but the median RVU was 2.75, which was less than the reference code. The presenters concluded that the respondents incorrectly assumed that they could only allot a total of 60 minutes of time rather than 60 minutes of intra-service time and the median survey value of 2.75 RVUs would create a rank order anomaly in this family of codes, as would the 75th percentile of 5.0 RVUs. The RUC compared 95978 to several other codes such as 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 3.52 and intra-service time of 60 minutes, pre-service time of 15 minutes, and post-service time of 20 minutes). Therefore, the RUC concluded that an RVU of 3.50 for 95978 would be appropriate and would fit well in comparison to 95810 as

95978 has the same 60 minutes of intra-service time but at a higher intensity, but also has lower pre and post-service time at 5 minutes each. **The RUC recommends a work RVU of 3.50 for code 95978.**

95979

The work value for this add on code was developed by comparing the additional intra-service time to the value recommended for 95978. Since 95978 has 10 minutes of pre and post service time, the RUC felt that this time should be omitted from 95979 and only 30 minutes of intra-service work should determine the value. Therefore the value for 95979 was determined by using the recommended value of 3.50 for 95978 and reducing the value by the 10 minutes of pre/post service (10 X.0224) = .224 3.50-.224=3.28. The value of 3.28 represents the 60 minutes intra-service work of 95978. This value is then cut in half to represent only the 30 minutes of intra-service work for 95979 for a total RVU of 1.64. **The RUC recommends a work RVU of 1.64 for code 95979.**

Practice Expense

The RUC accepted the proposed practice expense inputs without modification. The presenters clarified that clinical staff employed by the physician are involved in programming the neurostimulator and this work is not performed by equipment manufacturer representatives. The clinical staff time to assist the physician was set at 2/3rds of the physician intra-service time.

Cervical Laminoplasty (Tab 21)

John Wilson, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Richard Boop, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Charles Mick, MD, North American Spine Society (NADD)

The CPT Editorial Panel created these two new codes to describe a different method of cervical laminoplasty which is an alternative approach for posterior decompression of the cervical spinal cord. The presenters recommended the survey 25th percentile value of 20.75 RVUs for 63050 *Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments*. The RUC reviewed the survey data and considered the similarities and differences between reference code 63015 *Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical* (work RVU = 19.32) and 63050 *Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments*. The presenters explained that the typical number of vertebral segments will be four or five. Code 63015 identifies a multisegmental cervical laminectomy for decompression of spinal stenosis without facetectomy, foraminotomy or

diskectomy. For 63015, the posterior elements of the spine are completely removed, as compared with 63050, where the posterior elements are left intact on one side to allow for expansion of the cross sectional area of the spinal canal. This is more difficult and the intensity is greater because of the degree of precision required to expand the spinal canal without removing the laminae, while avoiding putting pressure on the spinal cord. The presenters explained that the survey respondents overestimated the additonal work invovled in 63050 and recommended the 25th percentile to keep the code in proper rank order. The RUC reduced the pre-service time slightly, but maintained the median intra-service time of 150 minutes. The survey 25th percentile RVW of 20.75 is slighlty higher that the reference code and reasonably accounts for the greater intensity/complexity of the intraoperative work for relative to 63015. **The RUC recommends a work RVU of 20.75 for code 63050.**

63051

Code 63051 adds reconstructive work to 63050. The discussion of work differences for 63050 compared to the reference serivce 63015 are the same for 63051. Therefore, the survey 25th percentile RVW of 24.25 would be appropriate to maintain proper rank order. This value is 3.50 RVUs greater than 63050 and reasonably accounts for the additional 40 minutes of intraservice work for reconstruction. In addition, the pre-service time was changed to match the pre-service time of 63050. **The RUC recommends a work RVU of 24.25 for code 63051.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

Osteoplastic Laminectomy Reconstruction (Tab 22)
John Wilson, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Richard Boop, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS)
Charles Mick, MD, North American Spine Society (NADD)

The CPT Editorial Panel created new code 63295 *Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)* to describe osteoplastic reconstruction of a laminectomy defect. In contrast to code 22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (work RVU = 12.56) where pedicle screws and plates are utilized for reconstruction, 63295 is a reconstructive technique where the dorsal elements of the spinal segment, including the laminae, spinous processes, and ligamentous structures are reconstructed and replaced into the spine. This results in a more normal

anatomic architecture, biomechanical properties, and a limit of post-surgical spinal deformity.

The presenters concluded that the survey median (RVU=15.00) and 25th percentile (RVU=8.00) RVWs were inconsistent with the difference in work between the two new laminoplasty codes (63050 and 63051 or 3.50 RVUs), which represents the work of reconstruction and would overstate the physician work of this code. The presenters instead recommended an RVW of 5.25, which is equal to the difference between 63050 work RVU 20.75 and 63051 work RVU = 24.25 multiplied by 1.5 to account for performing 63295 bilaterally. The RUC agreed not to double the difference in RVUs because the work to perform 63295 bilaterally is not twice the work to perform the reconstruction in 63051. For 630512, reconstruction is unilateral, but occurs within the body, near the spinal cord and therefore is more intense. For 63295, the laminae are removed and part of the bilateral reconstructive work is performed on the backbench, away from the spinal cord. A value that represents 1.5 times the work of the reconstruction in 63051 reasonably accounts for the additional bilateral work. **The RUC recommends a work RVU of 5.25 for code 63295.**

Practice Expense
Since this is an add on code performed only in the facility setting, the RUC recommends zero zero direct inputs.

Gastric Restrictive Procedure (Tab 23)
Michael Edye, MD, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)
Christine Ren, MD, American Society of Bariatric Surgeons (ASBS)

CPT created three new codes to describe gastric restrictive procedures. The specialty presented only two of the codes and will present the remaining code in the future. These two procedures, 43644 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* and 43645 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* achieve the same results as the open procedures 43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy* (work RVU = 24.01) and 43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption* (work RVU = 26.88) but there is considerably less post operative pain for the patient and a less lengthy incision. Over the past 10 years, the field of bariatric surgery has rapidly expanded and the new codes revise and enhance the existing code set for bariatric surgery.

43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)* The specialty was not able to conduct a survey for this service during the current 2005 cycle. It is anticipated that a survey will be completed in the future, perhaps by the September 2004 RUC meeting. The RUC understands that this is an infrequently performed surgery, particularly to Medicare patients. Therefore, the RUC recommends that this code be carrier priced for 2005.

43645 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption*
The presenters discussed code 43645 first and stated that although the survey respondents chose the corresponding open codes 43846 and 43847 as the reference code, the presenters felt that a better comparison would be between the new codes and other laparoscopic codes. The presenters felt that the open codes may be misvalued and were not based on complete RUC survey data, while the laparoscopic codes do have complete RUC survey data. The presenters stated that code 43645 is very similar in terms of breadth and depth and total work to another laparoscopic procedure, CPT 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (work RVU= 29.96). New code 43645 involves dividing both stomach and small intestine and completing two anastomoses in the technically challenging surgical terrain of the morbidly obese. The pre-, intra- and post-times and work are very similar to 44207. Also a value of 29.96 correctly places 43645 greater than another similar laparoscopic code, 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04), which includes only one anastomosis. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 45 minutes was assigned to evaluation and 30 minutes for positioning. This would not change the total pre-service time. **The RUC recommends a physician work RVU of 29.96 for code 43645.**

43644 Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) was reviewed in comparison to 43645. The RUC agreed that code 43644 has the same intraoperative complexity/intensity as 43645 however, there is 20 minutes less intraoperative time. The presenters recommended an RVU of 27.83 based on subtracting 20 minutes of intraservice time (at an intensity of .106 from code 43645) from the recommended value for 43645 of 29.96 (20 x 0.106). This RVW correctly places new code 43644 less than 43645 and relative to 44207. The RUC agreed with this methodology. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 30 minutes was assigned to evaluation and 30 minutes for positioning. This would not change the total

pre-service time. **The RUC recommends a physician work RVU of 27.83 for code 43644.**

Practice Expense
The RUC recommended the standard inputs for a 90 day global period code that is performed only in the facility setting.

Proximal to Splenic Flexure Colonoscopy Aspiration – Biopsy (Tab 24)
Michael Levy, MD, American Society for Gastrointestinal Endoscopy (ASGE)
Joel Brill, MD, American Gastroenterological Association (AGA)
Facilitation Committee #3

The CPT Editorial Panel added two new codes to describe a colonoscopy with ultrasound examination, with or without a biopsy. While two codes (45342 and 45341) are adequate to report the endoscopic examination of the rectum and sigmoid colon in combination with endoscopic ultrasound evaluations, they do not adequately describe the endoscopic examination of the entire colon in combination with an endoscopic ultrasound evaluation. Performing colonoscopy and endoscopic ultrasound evaluation of a detected abnormality with or without transendoscopic ultrasound guided fine needle aspiration/biopsy(s) during the same procedure is clinically useful to expedite the diagnostic work-up and to spare patients the added risk, discomfort, inconvenience and expense of multiple procedures.

45391
When the specialty society reviewed the physician work involved in code 45391 *Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination*, the proposed increment was 1.64. The increment was through the RUC's comparison of the work value for the base sigmoidoscopy code 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = .96) and compared this to code 45341 *Sigmoidoscopy, flexible; with endoscopic ultrasound examination* (work RVU= 2.60) for a difference of 1.64 RVUs for the ultrasound examination. This value of 1.64 was then added to the base colonoscopy code 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure*) (3.69 + 1.64) for a total value of 5.33 RVUs. However, the RUC felt that this increment (1.64) was too large and reduced the increment to 1.40, based on the same rationale to extract the ultrasound portion of work of a similar code under review, 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)*. In this code the RUC recommended subtracting the intra-service work of 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) from 43231 *Esophagoscopy, rigid or flexible;*

with endoscopic ultrasound examination (Work RVU = 3.19) to capture only the ultrasound portion of work, resulting in a work RVU of 1.40. For code 45391, the RUC recommends to add the base colonoscopy code, 45378, plus the new increment (3.69 + 1.40 = 5.09). **Therefore, the RUC recommends a 5.09 work RVU for 45391.**

45392

After extensive discussion the RUC felt that in order to maintain relativity between 45391 and 45392 using the 1.40 increment method of valuation for code 45392 *Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)* was appropriate and was consistent with previous RUC efforts to value a family of GI transendoscopic ultrasound and the needle/aspiration/biopsy codes. Therefore the specialty society recommended work RVU of 6.54 was also decreased by 0.24 applying the same 1.40 increment as 45391. There is also a difference of 20 minutes of intra-service time between 45391 and 45392 which the RUC felt that it was reasonable to apply the 1.40 increment to code 45392 in order to keep maintain the proper rank order. **The RUC recommends a 6.54 work RVU for 45392.**

In addition, the RUC understood that these procedures typically required conscious sedation in a facility setting, and therefore should on the conscious sedation list.

Practice Expense

The RUC assessed and modified the practice expense. Since these two codes are conducted in-facility only, a 000 day global would not have discharge day management time. Therefore, the RUC removed six minutes in each code for discharge day management time and added a three minute call in the post-op time.

Rectal Barastat Sensation Test (Tab 25)

Joel Brill, MD, American Gastroenterological Association (AGA)
Michael Levy, MD, American Society for Gastrointestinal Endoscopy (ASGE)

The CPT Editorial Panel created this code to describe the comprehensive assessment of sensory, motor and biomechanical function of the rectum in patients with irritable bowel syndrome, constipation and/or fecal incontinence.

91120

The RUC reviewed the specialty's survey results for 91120 *Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)*. The survey respondents recommended a median work RVU of 2.0, a 25th

percentile work RVU of 1.70 and low work RVU of 1.30. The survey respondents indicated that 91120 was comparable to the reference service code 91122 *Anorectal manometry* (Work RVU=1.77). However, the specialty society indicated that the reference code 91122 is not a good comparison when examining service time and intensity associated with this code. Accordingly, the specialty society based the values on the work value assigned to codes presented at the January 2004 RUC meeting, 91034 *Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation* (Work RVU=0.97) and 91037 *Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation* (Work RVU=0.97). The RUC felt that these codes were comparable in terms of the time and intensity. In addition, this valuation will keep this family of diagnostic codes in the proper rank order. **The RUC recommends adjusting the physician pre-service time to 15 minutes, the intra-service time of 15 minutes and the post-service time of 15 minutes, totaling 45 minutes. Therefore, the RUC recommends a work RVU of 0.97 and total physician time of 45 minutes for code 91120.**

CPT Code	Pre-Service	Intra-Service	Post-Service	Recommended RVU
91120	15 minutes	15 minutes	15 minutes	0.97

Practice Expense

The RUC reviewed and agreed with the specialty society's intra-service clinical labor time in the non- facility setting of 10 minutes and decreased the discharge day management time from five minutes to zero. In addition the supplies and equipment were assessed, modified and accepted by the RUC.

Esophageal Balloon Provocation (Tab 26)

Joel Brill, MD, American Gastroenterological Association (AGA)
Michael Levy, MD, American Society for Gastrointestinal Endoscopy (ASGE)

The CPT Editorial Panel created this code to describe an esophageal balloon distention provocation study, a test which helps identify an esophageal cause for non-cardiac chest pain. Current tests such as code 91030 *Esophagus, acid perfusion (Bernstein) test for esophagitis*, lack sensitivity and specificity needed to treat these patients. Other current CPT codes only examine acid causes for chest pain in patients with gastroesophageal reflux (GERD).

91040

The RUC reviewed the survey results for 91040 *Esophageal balloon distension provocation study*. The survey respondents indicated that 91040 was comparable to the reference service code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study*

(Work RVU=1.25). However, the specialty society indicated that the reference code 91010 is not a good comparison when examining service time and intensity associated with this code. Accordingly, the specialty society based their recommended values for 91040 on the work value assigned to codes 91034 *Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation* (Work RVU=0.97) and 91037 *Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation* (Work RVU=0.97) presented at the January 2004 RUC meeting. The RUC felt that these codes were comparable in terms of the time and intensity. In addition, this valuation will keep this family of diagnostic codes in the proper rank order. **The RUC recommends adjusting the surveyed physician pre-service time to 15 minutes, adjusting the surveyed intra-service time to 15 minutes and use the survey post-service time of 15 minutes, totaling 45 minutes. Therefore, the RUC recommends a work RVU of 0.97 and total physician time of 45 minutes for code 91040.**

CPT Code	Pre-Service	Intra-Service	Post-Service	Recommended RVU
91040	15 minutes	15 minutes	15 minutes	0.97

Practice Expense
The RUC reviewed and agreed with the specialty society's intra-service clinical labor time in the non- facility setting of 10 minutes and decreased the discharge day management time from five minutes to zero. In addition the supplies and equipment were assessed, modified and accepted by the RUC.

Ciliary Endoscopic Ablation (Tab 27)
Stephen A. Kamenetzky, MD, American Academy of Ophthalmology (AAO)

The CPT Editorial Panel revised an existing code and added a new code to separately report endoscopic and transscleral cyclophotocoagulation for the treatment of glaucoma.

The RUC reviewed the survey results of 22 ophthalmologists from the specialty society in regard to the valuation of 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic* and determined that the reference code, 67010 *Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy* (Work RVU=6.86) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more pre-service time than the reference code, 25 minutes and 19 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort and judgment, higher technical skill, and a higher intra-service intensity than the reference code. After reviewing the survey data, the RUC discussed several issues surrounding the valuation of this code including the fact that the surveyed code has several higher intensity office visits (4-99213 and 1-99212) associated with

it than the reference service code (4-99212). The specialty society explained that because these patients have severe glaucoma and have failed many other procedures, the next step would be to perform this invasive procedure. Because this procedure involves the making and closing of two incisions in the eye as well as the direct application of the endo-laser to ciliary body, this number and level of intensity follow-up office visits would be required to ensure a safe intra-occular pressure of the eye. In addition, the RUC discussed the issue of budget neutrality with the concern that there would be a large shift of patients who would be treated with this new procedure instead of the existing potentially lower valued procedures. The specialty society explained that there would be a small shift in patients because people with little to moderate glaucoma would respond to less invasive treatments. This procedure would only be used for those patients with severe glaucoma which considering the entire pool of glaucoma patients would be a relatively small number of patients. After discussion of these issues as well as the comparison to the reference code the RUC agreed with the specialty society recommendation of the 6.60 work RVUs for 66711, the specialty society's survey median. **The RUC recommends a work relative value of 6.60 for 66711**.

Practice Expense

The specialty society recommended the standard 090 day global practice expense inputs with modifications made to the supplies to remove ten pairs of sterile gloves as they are already included in the ophthalmology visit packages. Other modifications included the adding of half a discharge day management service to the clinical labor time. The modified practice expense recommendations were attached to the CMS submission.

Ophthalmic Ultrasound (Tab 28)

Stephen A. Kamenetzky, MD, American Academy of Ophthalmology (AAO)
Ronald L. Green, MD, American Academy of Ophthalmology (AAO)
Pre-Facilitation Committee #1

The CPT Editorial Panel revised four codes and created a new code to report contact B-scan and quantitative A-scan performed during the same patient encounter. This action was instigated by the potential removal of a CCI edit by CMS which did not allow the A-scan and B-scan to be performed in the same visit if the descriptor for CPT code 76512 *Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan)* did not include an A-scan.

76511 and 76512

Upon reviewing the specialty society's recommendations, the RUC agreed that the survey data for 76511 and 76512 was flawed. The survey appeared to indicate that performing both the A and B scan during the same inpatient

encounter took the same amount of intra-service time as performing each exam separately. The society constructed the recommendations through a consensus panel and determined to maintain the value of 76511 *Ophthalmic ultrasound, diagnostic; quantitative A-scan only* (Work RVU=0.94) citing that the uterine ultrasound codes, 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation* (Work RVU=0.99, Pre-Service Time=5 minutes, 15 minutes Intra-Service Time and 7 minutes Post Service Time) and 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (Work RVU=0.99, Pre-Service Time= 5 minutes, Intra-Service Time=15 minutes, Post Service Time= 6 Minutes) that the RUC recently reviewed provided the best reference codes due to the similar intensity and physician times. The RUC agreed with this rationale and recommends maintaining the value of 76511. The specialty society also recommended that 76511 and 76512 *Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan*) had equivalent intensities and technical skill. In addition, the specialty society reviewed the survey information presented by the specialty society and agreed with that 76511 and 76512 had similar physician times:

	76511	76512
Pre-Service Time	5 Minutes	10 Minutes
Intra-Service Time	15 Minutes	15 Minutes
Post-Service Time	10 Minutes	10 Minutes
Total Time	30 Minutes	35 Minutes

Therefore, the RUC agreed with the specialty society recommendation of cross-walking the recommended work RVUs from 76511 to 76512. **The RUC recommends a work relative value of 0.94 for 76511 and 76512.**

76510

Because of the flawed survey data, the specialty society used a consensus panel to develop work relative value recommendations for 76510 *Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter*. The specialty society implemented a building block methodology to determine the work RVUs for 76510 based on the recommended values for 76511 and 76512. The specialty society recommends adding the recommended work RVUs for 76511 and 76512 and then removing the work associated with the pre-service time of 76512 and half of the work associated with the post-service time of 76512 and ultimately achieved a value of 1.55 work RVUs for 76510. The calculation is as follows:

Recommended Work RVU 76511	0.94
Recommended Work RVU 76512	0.94
	1.88
Pre-Service Work of 76512	- 0.22
	1.66
Post-Service Work of 76512	- 0.11
	1.55
Recommended Work RVU for 76510	

The RUC agreed with the specialty society recommendation. **The RUC recommends a work relative value of 1.55 for 76510.**

Practice Expense
The specialty society presented their recommendations for practice expense inputs and informed the RUC that 76512 would be reported in conjunction with an evaluation and management service and therefore made modifications to the clinical labor time accordingly. The practice expense inputs were attached to the CMS submission.

Pelvic Floor Defect Graft Repair (Tab 29)
Robert Harris, MD, American College of Obstetricians and Gynecologists (ACOG)
George Hill, MD, American College of Obstetricians and Gynecologists (ACOG)
Sandra Reed, MD, American College of Obstetricians and Gynecologists (ACOG)

The CPT Editorial Panel created a new code to describe a new improvement in female reconstructive surgery i.e. the insertion of mesh or other prothesis for the repair of a pelvic floor defect via the vaginal approach.

The RUC reviewed the specialty society's recommendations for 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* and agreed that because the survey respondents may have been confused by the concept of an add-on code and that as a result physician time and work recommendations were inflated, information gathered by the consensus panel regarding physician time and work RVU recommendations would be more appropriate to review. The RUC reviewed the consensus panel's recommendation of physician pre-service time, 5 minutes, and felt that this was inappropriate because this time is accounted for within the base code for vaginal repair and therefore removed this time resulting in a physician time recommendation of only 45 minutes of intra-service time. To construct a relative value recommendation the society made a comparison to CPT code 49568 *(Implantation of mesh or other*

prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)(RVU=4.88, Intra-Service Time=52 minutes). The RUC agreed that the physician work of the reference service and the surveyed code was similar in physician time and intensity was able to make a good cross-reference. The specialty clarified that this service is typically provided using a single approach and reporting this code once in response to questions on whether the code could be reported for both the posterior and anterior approach. **The RUC recommends a work RVU value of 4.88 for 57267.**

Practice Expense
There is no practice expense inputs associated with this procedure since it is an add-on code performed in the facility setting only.

Endometrial Cryoablation Therapy (Tab 30)
Robert McLellan, MD, American College of Obstetricians and Gynecologists (ACOG)

The specialty society did not present survey data for CPT code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage when performed* at the April 2004 RUC meeting as it was first necessary to seek clarification on the code descriptor at the May CPT Editorial Panel meeting. The RUC recommends that this infrequently performed service be carrier priced in 2005. The RUC anticipates that it will review survey data for this code at the September 2004 meeting. **The RUC recommends that CPT code 58356 be carrier priced in 2005.**

Hysteroscopic Fallopian Tube Cannulation and Microinsert Placement (Tab 31)
George Hill, MD, American College of Obstetricians and Gynecologists (ACOG)
Craig Sobolewski, MD, American College of Obstetricians and Gynecologists (ACOG)

The CPT Editorial Panel has created a new code to report female sterilization via hysteroscopy that avoids abdominal incisions for access to the fallopian tubes.

The RUC reviewed the recommendations for 58565 *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants* forwarded by the specialty society. The society felt that the survey times and hospital/office visits associated with the new code were incorrect due to the inexperience of the survey respondents and therefore, the specialty society, using a consensus panel assigned the following times:

60 minutes	Pre-service time
50 minutes	Intra-service time
30 minutes	Post-service time
18 minutes	Half a discharge day management visit (99238)
30 minutes	2 –level two office visits (99212)

Using these newly assigned times, the RUC used a building block approach to determine the work RVU recommendation for 58565. The RUC agreed that the recommended work RVU for the new code should be constructed by adding the work RVUs of 58559 *Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)* (Work RVU=6.16) and two-level two office visits 99212 *Office/outpatient visit est.* (Work RVU=0.43) resulting in 7.02 work RVUs. The RUC felt comfortable using 58559 as a reference code because there was similar time and intensity in comparison to the new code. **The RUC recommends 7.02 work RVUs for 58565.**

Practice Expense

There was significant discussion regarding the clinical labor time of 58565. The society recommends that there are two staff members assisting the physician while performing the service. The society explained that one scrubbed staff member, an RN/LPN/MTA, is assisting the physician manipulate the catheter used in coordination with the hysteroscope while the other staff member, an RN, is assisting the physician with the actual procedure. The RUC agreed with this rationale and made further modifications to staff times to be consistent with PEAC accepted standards. The supplies were modified to include a cleaning scope pack and the removal of one gown.

Doppler Velocimetry, Umbilical and Middle Cerebral Arteries (Tab A)
American College of Obstetricians and Gynecologists (ACOG)

The specialty society did not present survey data to the RUC at the April 2004 meeting. The specialty will be re-surveying CPT codes 76820 *Doppler velocimetry, fetal; umbilical artery* and 76821 *Doppler velocimetry, fetal; middle cerebral artery* for presentation to the RUC at the September 2004 meeting. **Accordingly, the RUC recommends that CPT codes 76820 and 76821 be carrier priced in 2005 until the RUC has the opportunity to review recommendations expected to be presented at the September 2004 meeting.**

Dual X-Ray Absorptionmetry for Vertebral Assessment (Tab B)
Bibb Allen Jr., MD, American College of Radiology (ACR)
Sanford Baim, MD, International Society for Clinical Densitometry (ISCD)

In order to create more clarity in the service of dual energy x-ray absorptiometry, bone studies on the vertebra, the CPT Editorial Panel created code 76077 *Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment* and editorially changed code 76075 *Dual energy x-ray absorptiometry (DXA~~DEXA~~), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)* (Work RVU=0.30). The changes specify the service of vertebral fracture assessment, as a low radiation lateral examination creating an enhanced view of the vertebra to assess bone density and vertebra fracturing.

76077
The RUC reviewed the survey results for this new code and understood that it would typically be billed with code 76075 and sometimes with code 76076 *Dual energy x-ray absorptiometry (DXA~~DEXA~~), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (Work RVU=0.22). The specialty society and the RUC believed that since 76077 was typically billed with another service, the pre-service and post-service physician time would be lower than the specialty's survey results indicated. **The RUC recommends one minute for pre-service, and one minute of immediate post-service physician time.**

The RUC and the specialty society believed that to establish a proper rank order code 76077 should be valued below 76075 and 76076. The specialty recommended the 25th percentile survey results to create the rank order of the family of codes. The RUC agreed with the specialty's recommendation of 0.17 work relative value units. **The RUC recommends a work relative value of 0.17 for code 76077.**

Practice Expense
The RUC reviewed the practice expense inputs for code 76077 in relation to existing codes 76075 and 76076. The RUC agreed with the practice expense inputs recommended by the specialty. The RUC recommends no practice expense inputs in the facility setting and the non-facility inputs were attached to the CMS submission.

Positron Emission Tomography and computed Tomography Procedures (Tab C)
Bibb Allen Jr., MD, American College of Radiology (ACR)
Kenneth McKusick, MD, Society of Nuclear Medicine (SNM)
Pre-Facilitation Committee #2

The CPT Editorial Panel agreed to delete one code and added six new codes to allow for more specificity in the levels of physician work for positron emission tomography (PET). The Editorial Panel created three separate codes for tumor imaging and three additional codes for tumor imaging with CT, with varying levels of physician work.

78811-3
The entire set of new CPT codes were pre-facilitated by the RUC so that the specialty society and the RUC had a firm understanding of the physician work involved in all of the codes. It was understood by the specialty society and the RUC that the typical PET service had changed since it was first reviewed by the RUC in 1994. Newer technologies allowed for less physician time for the typical patient but a more comprehensive study is involved. The RUC reviewed the specialty society's reference code 78810 *Tumor imaging, positron emission tomography (PET), metabolic evaluation* (Work RVU = 1.93, RUC reviewed September 1994) in relation to the three new codes. The RUC believed that the work of 78810 was similar to the new code 78812 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck); skull base to mid-thigh.* In addition, code 78813 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck);whole body,* represented more physician work than code 78810, and code 78811 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck); limited area (eg. Chest, head/neck)* represented less work than 78810.

CPT Code	Descriptor	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	IWPUT	RUC Recommended Work RVU
78811	**Tumor imaging, PET; limited area (eg, chest, head/neck)**	**10**	**20**	**10**	**40**	**.055**	**1.54**
78812	**Tumor imaging, PET; skull base to mid-thigh**	**10**	**30**	**10**	**50**	**.049**	**1.93**
78813	**Tumor imaging, PET; whole body**	**15**	**30**	**10**	**55**	**.048**	**2.00**

The RUC recommended values for 78812 and 78813 to correspond to the 25th percentile work values from the specialty's surveys. The 25th percentile value for 78811 value could not be justified based on the survey times, and therefore was calculated based on a ratio of the survey times (80% of 78812). **The RUC recommends the following relative work values for codes 78811-3 shown in the table below:**

78814-6

Codes 78814-6 were reviewed in relation to the specialty society's reference code 78810 *Tumor imaging, positron emission tomography (PET), metabolic evaluation* (Work RVU = 1.93, RUC reviewed September 1994). The RUC believed that the 25th percentile survey results for these three codes would best represent the work associated with 78814, 78815, and 78816. This was validated by the RUC based on the intra service work per unit of time (IWPUT) for each of the codes. **The RUC recommends the following relative work values for codes 78814-6 shown in the table below:**

CPT Code	Descriptor	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	IWPUT	RUC Recommended Work RVU
78814	**Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)**	**15**	**30**	**15**	**60**	**.051**	**2.20**
78815	**Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; skull base to mid-thigh**	**15**	**35**	**15**	**65**	**.051**	**2.44**
78816	**Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; whole body**	**15**	**40**	**15**	**70**	**.046**	**2.50**

Practice Expense for 78811-6

The RUC reviewed the practice expense inputs for codes 78811-X6 in relation to codes 78306 *Bone and/or joint imaging; whole body* and 78803 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)*. The RUC lowered some clinical staff times to eliminate any duplication in clinical staff activities. The RUC also adjusted the medical supplies to only those necessary for the procedures. **The revised RUC recommended practice expense inputs were attached to the CMS submission.**

Radiopharmaceutical Therapy (Tab D)
Bibb Allen Jr., MD, American College of Radiology (ACR)
Kenneth McKusick, MD, Society of Nuclear Medicine (SNM)
Pre-Facilitation Committee #2

In CPT Editorial Panel revised its radiopharmaceutical therapy family of codes by deleting eight CPT codes, creating 3 new codes, and editorially changing five codes to define these services according to the route of administration rather than disease specific. The RUC approached the CPT revisions in three separate issues, oral, intravenous, and intra-arterial administration. The RUC examined the CPT Panel's revisions to the family of codes regarding changes in physician work and work neutrality.

79005
Reference code 79000 *Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient* (Work RVU = 1.80, MPC listed) was reviewed in relation to new code 79005 *Radiopharmaceutical therapy, by oral administration*. The RUC believed that 79000 was the appropriate reference code for the survey instrument. 79005 *Radiopharmaceutical therapay, by oral administration*, has replaced code 79000 and the following other codes:
79001 *Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy* (Work RVU=1.05)
79020 *Radiopharmaceutical therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient* (Work RVU=1.05)
79030 *Radiopharmaceutical ablation of gland for thyroid carcinoma* (Work RVU = 2.10)
79035 *Radiopharmaceutical therapy for metastases of thyroid carcinoma* (Work RVU = 2.52)

The RUC believed that the physician time elements listed as the survey results for new code 79005 may be inappropriate for the service being provided. The RUC believed the survey reported intra-service and immediate post operative work physician times were too high for the service provided. The RUC recommended lower times listed below, and were then comfortable with the physician work relative value recommended by the specialty society, which was the same as code 79000. In addition, it was understood by the RUC that the typical patient is being treated for Grave's disease, and the radiologist or nuclear medicine physician administrating a radiopharmaceutical would not include an E/M service on the same day of service for 79005. **The RUC recommends that the following physician time and work relative values for code 79005.**

CPT Code	Pre-Service Time	Intra-Service Time	Immediate Post Service Time	RUC Recommended RVU
79005	**20 minutes**	**15 minutes**	**10 minutes**	**1.80**

79101

Reference code 79400 *Radiopharmaceutical therapy, nonthyroid, nonhematologic by intravenous injection* (Work RVU = 1.96) was reviewed in relation to new code 79101 *Radiopharmaceutical therapy, by intravenous administration*. The RUC believed that 79400 was the appropriate reference code for the survey instrument, and that code 79101 has appropriately replaced it and code 79100 *Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy* (Work RVU=1.32). The specialty society and the RUC believed that the survey data supported a work neutral relative value of 1.96, although the median survey value was 2.10. The RUC also reviewed recently reviewed code 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion* (Work RVU = 2.25, RUC reviewed April 2003). Although the physician time components were similar for 79403 and 79101, 79403 is a much more intense service. Therefore, by valuing 79101 less than 79403, the proper rank order is established. **The RUC recommends a relative work value of 1.96 for code 79101.**

79445

The RUC agreed with the specialty society using code 79400 as its reference code for new code 79445 *Radiopharmaceutical therapy, by intra-arterial particulate administration.* The RUC also agreed that the survey results would be typical even though the response rate was low. The RUC reviewed the specialty's survey results for code 79445, and for its rank order with 79005 and 79445. The RUC agreed with the specialty's recommendation and physician time components. **The RUC recommends a relative work value of 2.40 for code 79445.**

79300

The RUC believed the CPT Editorial Panel's change in the descriptor for 79300 was editorial. **The RUC therefore recommends the physician work relative value remain at 1.60 RVUs.**

Practice Expense

The RUC reviewed the practice expense inputs for codes 79005-3 in relation to codes 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion*. The RUC lowered some clinical staff times to eliminate any duplication in clinical staff activities. The RUC also adjusted the medical supplies to only those necessary for the procedures. **The revised RUC recommended practice expense inputs were attached to the CMS submission for the non-facility setting. The RUC recommends no practice expense inputs in the facility setting.**

Protein Electrophoresis (Tab E)
David C. Heibel, MD, College of American Pathologists (CAP)

The CPT Editorial Panel revised two existing codes and created two additional codes to describe the differing resources required for the analysis of serum, urine and other specimen sources by gel and capillary electrophoresis methods and to differentiate the different electrophoresis techniques (e.g. gel vs. capillary) and procedures for various specimens.

The specialty society has requested to maintain the work relative value units for the revised codes 84165 *Protein, electrophoretic fractionation and quantitatio;, serum* and 86334 *Immunofixation electrophoresis,* which both currently have a 0.37 work RVUs. In addition the society requests that the work relative value units for the new protein electrophoresis codes (84166 *Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)* and 86335 *Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)*) be cross walked to these existing codes (84165 and 86334). The RUC reviewed this request and felt that it was appropriate because this work relative value recommendation is consistent with other laboratory tests, which are billed with a 26 modifier for professional interpretation of services and report. In addition, the professional liability cross walk for the new codes should also be cross walked from the existing codes. **The RUC recommends that the physician times for 84165 (3 minutes of pre-service time, 5 minutes of intra-service time and 5 minutes of post-service time) be cross-walked to 84166 and the time for 86334 (4 minutes of pre-service time, 6 minutes of intra-service time and 5 minutes of post-service time) be cross-walked to 86335. The RUC recommends 0.37 work RVUs for 84165, 84166, 86334, and 86335**.

Practice Expense
The RUC reviewed the practice expense recommendations for 84165, 84166, 86334 and 86335. The RUC agreed with the specialty society to crosswalk the clinical labor time (8 minutes) from the existing codes to the new codes. However, the RUC felt that these inputs should be interim until the Practice Expense Subcommittee reviews with the specialty society the overall rationale of assigning practice expense inputs to the professional component of the pathology services.

Flow Cytometry (Tab F)
Stephen N. Bauer, MD, College of American Pathologists (CAP)

The CPT codes descriptors for CPT codes 88184 – 88189 describing flow cytometry were not finalized until the May 2004 CPT Editorial Panel meeting. Therefore, the RUC was unable to review recommendations for these services at our April 2004 meeting. The RUC anticipates that it will review recommendations for these services at the September 2004 RUC meeting. **The RUC does not submit any recommendations for CPT codes 88184-88189 at this time.**

In Situ Hybridization (eg, FISH) Procedures (Tab G)
Stephen N. Bauer, MD, College of American Pathologists (CAP)

The specialty society responsible for developing work relative value recommendations for the CPT codes describing in situ hybridization was unable to identify physicians who had a familiarity with these procedures resulting in an inaccurate low response rate. Therefore, the RUC was unable to review recommendations for these services at our April 2004 meeting. The RUC anticipates that it will review recommendations for these services at the September 2004 RUC meeting. **The RUC does not submit any recommendations for CPT codes 88360, 88361, 88365, 88367 and 88368 at this time.**

XI. Review of Excision of Lesion Data – Develop Response to CMS (Tab H)

After discussions at the January 2004 RUC meeting, specialty society Advisors from the specialties of dermatology, general surgery, otolaryngology, plastic surgery, and podiatry agreed to survey one code from each of the six benign/malignant excision code families. Common vignettes and a common reference list were developed. All six codes were surveyed by dermatology, general surgery, and plastic surgery societies. The two codes that reference *feet* (11423 and 11623) were surveyed by podiatry (utilizing an anatomical variation to the vignette). The four codes that reference *scalp* and *face* (11423, 11443, 11623, and 11643) were surveyed by otolaryngology. The survey data, presented as Attachments A and B, clearly show that for each anatomical benign/malignant code pair, the total time, intra-time, and estimated work-RVU for excising a malignant lesion is *greater* when compared with excising a similar diameter benign lesion. The survey vignettes are shown in Attachment C. The reference table is shown in Attachment D.

We believe that the results of these surveys respond to CMS' request to prove that there is a difference in physician work for excising benign and malignant lesions with similar diameters. **The RUC submits survey results to CMS as substantiation to reaffirm the RUC's previous work-relative value recommendations from the April 2002 meeting**.

The RUC did consider comments from the American Academy of Family Physicians regarding a request to further clarify the CPT descriptors for these services. The RUC understands that there may be inconsistent payment policies regarding whether one must wait for a pathology report prior to submitting claims for these services. The RUC suggests that specialties pursue this issue with the CPT Editorial Panel if they believe it to be necessary. The CPT Editorial Panel did discuss this issue at their May 2004 meeting and understands that representatives from Dermatology will submit language to the Panel to clarify the guidelines for these services.

XII. Five-Year Review Workgroup Report (Tab I)

Doctor Meghan Gerety presented the report of the Five-Year Review Workgroup. Doctor Gerety thanked the Workgroup for all of its efforts in preparing the proposals and ground rules for the next Five-Year Review of the RBRVS. The Five-Year Review Workgroup developed a number of documents to be approved at the April 2004 RUC meeting and then submitted to CMS for consideration.

- **The RUC approved of the Compelling Evidence Standards document, as attached to these minutes. The RUC will submit the this document to CMS and clarify that the RUC is requesting CMS to publish this list of Compelling Evidence Standards as information for those preparing comments on codes for the Five-Year Review.**

- **The RUC approved the Five-Year Review Process, Work Plan, and Timetable document and will submit it to CMS. This document and the May 3, 2004 cover letter formally submitting the proposal to CMS is attached to these minutes.**

- **The RUC approved the Procedures for the August 2005 Workgroup and September/October 2005 RUC Meeting, as attached to these minutes.**

The March 2004 conference call report and April 2004 face-to-face meeting report for the Five-Year Review Workgroup were approved and are attached to these minutes.

The May 3, 2004, submission to CMS is attached to these minutes.

XIII. Professional Liability Insurance Workgroup Report (Tab J)

Doctor Gregory Przybylski thanked the PLI workgroup and Rick Ensor, CMS staff, for participating in the April 22, 2004 meeting. Doctor Przybylski reported that the PLI Workgroup had reviewed a written technical proposal from Bearing Point on the Five-Year Review of the PLI component of the RBRVS. The Workgroup reviewed specialty society comments on the specialty risk factor assignment for individual CPT codes, as well as the overall proposed methodology. The Workgroup offered a number of recommendations that CMS might consider in developing its *Proposed Rule* on the PLI refinement.

Specialty Risk Factor Assignment:

The RUC agrees with the comment from cardiology regarding the risk factor special cases exceptions and recommends the following revisions:

***Invasive Cardiology Procedures*. The following codes will receive the greater of their actual average risk factor or the risk factor for Cardiac Catheterization (3.16): ~~92980-92998~~ 92973-92974, 93501-~~9355~~93533, 93580-93581, 93600-~~9361~~93613, ~~93617-93641~~ and ~~93643~~ 93650-93652.**

General Comments Regarding Methodology:

In general, **the RUC would reaffirm its earlier recommendations made to CMS regarding PLI as many of these recommendations were not incorporated into this technical proposal.** For example, the technical proposal mentions that the dominant specialty recommendation will be considered as one option. However, this proposal does not reflect the complete recommendation on this issue and does not address the removal of the assistant-at-surgery claims from the utilization data.

In addition, a number of observations were made by specialty societies and the PLI RUC recommends the following new recommendations:

- **Any budget neutrality adjustments deemed necessary in the Five-Year Review of PLI relative values should be made to the conversion factor, rather than the relative value units. The RUC notes that this would be consistent with the application of budget neutrality in the Five-Year Review of physician work relative values.**

- **CMS should evaluate the PLI relative values related to the professional component/ technical component relative values. For example, CPT code 76092 *Screening mammography* has a global PLI RVU of 0.11, the professional component is allocated .04 and the**

technical component is allocated .07. The actual PLI risk is related to the physician review and interpretation, not the performance of the mammogram. Therefore, the current breakdown of the PLI RVUs is problematic. The RUC recommends that CMS conduct a comprehensive review of this issue during this Five-Year Review of PLI relative values.

- **The RUC expresses concern regarding the proposal's step to "normalize" the data to account for specialty concentration in higher or lower than average risk regions to avoid the purported "double counting." The RUC would like to review further information regarding this data as it has concern about these assumptions.**

- **CMS appropriately considers a differential in PLI costs for obstetrical codes. The RUC recommends that CMS also consider the increased costs for CPT codes provided by other providers for obstetric services, specifically anesthesiologists and pediatricians.**

The PLI Workgroup Report was approved by the RUC and is attached to these minutes.

A letter was submitted to CMS on June 1, 2004 regarding these RUC recommendations and is attached to these minutes.

XIV. Research Subcommittee Report

Doctor James Borgstede presented the report of the Research Subcommittee.

The Research Subcommittee discussed the development and maintenance of reference service lists. The Subcommittee concluded that the reference service lists are a specialty society prerogative but the research subcommittee will create guidelines for developing reference service lists.

The RUC passed the following recommendation:

- **The reference service list is a specialty society prerogative.**
- **The Research Subcommittee will create guidelines for developing reference service lists that will address criteria such as inclusion of MPC codes, RUC validated codes, a range of values, codes in the same family as the surveyed code, and codes with the same global period as the surveyed code.**
- **Add the following question to the summary form: "Is the reference service list consistent with the RUC guidelines? If not please explain."**

The Subcommittee also discussed a recommendation that was forwarded from the RUC's MPC workgroup to include MPC codes in the summary of recommendation form. Doctor Gage stressed that the recommendation should be changed so as not to compel specialties to include MPC codes until the MPC list has been validated by the RUC as a cross-specialty relative instrument. Doctor Gage requested that the language be changed from "should" to "may" so that specialties would not be compelled to include MPC codes. Also, other RUC members felt that just a listing of MPC codes would not be helpful without further analysis of the supporting data. Alternatively, several RUC members stated that the inclusion of MPC codes would mainly benefit specialties that do not frequently present to the RUC. It was also mentioned that including MPC codes as additional reference codes could assist the RUC in its magnitude estimation deliberations.

The RUC approved the following addition to RUC documents:

Addition to Instructions
The specialty committee, if appropriate, may compare the relative value recommendations for the newly surveyed code to existing relative values for codes on the RUC's Multi-Specialty Points of Comparison (MPC). The Summary of Recommendation form would allow the specialty to include comparisons of the relative value unit recommendations for new codes against codes with the same global periods from the MPC list. If possible, at least two reference codes from the MPC list may be chosen that have relative values higher and lower (i.e. to book-end your recommendation and show proper rank order) than the requested relative values for the code under review.

Addition to Summary of Recommendation Form

Compare the Surveyed Code to Codes on the RUC's MPC

Reference codes from the MPC list may be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

Code	**Descriptor**	**Work RVU**

The RUC approved Subcommittee Report is attached to these minutes.

Other Announcements:

- Doctor James Borgstede stated that the Research Subcommittee is assigned the task of reviewing any alternative methodologies that specialties may propose for use in the next five-year review.

Specialties considering using an alternative methodology should let the Subcommittee know as soon as possible so it can be placed on the agenda for the September, 2004 meeting.

- The Research Subcommittee was assigned the task of researching issues involved in the valuation of ultrasound procedures. Doctor Borgstede announced that a number of issues were raised such the variability in ultrasound values according to whether the procedure is a stand alone code, an add-on code or incorporated into another code. Several specialties have already been identified as having an interest in the issue such as Gastroenterology, Cardiology, Radiology, Urology, Obstetrics/Gynecology, Vascular Surgery, Neurology, Pulmonology, Ophthalmology, Urology, Emergency Medicine, Anesthesia, and Endocrinology. The RUC will solicit input from specialties so they can provide any comments for the September, 2004 RUC meeting. The initial issues identified are comparing stand alone codes vs. add on codes, examining level of invasiveness, scope of ultrasound exam, level of physician involvement, and timing of physician interpretation.

XV. Practice Expense Subcommittee

The Practice Expense Subcommittee met during the April 2004 RUC meeting to discuss the allocation of physician time components, and hear an update in the AMA's plans for practice expense data collection.

For this meeting, AMA staff obtained physician time allocations for 12 CPT codes. Subcommittee members first reviewed 8 physician time allocations presented by the American Society for Therapeutic and Radiology and Oncology (ASTRO), and then 4 from the American Academy of Orthopaedic Surgery (AAOS). One time submission from ASTRO and all of the submissions from AAOS were modified slightly from the society's original submissions, and were accepted by the RUC. All of these time allocations are shown in the full minutes of the Practice Expense Subcommittee report.

Sarah Thran from the AMA's survey research area came to this Subcommittee to provide an update on the SMS survey. There has been a significant need for more current data as CMS is currently using data from the 1999 SMS survey in its practice expense methodology. Ms. Thran announced that the AMA is in the planning and draft stage of conducting another physician survey. The survey could potentially be conducted early in 2005 and end later in the year, with delivery to CMS early in 2006. AMA will add questions requested by CMS to differentiate separately billable supplies and services provided by clinical staff. The survey topics will potentially include; practice

expenses, practice characteristics, professional liability, charity care, bad debt, EMTALA, and managed care.

The RUC Approved Practice Expense Subcommittee report is attached to these minutes.

XVI. Administrative Subcommittee Report

Doctor Chester Schmidt presented the Administrative Subcommittee Report to the RUC. The Administrative Subcommittee met to discuss two issues: 1.) Overview of Internal Medicine Rotating Seat Election Process and the RUC Database Distribution. In its discussion of the Internal Medicine Rotating Seat Election Process, the Administrative Subcommittee at the request of AMA staff agreed that there needed to be further clarification in regard to the length of a cycle for a society to be eligible for nomination to the Internal Medicine Rotating Seat of the RUC. Therefore to clarify any confusion, the Administrative Subcommittee recommends the following language to be adopted into the RUC's Rotating Seat Policies and Election Rules:

Specialty Societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle. (i.e. two years)

The RUC approved this revision to the Rotating Seat and Election Rules Policy.

In its discussion of the RUC database distribution to the Centers for Medicare and Medicaid Services (CMS) Carrier Medical Directors (CMDs), the Administrative Subcommittee raised two issues. The first issue was raised as a result of the AMA staff meeting with Legal Counsel. Legal Counsel recommended that for the RUC to consider this issue, CMS would need to write a letter to the Chair of the RUC to request that the databases be distributed to their CMDs, because the CMDs are licensed for CPT through CMS. In addition, the AMA would require an addendum to the CMS CPT License that would specifically include provisions regarding its intended use. Pending the receipt of this letter, the Administrative Subcommittee has agreed to form a workgroup to address not only this issue, but also issues surrounding broader distribution of the RUC database. This workgroup will write a report and give a presentation to the RUC pending approval of the Administrative Subcommittee. This report will be scheduled for the September 2004 Administrative Subcommittee Meeting.

In addition to discussing the CMD request, the Administrative Subcommittee addressed two other groups' request of the database. In the past, the database has been supplied to the CPT Editorial Panel with the restriction that all of the

information contained is confidential and/or proprietary and should only be used pursuant to participation in the AMA/Specialty Society RUC and CPT Processes. The Administrative Subcommittee agreed to continue to supply the CPT Editorial Panel Members with the RUC database.

The RUC approved the motion to continue to supply the CPT Editorial Panel Members with the RUC database.

The second group to request the RUC database is from individuals on the Specialty RVS Committees that do not have formal designation as a participant in the RUC process. Currently, the RUC Database license that is given upon receipt of the database, does specifically state that the distribution of the CD is for RUC members, RUC Advisory Committee members and Specialty Society Staff contacts, thus precluding distribution of the RUC database to other members of individual specialty societies. Several RUC members expressed concern about the wider distribution of the database citing that there is a strong potential for inappropriate use. In addition, RUC members agreed that the database is still incomplete and therefore would not be appropriate for use outside the CPT/RUC process.

The RUC approved a motion not to distribute the RUC database to Specialty RVS Committees.

The Administrative Subcommittee was also informed by AMA staff that at the April/May 2004 CPT Meeting, the Panel members will be discussing the proposal of changing the number of CPT meetings from four times a year to three time a year beginning with the 2007 CPT cycle. If this proposal is approved, the Administrative Subcommittee will discuss the dates of future RUC meetings to ensure that the RUC process is unaffected.

The Administrative Subcommittee Report was approved and is attached to these minutes.

XVII. RUC HCPAC Review Board Report

Ms. Mary Foto, RUC HCPAC Co-Chair, presented the HCPAC report to the RUC. The RUC HCPAC Review Board reviewed several administrative issues including the Financial Disclosure and Conflict of Interest Policies. The members were instructed that the Conflict of Interest forms needed to be signed by all members and all forms need to be received by AMA staff before the end of the meeting. In addition, the HCPAC discussed several issues involving HCPAC alternates. Doctor Whitten indicated that currently ten out of the twelve societies on the HCPAC have nominated permanent alternate members. Each specialty is encouraged to identify its permanent member and

alternate member, which may be any member it chooses, including a staff person if that person meets all membership criteria and any other criteria that the society has set for its representatives. Additionally, Nelda Spyres, LCSW regretfully had to step down as the HCPAC Alternate Co-Chair. Therefore, a new HCPAC Alternate Co-Chair will be elected at the September 2004 meeting and will complete Ms. Spyers' two-year term.

In addition, the HCPAC reviewed the recommendations for Acupuncture/ Electroacupuncture, Evaluation of Central Auditory Function and Comprehensive Tinnitus Assessment. Work relative value and practice expense input recommendations for Acupuncture/Electroacupuncture were assessed, modified and approved by the HCPAC. Additionally, the practice expense input recommendations for Evaluation of Central Auditory Function and Comprehensive Tinnitus Assessment were assessed, modified and approved by the HCPAC. These recommendations are included in the RUC HCPAC Review Board Report.

The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.

XVIII. PEAC Report

Doctor Moran updated RUC members with recent PEAC activities from the January and March 2004 PEAC meetings. The PEAC refined almost 500 codes in January, and over 800 codes at its last meeting in March 2004. In March 2004 the PEAC refined several codes were the PEAC hadn't received recommendations from specialties, and were then deemed unclaimed codes. Doctor Moran also highlighted that the PEAC had refined almost all of the codes it had been assigned, and there are only approximately 235 codes that have not been reviewed. Most of the remaining unrefined 235 codes, identified during the March 2004 meeting, had not been high priority codes and typically are low volume. The RUC discussed how these remaining codes should be refined, and made the following recommendation:

The RUC chair will have the flexibility to determine how the RUC will refine the practice expense inputs of these remaining PEAC codes.

Doctor Moran also mentioned that, as with the RUC, the PEAC was an evolving committee, and that some codes that were reviewed early on in the process went through a different refinement process than those that were refined at the last few meetings. Doctor Moran stressed that there should be a mechanism whereas the PEAC should be able to review additions or reductions in practice expenses, and correct anomalies as time goes on. He mentioned that perhaps a five year review of practice expenses should be

formed and implemented. Doctor Rich stated that the Practice Expense Subcommittee will discuss the issue at its next meeting in September 2004.

A list of modifications to the conscious sedation list from the March 2004 PEAC meeting was also submitted by the PEAC for the RUC's information.

The RUC approved the PEAC's practice expense input recommendations from both the January and March 2004 meetings, as presented.

XIX. Other Issues

Analysis of Spine Infusion Pumps (Tab P)

The Medicare Physician Payment Schedule has assigned relative values for CPT Code 62367 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming* and CPT Code 62368 - *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* for only the professional component. For reasons unknown, the technical component and the global service are carrier priced (Status C). The RUC reviewed these services in April 1995 for work and in March 2003 for practice expense inputs (previous recommendations were attached to the CMS submission). **The RUC requests that CMS consider the RUC's previous recommendations in establishing relative value units for all components of CPT codes 62367 and 62368.**

A number of referrals were made to the subcommittees at this RUC meeting:

- The Ad Hoc Physician Pre-Service Workgroup will review physician pre-time standards at the September 2004 RUC meeting.

- Ultrasound work RVUs was referred to the Research Subcommittee. Previously during the RUC meeting, the Research Subcommittee was assigned the task of researching issues involved in the valuation of ultrasound procedures. Doctor Borgstede announced that a number of issues were raised such the variability in ultrasound values according to whether the procedure is a stand-alone code, an add-on code or incorporated into another code. Several specialties have already been identified as having an interest in the issue such as Gastroenterology, Cardiology, Radiology, Urology, Obstetrics/Gynecology, Vascular Surgery, Neurology, Pulmonology, Ophthalmology, Urology, Emergency Medicine, Anesthesia, and Endocrinology. The RUC will solicit input from specialties so they can provide any comments for the

September, 2004 RUC meeting. The initial issues identified are comparing stand alone codes vs. add on codes, examining level of invasiveness, scope of ultrasound exam, level of physician involvement, and timing of physician interpretation.

- Pathology clinical staff time was referred to the PE Subcommittee

- Doctor Gee suggested that the Research Subcommittee look into electronic on-line survey forms. Doctor Rich referred this issue to the Research Subcommittee. Doctor Rich also indicated that if any specialties with experience using electronic survey forms may offer their expertise to the Research Subcommittee, such as Urology and Obstetrics/Gynecology.

- A RUC Member indicated that there is no formal process to re-review codes after a certain period of time. Doctor Rich referred this to the Administrative Subcommittee for discussion.

Doctor Whitten clarified the following:

1. In the RUC minutes, the RUC requested that CMS change the pre-service definition for 000, 010 and 090 day global periods and a letter was sent requesting this modification. Specialties should understand that this is a request and nothing has been changed in the current survey instrument. Also, instructions in the Structure and Functions book remain the same at this time.

2. In the Structure and Functions book under section III.(B)3 the words "Specialty Society representative, to the extent practicable, shall not be the same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee. The AMA shall approve all Specialty Society nominations to the AC". The intent was to keep the person presenting separate from the RUC members. Except in rare, unavoidable circumstances, it is inappropriate for a RUC member to present. If you do present, you should excuse yourself from voting and not participate in the debate as a member of the RUC. The implication is that members seated at RUC table wear a "RUC hat" and do not wear an "Advocacy hat" and should not be advocating a specialty's recommendation.

Lastly, Doctor Rich:

- Acknowledged our CMS colleagues from Baltimore for their expertise and the dedication they show.

- Commended the all specialty staffs with the improvement apparent in the preparation of their materials. He urged everyone to go back and examine how quality is affected by good preparation. Doctor Rich also urged the specialties to have the PEAC experts look at recommendations prior to presenting as well.
- Commended the PEAC for their time and their valuable input.
- Thanked AMA staff for their efforts at the meeting

The meeting was adjourned on Saturday, April 24, 2004 at 3:55 p.m.

AMA.Specialty Society RVS Update Committee
Five-Year Review Workgroup Report
April 22, 2004

The following Five-Year Review Workgroup members met via conference call on March 24, 2004 (refer to report on page 1471 of the RUC agenda book) and then face-to-face on April 22, 2004, to review and propose final documents for the five-year review including: the compelling evidence standards; Process, Work Plan, and Timetable Submission to CMS; and the Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, James Maloney, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Compelling Evidence Standards

The Workgroup recommends approval of the Compelling Evidence Standards document (page 1474 of RUC agenda book) with the following modification:

- An anomalous relationship between the code being valued and other codes. ~~multiple key reference services.~~ For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

The workgroup suggests this revision to remove any perception that these codes must be on the Multi-Specialty Points of Comparison (MPC) or any other specialty reference service list.

The Workgroup also would like to clarify that when this document is sent to CMS, the RUC intended to ask CMS to publish this list of Compelling Evidence Standards as information for those preparing comments on codes for the Five-Year Review. .

The Workgroup discussed the RUC's prior recommendation that the Standards for Compelling Evidence be published by CMS in the Notice of Proposed Rule Making (NPRM). By requesting this, the RUC intended to widely disseminate its Standards so that all commenters would have early access to the standards and, hopefully, formulate their comments using these standards. By publishing these in the NPRM, public comments would be invited about the standards, requiring CMS to comment on them and forward comments to the RUC for potential revision. The workgroup believes that the RUC's intention was to provide these standards for information only. The Workgroup recommends that the RUC convey this intention to CMS and refrain from making any formal recommendation regarding publication in the NPRM.

Process, Work Plan, and Timetable Document for Submission to CMS

The Workgroup recommends approval of the Process, Work Plan, and Timetable document (page 1479 of the RUC agenda book) with the following modification:

Modification to page ten of the document (page 1488 of the RUC agenda book):

For each code, the Workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

For each of the above actions, the Workgroup should have a reason for the action it takes. Recommended increases or decreases should only be adopted if compelling evidence has been provided by either the specialty society or those commenting that the current relative values are incorrect. Rationale must also be provided for referrals to CPT and for decisions to maintain the current relative values. In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five Year Review.

- ~~Codes cannot be withdrawn from the five-year review by a specialty society or a workgroup. The withdrawal of a recommended change is an action to accept the lower of the current work RVU or the recommended decrease.~~

The Workgroup discussed the issue of withdrawn codes in great detail. There was overall consensus that any commenter may withdraw its original comment/codes. Further, the withdrawal action should not be considered to be a comment about the code's current valuation. Therefore, the Workgroup recommends the creation of an additional action key to reflect withdrawal by the original commenter. Proposed action key # 7 reads, "Accept withdrawal by commenter, without prejudice."

Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings

The Workgroup recommends approval of the Procedures for the August 2005 Workgroup and September/October 2005 RUC Meeting (page 1492 of the RUC agenda book) with the following modification:

Modification to page two of the document (page 1493 of the RUC agenda book):

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five Year Review.

~~Codes cannot be withdrawn from the five-year review by a specialty society or a workgroup. The RUC will take an action on each code included in the submission from CMS. Therefore, if a specialty requests to withdraw a code, an action key must be recommended (eg, #2 - Maintain the current RVUs).~~

The Workgroup recommends this change to be consistent with the modification suggested in the Proposed Process, Work Plan, and Timetable document.

AMA/Specialty Society RVS Update Committee
Five-Year Review Workgroup
March 23, 2004 Conference Call Meeting

The following Five-Year Review Workgroup met via conference call on March 23, 2004: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, J. Leonard Lichtenfeld, Trexler Topping, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C. The workgroup considered specialty society comments on the *Compelling Evidence Standards*; the draft proposal to CMS; and the draft Five-Year Review Procedures document.

Compelling Evidence Standards

AMA staff indicated that twenty specialty societies responded that the draft *Compelling Evidence Standards* were fine as presented. The American College of Surgeons and the Society of Thoracic surgeons offered comments on this document. The Workgroup considered these comments and made the following revisions:

Removal of the adjectives "significant" and "seriously" as these terms may not be defined. A new sentence will be added to the preamble of the *Compelling Evidence Standards* document to reflect the sentiment that the evidence must be substantial and meet the compelling arguments.

Revision to second bullet, last sentence to read "These reference services ~~should~~ may be both inter- and intra-specialty." The Workgroup understands that specialty societies will include comparison of codes under review to codes on the MPC on the RUC *Summary of Recommendation Form*,. However, specialties are not required to include inter-specialty reference services on their surveys or to use in the formulation of their recommendation.

The Workgroup also agreed to clarify the preamble to indicate that the compelling evidence argument must be provided in the comment letter to CMS and then later to the RUC in writing on the Summary of Recommendation form.

The Society of Thoracic Surgeons (STS) requested a modification to the first and fourth bullets. The Workgroup believes that "other reliable data" incorporates the STS recommendation to add "national and other representative databases" and therefore, does not recommend an addition of this phrase in the first bullet. The Workgroup does agree that the language should be added to the fourth bullet to now read: "Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

Review of Draft Five-Year Review Proposed Process, Work Plan, and Timetable for Submission to CMS

The Workgroup reviewed the draft proposal to CMS on the Five-Year Review. This document will be submitted to CMS following the April 2004 RUC meeting. AMA staff

indicated that the appeals process section from the RUC's *Rules and Procedures* document has been included per the request in the ACS letter.

The Workgroup made a few changes to this document, including:

- Clarification regarding the initial screen of codes to indicate that a screening process will not be utilized in this Five-Year Review as the RBRVS is now fifteen years old and opportunity should be provided to review any code.

- An additional sentence was included in the surveys and alternative methodologies sections to indicate that previously approved methodologies will be considered appropriate for this Five-Year Review (eg, SVS mini-survey methodology).

- Clarification to the appeals process section to specify that a formal appeal would occur after the September/October 2005 RUC meeting and any re-consideration would be discussed at a future RUC meeting.

Review of Draft Five-Year Review Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings

The Workgroup also reviewed the draft *Procedures for the August 2005 and September/October 2005 RUC Meetings*. This document will be attached to the proposal to CMS and serves as a tool for the workgroups and RUC to use in these meetings next year.

The Workgroup made a few revisions to this document, including:

- Re-wording of sentence regarding the issue of code withdrawal from the Five-Year Review on page Two of the document to be more concise.

- Re-titled the "Discussion Checklist" to "Potential Discussion Points."

- Clarified the first bullet in this list on page three to include a RUC survey or "other approved methodology."

The Workgroup will circulate these documents to all RUC participants via the RUC agenda book and CD prior to the April 22 meeting. The Workgroup, and then the RUC, will review the documents and finalize them at the April 2004 RUC meeting for submission to CMS in late April.

AMA/Specialty Society RVS Update Committee
Five-Year Review - Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to CMS, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

  - technique
  - knowledge/technology
  - patient population
  - site-of-service
  - length of hospital stay
  - physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

  - a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and/or

- a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

Insert Letter

AMA/Specialty Society RVS Update Committee
Five-Year Review of the Work Component of the RBRVS
Proposed Process, Work Plan, and Timetable

April 24, 2004

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) played an instrumental role in both the 1997 and 2002 Five-Year Review processes to review the physician work component of the Resource-Based Relative Value Scale (RBRVS). This review is required according to Section 1848(C)2(B) of the Omnibus Budge Reconciliation Act of 1990, which requires the Centers for Medicare and Medicaid Services (CMS) to comprehensively review all relative values at least every five years and make any needed adjustments. CMS is expected to announce the initiation of the 2007 Five-Year Review in the November 2004 *Final Rule* and call for comments on the physician work relative values. The RUC submits this proposed process, work plan, and timetable for CMS to consider in its planning for this upcoming review.

This proposal will use the framework and ground rules from the previous Five-year review to outline a process, work plan, and timeframe for the upcoming Five-Year Review to begin in February 2005 and conclude with the implementation of the values on January 1, 2007. It should be noted that the time for this Five-Year Review will be similar to the previous processes, as the RUC will have approximately seven months to complete its review.

Historical Overview of Previous Five-Year Review Processes:

On February 23, 1995, the Health Care Financing Administration (HCFA) sent 70 comments on approximately 700 codes to the AMA/Specialty Society RVS Update Committee (RUC) to review and develop specific work relative value unit (RVU) recommendations for submission back to HCFA by September 1995. HCFA also forwarded comments from Medicare Carrier Medical Directors (CMDs) for 300 codes. In addition, large studies from the American Society of Anesthesiology and the American Academy of Orthopaedic Surgeons were sent for review. The American Academy of Pediatrics had also requested more than 1,500 new CPT codes to identify varying levels of work from different age groups. The RUC took on the challenge of reviewing this magnitude of codes and delivered the recommendations to HCFA, on time, seven months after receiving notice of the specific codes to be reviewed.

The RUC accomplished this task by developing a detailed process, work plan, and timetable prior to the submission of the codes to HCFA. The RUC's efforts were successful, as more than 93% of the RUC recommendations were accepted by HCFA, with a greater number accepted after a refinement panel review. Many anomalies in the RBRVS were corrected, including gynecological and neurosurgical services. In addition, the work relative values for the Evaluation and Management services were increased, both for the individual codes and all of the codes with global surgical periods. The 1997

Five-Year Review did not result in increases for all codes as the RUC also recommended decreases for more than 100 codes.

In the November 2, 1999 *Final Rule*, HCFA announced the second, Five-Year Review (2002) and stated its intention to share comments the agency received with the RUC. HCFA noted that the RUC process used during the 1997 Five-Year Review was "beneficial" and further states:

> *The RUC's perspective will be helpful because of its experience in recommending relative values for codes that have been added to, or revised by, the CPT Editorial panel since we implemented the physician fee schedule in 1992. Furthermore, the RUC, by virtue of its multi-specialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process. We emphasize, however, as we reiterated for the first Five-Year Review, that we retain the responsibility for analyzing the comments in the 2000 physician fee schedule, developing the proposed rule for 2001, evaluating the comments on the proposed rule, and deciding whether to revise relative value units. We are not delegating this responsibility to the RUC or any other organization.*

CMS received only 30 public comments in response to its solicitation of misvalued codes to be reviewed in the second, Five-Year Review. However, 870 codes were identified for review as several specialties (general surgery, vascular surgery and cardiothoracic surgery) commented that nearly all of the services performed by their specialty were misvalued. The process that the RUC utilized in the 2002 Five-Year Review was very similar to the process utilized in the 1997 Five-Year Review. Multidisciplinary workgroups were utilized to review the large number of codes. The entire RUC then reviewed and discussed the reports of these workgroups.

In October 2000, the RUC submitted recommendations to: increase the work relative values for 469 CPT codes; decrease the work relative values for 27 CPT codes; and maintain the work relative values for 311 CPT codes. As in the 1997 Five-Year Review, the RUC also referred 63 codes to the CPT Editorial Panel to consider coding changes. In addition, the RUC reviewed a comment from the American Society of Anesthesiologists that the anesthesia conversion factor was too low. The RUC was able to review a simulated work relative value for 19 anesthesia services and made specific recommendations related to these codes to CMS. The CMS published a Proposed Rule on June 8, 2001, and a Final Rule on November 1, 2001, announcing the agency's intention to accept and implement more than 95% of the RUC's recommendations on January 1, 2002.

<u>Potential Scope of the 2007 Five-Year Review</u>

The scope of the 2007 Five-Year Review is unknown at this time, as CMS comment period will not be initiated until November 2004. AMA RUC staff asked specialty

societies to share their intentions regarding the next five-year review. Thirty specialties responded to this query, indicating that as many as 500 CPT codes could be identified. Therefore, it will be prudent, and realistic, to assume that CMS will receive comments on a large number of codes and a special process will need to be developed to review these codes.

Final Rule Comment Process

In the past, CMS has announced at least a 60 day comment period for the public to identify any misvalued code for review and clarified that the scope of the review will be limited to the work relative values. The practice expense relative values were not fully transitioned until 2002 and are currently undergoing refinement. The professional liability insurance (PLI) relative values were implemented on January 1, 2000 and will be refined for January 1, 2005. The RUC has discussed this issue and has agreed that the 2007 Five-Year Review should be restricted to the review physician work relative values. While it is expected that certain elements of the direct practice expense inputs will be modified due to changes in physician time and/or number of follow-up visits, the RUC considers any independent review of practice expense to be unnecessary at this time.

In the previous comment processes, CMS has stated that their preferred format for submitting a code for review is to include the following:

- CPT code
- Clinical description of the service
- Discussion of how the work of that service is analogous to one or more reference services
- Additional information for services with global periods:
    - physician time - on the same date as the service
    - whether the patient goes home, to a hospital bed, or to an ICU on the same day
    - number, time, type of physician visits after the day of procedure until the end of the global period (distinguish between outpatient and inpatient visits).
    - CMS requests that commenters provide nationally representative data from operating room logs, reports, or medical charts to explain this post-service time.

The RUC has extensively discussed measures to ensure that each specialty society, carrier medical director, or any member of the general public has equal opportunity to comment on misvalued codes and present their argument in a uniform manner. The RUC has developed compelling evidence standards and proposes that these standards be utilized throughout the process. The RUC recommends that the existing work relative value for a code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.

These compelling evidence standards have been reviewed by the specialty societies who participate in the RUC process. The RUC believes that these standards should be

reviewed by the carrier medical directors and the public prior to their use in the comment period. Therefore, the RUC requests that CMS publish these standards in the *Proposed Rule* this spring and review comments before publishing final compelling evidence standards in the *Final Rule* in November 2004. The RUC envisions that CMS would specify the format of comment letters to include documentation of compelling evidence. The RUC also requests that CMS review and screen comment letters to make sure that they meet the minimal standards regarding compelling evidence prior to sharing with the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted. The compelling evidence standards developed by the RUC are as follows:

Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to CMS, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

    - technique
    - knowledge/technology
    - patient population
    - site-of-service
    - length of hospital stay
    - physician time

- An anomalous relationship between the code being valued and multiple key reference services. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

  - a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and/or

  - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

Timetable

April 2004	Submission of RUC Proposal on Five-Year Review to CMS
December 30, 2004	Comment period closes on public solicitation of codes to be reviewed. *Assumes publication date of CMS Final Rule of November 1, 2004*
February 1, 2005	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
February 3-6, 2005	Research Subcommittee to review any changes to the existing RUC survey instrument.
February 15, 2005	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1.
March 15, 2005	Responses to the LOI due to the AMA.
March 2005	Five-Year Review Workgroup to Review Comment Letters for codes in which there is no interest expressed to determine next steps for the review of these services.
April 28 – May 1, 2005	Summary of codes under review and specialty society assignments Research Subcommittee to review any alternative methodologies introduced.
May 9, 2005	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.

August 2, 2005	Recommendations due to the AMA from specialty societies.
August 25-28, 2005	Five-year review workgroups meet and review recommendations.
September 14, 2005	Workgroup recommendations and consent calendars sent to the RUC.
September 29 – October 2, 2005	RUC meeting to review workgroup recommendations and consent calendars
October 31, 2005	RUC recommendations submitted to CMS.
November 2005-February 2006	CMS Review
March 2006	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2006	Final Rule on Five-Year Review
January 1, 2007	Implementation of new work relative value units.

Process, Work Plan, and Policies

Drawing on the ground rules and policies from the previous five-year reviews, the following proposed process should provide the framework for the 2007 Five-Year Review.

CMS Submission and Level of Interest Process

CMS has shared the comments received within three weeks of receipt in both the 1997 and 2002 Five-Year Review processes. Therefore, we would request to receive the comments by February 1, 2005. It would also be preferable to receive the comments and list of codes in a similar format as the previous five-year reviews. This format is illustrated in attachment A and included the following fields:

1. CPT Code
2. Ref Set? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
3. Short or Medium CPT Descriptor
4. Control Number - linked the code back to a comment letter where the specific comment was identified.
5. Commenter - the specialty society or individual commented on the code (a key was provided to define acronyms).
6. Current RVU - the 2005 work RVU would be included here.

7. Rec RVU - the recommended RVU - or a note that the presenter requested an increase or decrease.
8. 1 Ref Code - Code number for a reference code identified
9. Ref Set? - an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
10. 2 Ref Code - Code number for second reference code identified
11. Ref Set ? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
12. Source - the source of the current RVU, for example, Harvard, RUC surveyed, etc (a key was included for this field).
13. Year - the year the current value was determined
14. Freq – 2004 frequency of claims for the code
15. Dif. - the difference between work RVU requested and the current work RVU.
16. % Dif. - the percentage difference between the work RVU requested and the current work RVU
17. Impact - difference in work RVU x conversion factor x frequency

The inclusion of this information in the material to the RUC was very important and crucial in the compressed schedule to review these services. The RUC will request that CMS follow this same format.

The specialty societies were extremely responsive in the previous five-year reviews in coordinating the Level of Interest process in a few weeks. The same timeframe will be necessary for this five-year review.

Initial Screen of Codes

In the 1997 and 2002 Five-Year Review processes, the RUC applied a series of initial screens to the potentially misvalued codes identified through the comment process. For example, the RUC had decided that due to the number of codes to be reviewed, it could not review low volume codes (ie, less than 1,000 per Medicare utilization). The RUC has reviewed these previous screens and agreed that they are not necessary for the 2007 Five-Year Review. The RUC believes that since the RBRVS will be fifteen years old, an opportunity should be provided to review any code. All codes that are identified should be reviewed based on the merit of the data and adherence to the compelling evidence standards.

Although the RUC agreed that an automated screening process should not be used in the 2007 Five-Year Review, the RUC is also concerned that codes not be excluded from the review if an interest has not been expressed in reviewing the code(s). Therefore, the Five-Year Review Workgroup will convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.

Surveys and Alternative Methodologies

The Research Subcommittee will review the current RUC survey used to develop work RVU recommendations at the February 2005 RUC meeting to determine if any changes need to be incorporated for the five-year review. During the previous five-year reviews, the survey instrument was substantially improved and used for the new and revised code review process after these five-year reviews were completed. However, there may be relevant questions that should be added to the current survey. For example, questions that solicits information on how the service has changed in past five years.

The Research Subcommittee will also be charged with reviewing any alternative methodologies introduced for this five-year review. At this time, it is not known whether any specialty society will be submitting any such study or request the RUC to review a specialty methodology for their services. However, if this does occur, the Research Subcommittee will be prepared to discuss these issues in April and the RUC will determine the appropriateness of any such study/methodology at their April 2005 meeting. Previously approved methodologies are acceptable and will not require a new review by the Research Subcommittee (eg, mini-survey methodology previously utilized by the Society for Vascular Surgery).

The surveys for the five-year review will be mailed to the specialty societies immediately following the April RUC meeting. As in the past, specialty societies may, if they choose, share their vignettes with the workgroup who will be reviewing their codes to receive feedback prior to the release of their surveys. Copies of all final survey instruments, including vignettes and cover letters, must be provided to the AMA for filing. The completed summary of recommendation forms will be submitted to the AMA RUC staff by August 2, 2005.

Workgroups

The previous five-year refinement processes incorporated workgroups to review the recommendations. Eight workgroups were utilized with four RUC members or RUC alternate members on each workgroup. For planning purposes, a similar structure will be implemented in the 2007 Five-Year Review process. The assignment of the workgroup Chairs, composition, and topics to be addressed will be done prior to the April 2005 RUC meeting. The RUC Chair will assign individuals to these workgroups. The workgroups will meet for organizational purposes at the April RUC meeting and for 1 and 1/2 days in August 2005 to review their assigned codes.

It should be noted that for services performed only by non-MDs/DOs, the Health Care Professionals Review Board would meet in April and September 2005 to discuss these issues.

Workgroup Rules and Policies

The attached document, *Procedures for August Workgroup and September/October RUC Meetings* was developed to guide the workgroups and to ensure consistency in the rules used by each workgroup. The Workgroup on the Five-Year Review agrees that principles in this document were appropriate and recommends that an update version of this document be forwarded as instructions for the August 2005 workgroup meetings. A few key points from this document are as follows:

- All specialty societies will have equal opportunity to collect and present data to the Workgroup meetings in August 2005. Specialty societies will not be provided with additional opportunity to collect new data following these meetings.

- Following the presentation of each code or issue, the workgroup members will ask questions of the presenters. Time permitting, other RUC members, specialty society advisors, or staff who are present should also feel free to make comments about the codes. The workgroup on the five-year review also recommends that it be explicitly stated that the entire workgroup process will be open to the presenters, and all other RUC participants who wish to attend, including the decision-making process regarding the codes under review.

For each code, the workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

For each of the above actions, the workgroup should have a reason for the action it takes. Recommended increases or decreases should only be adopted if compelling evidence has been provided by either the specialty society or those commenting that the current relative values are incorrect. Rationale must also be provided for referrals to CPT and for decisions to maintain the current relative values. In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five-Year Review.

- Because preliminary review of the materials is so important, no substitutions for attendance by workgroup members at meetings will be permitted.

RUC Review/Consent Calendar Process

At the September 29 - October 2, 2005 RUC meeting, the recommendations from each workgroup will be presented to the RUC in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, following each of the first five action keys. Codes for which the workgroup does not reach consensus will be listed individually. During the previous five-year review, there were not significant issues concerning the ability to reach consensus within the workgroups.

The workgroups will meet in executive session to discuss the codes to be extracted, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and September/October meetings.

Appeals Process

Codes on the consent calendar may be extracted by any RUC member or specialty society advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value voted upon. As required by the RUC's Structure and Functions document, a vote by two-thirds of the representatives present at the RUC meeting shall constitute passage of each RVS recommendation.

If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the specialty society, the workgroup, or the RUC chair.

The RUC also has a formal appeals (re-consideration) process included in the RUC's Rules and Procedures document. This formal appeal would occur after the September/October 2005 RUC meeting and any re-consideration would occur at a future RUC meeting. These appeals process is outlined as follows:

II. **Appeals Process for Reconsideration of RUC Recommendations**

A. If a specialty requests an appeal of a RUC recommendation, the Chair will appoint an Ad Hoc Facilitation Committee as in I.F.1. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

B. The Ad Hoc Facilitation Committee shall meet in person or by telephone conference within two weeks of receipt of a written request for an appeal.

C. All appeals of RUC decisions shall be in writing.

D. The Ad Hoc Facilitation Committee shall invite appellants to meet with the Ad Hoc Facilitation Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

E. The Ad Hoc Facilitation Committee will notify anyone who previously commented on an issue under appeal and elicit further comments.

F. The Ad Hoc Facilitation Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC.

G. The Ad Hoc Facilitation Committee shall provide its recommendation to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner.

H. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

Submission to CMS

AMA staff will develop detailed recommendations to be submitted to HCFA immediately following the September/October 2005 RUC meeting. These recommendations will be circulated to the RUC for comment prior to their submission to HCFA in October 2005.

CMS Review of RUC recommendations

The RUC will request to be invited to any Carrier Medical Director or other committee meetings convened by CMS to review the RUC recommendations. The RUC believes that this participation is necessary to clarify any questions that may arise regarding the RUC recommendations. CMS will publish a *Proposed Rule* in spring of 2006 announcing its review of the RUC's recommendation.

AMA/Specialty Society RVS Update Committee
RBRVS Five-Year Review
Procedures for the August Workgroup and Sept/Oct RUC Meetings

April 24, 2004

The August 25-28, 2005 meetings of the eight multidisciplinary workgroups and the September 29-October 2, 2005 meeting of the full RUC will be the only opportunity for the RUC to evaluate and finalize its recommendations for the RBRVS five-year review.

This document originated from the previous five-year review and has been revised to reflect actions taken by the five-year review workgroup and the RUC at the April 2004 RUC meeting.

AUGUST 2005 WORKGROUP MEETINGS

At the August 25-28 meetings, each of the eight workgroups will meet to discuss its designated codes. Agendas will be prepared for each topic and the agenda books for all eight workgroups will be distributed to all RUC members, Advisory Committee members, and staff contacts.

Just like at the full RUC meetings, Advisory Committee members attending the workgroup meetings should provide a brief oral presentation to the workgroup about their specialty society's recommendations. Presentations should follow the order of the codes on the agenda. Workgroups must cover all the codes assigned to them in the time scheduled for their meeting, and they may continue their meetings into the evening hours or begin earlier in the morning to accomplish this if necessary. Conference calls prior to the face-to-face meetings may also be appropriate. Comments should be reviewed and some action taken even if no one has submitted any recommendation for the code.

Following the presentation for each code or issue, the workgroup members will ask questions of the presenters. Time permitting, other RUC members, specialty advisors, or staff who are present should also feel free to make comments or ask questions about the codes. The entire workgroup process will be open to presenters, and all other RUC participants who wish to attend, including the decision making process regarding the codes under review.

All specialty societies will have equal opportunity to collect and present data to the workgroup meetings in August 2005. Specialty societies will not be provided with additional opportunity to collect new data following these meetings.

For each code, the workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs

3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

The workgroup may want to suggest a new RVU (action #4) if, for example, it agrees with the commenter and/or specialty society that the RVUs should be increased or decreased, but believes that a different key reference service is more equivalent to the service under review than the one initially presented by the commenter or specialty.

For all of the above actions, the workgroup should have a reason for the actions that it takes. Recommended increases and decreases should only be adopted if compelling evidence has been provided by either the specialty society or the commenter that the current RVUs are incorrect. Rationale must also be provided for referrals to the CPT Editorial Panel and for decisions to maintain the current RVUs. The only situation in which a detailed discussion and rationale may not be necessary is if the specialty society originally recommended a change and now believes that it has not developed sufficient evidence to support the change and agrees that the current RVUs should be maintained.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five-Year Review.

In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus. In other words, if four workgroup members believe the specialty's recommendation should be adopted and one member does not, that member must offer some rationale for not adopting the recommendation.

An AMA staff member will attend each workgroup's meeting to record the discussion and decisions at the meeting and draft a report from each group to the RUC. These reports will include the nature of the group discussion, the action taken and rationale for it, and other expressed opinions about the action. Workgroup members will have an (brief) opportunity to review and comment on these drafts before they are disseminated to the full RUC.

It is critical that members of the workgroup read their group's agenda material prior to their August workgroup meeting. The list on the following page is a checklist of the questions and issues that the workgroup members should consider for each code assigned to them. Each of these questions should have been considered by each workgroup member in reviewing their group's materials and/or explicitly by the group in its discussion in August **prior to** a recommendation being made to the full RUC. By having the major evaluation of each code done by a workgroup, the RUC is essentially delegating responsibility for the rigorous review that usually takes place at RUC meetings

to the workgroups. The groups need to anticipate and consider all the questions, therefore, that would have been asked if the codes were being evaluated by the full RUC.

Because preliminary review of the materials is so important, no substitutions for attendance by workgroup members at meetings will be permitted.

Doctors Rich, Gerety, and Moran will attend the workgroup meetings for the whole time but, since they are not members of a particular group, they will circulate to the various group meetings and try to help with any problems that may arise.

Potential Discussion Points

1. Has a RUC survey or other approved methodology been conducted for the code?

2. Review the survey instrument and results:

   Is the survey instrument and any cover letter and/or supplemental materials provided to respondents appropriate for a RUC survey, or does it contain leading or misleading information? (Staff will have copies of survey instruments available at the August meetings)

   Does the vignette describe the typical patient and service for the code?

   How many physicians responded to the survey?

   Were the survey responses tightly clustered around the median value or was there a large spread?

   What was the level of agreement or disagreement between the different specialties or professions surveyed?

3. Compare the work of the service being rated to the work of the key reference services. Did the specialty society and/or commenter select appropriate key reference services?

4. Compare the work, time, and work per unit time of the service to similar codes on the Multispecialty Points of Comparison (MPC).

5. Assess whether the specialty recommendation and rationale is pertinent to the comment, relevant, and includes valid data.

6. Evaluate and compare the pre-and post-work and time of the services under review, key reference services, MPC codes, noting the global periods.

7. How do the data provided and arguments made by the specialty compare to the Harvard and Medicare claims data for the code:

8. What is the nature of the compelling argument that the current RVUs are wrong? What evidence is there that the current RVUs or Harvard data for the service is currently incorrect? For example, has evidence been provided that the technology of providing the service has changed, the patient population has changed, or the providers have changed? See the RUC's Standards for Compelling Evidence and make certain that at least one of these standards are met.

9. How would the recommendation affect closely related codes? Would it create rank order anomalies?

Other Issues

- There are no predetermined limits on changes. If a 1%, 5% or 10% change is warranted, the change should be recommended.

- Along the same lines, workgroups should exercise caution in reviewing specialty society recommendations for which a survey of a small number of people is being used to justify a large increase when the original comment requested a small increase.

- If a specialty society identifies a service as potentially misvalued in the course of reviewing other codes, the code should not be included in the workgroup recommendations. The range of specialty societies on the Advisory Committee would not have had the opportunity to consider these services. If the workgroup thinks that the specialty society's recommendations warrant adding the service to the list of codes under review, it should make this recommendation to the RUC. Subject to the workgroup's recommendation to include these services and RUC and CMS agreement with this recommendation, they would be considered at the February RUC 2006 meeting.

SEPTEMBER/OCTOBER 2005 RUC MEETING

At the September 29-October 2, 2005 RUC meeting, the recommended actions of each workgroup will be presented in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, therefore, with recommendations stating, for example, "For the following codes, Group X recommends that the RUC adopt the recommended increase in RVUs." Codes for which the workgroup does not reach consensus will be listed individually.

Codes on the consent calendars may be extracted by any RUC member or specialty society advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. After the workgroup reports are made available in September, advisors and RUC members should attempt to inform workgroup chairs in writing of the codes they wish to have extracted and provide a reason for the extraction. A copy of this correspondence should be provided to AMA staff.

A lunch meeting will be arranged for each workgroup on Thursday, September 29. At that time, the groups will meet in executive session to discuss the extracted codes, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and September/October meetings.

An order of business will be developed for the September/October meeting to allow each workgroup's recommendations to be considered in a timely manner. A certain time period will be allotted for each workgroup, and when that period ends, the RUC will move on to the next group. Any codes that are not completed by the end of the day for the workgroups scheduled on that day will be considered in a prolonged or evening session on that day. If, on the other hand, the RUC is ahead of schedule on a day, it will move on to the next workgroup and not adjourn.

If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value to be voted upon.

If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the society, the workgroup, or the RUC chair.

AMA/Specialty Society RV S Update Committee
Professional Liability Insurance Workgroup
April 22, 2004

The following members of the Professional Liability Insurance (PLI) Workgroup met on April 22, 2004 to discuss specialty society comments on the risk classification for individual CPT codes and the Bearing Point proposal for the Five-Year Review of PLI RVUs: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Stephen A. Kamenetzky, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith.

Background

Doctor Przybylski began the meeting by reviewing the eight recommendations the RUC provided to CMS following the September 2003 RUC meeting, including:

- CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data from pervious years.

- CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.

- In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty society does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provide whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to Assistant at Surgery should be removed from this analysis.

- The RUC requested that CMS share the PLI data used in the formulation of the new 2004 PLI GPCIs.

- The RUC will request a list of all CPT codes with their assigned category of risk (ie, surgical or non-surgical).

- The RUC will comment that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable. That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

- The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume.

- The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.

Doctor Przybylski indicated that CMS has responded positively to only two of these recommendations to date. CMS has provided the PLI data utilized in computing the PLI GPCIs and the risk classifications per CPT code to the RUC.

CMS Update

Mr. Rick Ensor, Health Insurance Specialist at CMS, participated in the meeting via speaker phone. Mr. Ensor had prepared written remarks prior to the meeting and these notes are included in the agenda materials. These remarks clarified that tail coverage was not incorporated into the PLI premium data. Mr. Ensor also indicated that CMS is unable to provide specific guidelines regarding the data requirements necessary for the PLI Workgroup and the RUC to consider in collecting independent PLI premium data. He did indicate that CMS remains very interested in identifying any PLI premium sources.

Risk Factor Classifications for Individual CPT Codes

CMS shared an August 13, 2003 technical proposal prepared by Bearing Point regarding the Five-Year Review of the PLI relative value units. This report indicates that, in general, surgical risk factors will be utilized for CPT codes 10000-60000 and all other codes will be assigned a non-surgical risk factor. A few exceptions are made to this general principal and are included in this report. The RUC provided this technical proposal to all specialty societies and solicited specific comments on the risk factor classification exceptions. The PLI Workgroup received a limited response to this request. The American College of Cardiology did indicate that revisions should be made to the Invasive Cardiology Procedures exception. **The PLI Workgroup agrees with these comments and recommends the following:**

***Invasive Cardiology Procedures*. The following codes will receive the greater of their actual average risk factor or the risk factor for Cardiac Catheterization (3.16): ~~92980-92998~~ 92973-92974, 93501-~~9355~~93533, 93580-93581, 93600-~~9361~~93613, ~~93617-93641~~ and ~~93643~~ 93650-93652.**

The American College of Radiology mentioned that the Workgroup may discuss the creation of a new exception for mammography services. The Workgroup did not agree that this would be appropriate as PLI premium data does not typically vary for radiologists based on whether they read mammograms. It was noted that Florida and Connecticut do reflect these variances in their rates.

Review of Bearing Point Technical Proposal on PLI Five-Year Review

CMS shared the August 13, 2003 Bearing Point Technical Proposal on the Five-Year Review of the PLI relative values with the RUC. The RUC distributed this report to the specialty
societies and solicited comments. Mr. Rick Ensor indicated that a more detailed report will be available from Bearing Point in May and this report will be provided to the RUC.

The Workgroup considered the comments received on the technical proposal. In general, **the Workgroup would reaffirm its earlier recommendations made to CMS regarding PLI as many of these recommendations were not incorporated into this technical proposal.** For example, the technical proposal mentions that the dominant specialty recommendation will be considered as one option. However, this proposal does not reflect the complete recommendation on this issue and does not address the removal of the assistant-at-surgery claims from the utilization data.

In addition, a number of observations were made by specialty societies and the PLI workgroup recommends the following new recommendations:

- **Any budget neutrality adjustments deemed necessary in the Five-Year Review of PLI relative values should be made to the conversion factor, rather than the relative value units. The Workgroup notes that this would be consistent with the application of budget neutrality in the Five-Year Review of physician work relative values.**

- **CMS should evaluate the PLI relative values related to the professional component/ technical component relative values. For example, CPT code 76092 *Screening mammography* has a global PLI RVU of 0.11, the professional component is allocated .04 and the technical component is allocated .07. The actual PLI risk is related to the physician review and interpretation, not the performance of the mammogram. Therefore, the current breakdown of the PLI RVUs is problematic. The PLI Workgroup recommends that CMS conduct a comprehensive review of this issue during this Five-Year Review of PLI relative values.**

- **The PLI Workgroup expresses concern regarding the proposal's step to "normalize" the data to account for specialty concentration in higher or lower than average risk regions to avoid the purported "double counting." The Workgroup would like to review further information regarding this data as it has concern about these assumptions.**

- **CMS appropriately considers a differential in PLI costs for obstetrical codes. The Workgroup recommends that CMS also consider the increased costs for CPT codes provided by other providers for obstetric services, specifically anesthesiologists and pediatricians.**

AMA/Specialty Society RVS Update Committee
Research Subcommittee
April 22, 2004

The following members participated in the Research Subcommittee: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Meghan Gerety, Barbara Levy, J. Leonard Lichtenfeld, Bernard Pfeifer, Alan Plummer, Trexler Topping, and Richard Tuck.

Development and Maintenance of Reference Service Lists

The subcommittee continued its discussion regarding reviewing the criteria for establishing and maintaining specialty society reference service lists. The subcommittee was divided on whether anyone other than the individual specialty society should determine the criteria for the reference service lists. The subcommittee examined the existing RUC criteria that provides guidelines for developing reference service lists. The RUC states that the reference service lists should "include a broad range of services and RVW for the specialty. Services on the list should be those which are well understood and commonly provided by physicians in the specialty."

The subcommittee agreed that the specialty societies should determine the composition of their reference service lists used for each new/revised code survey but that a set of guidelines should be established that the specialties would follow in developing their lists.

The subcommittee agreed to develop a set of guidelines for reference service list development. It is the intent of the subcommittee that such an approach would not be overly prescriptive. The subcommittee intends to finalize the criteria at the September RUC meeting after soliciting input from RUC participants.

The subcommittee passed the following recommendation:

- **The reference service list is a specialty society prerogative.**
- **The Research Subcommittee will create guidelines for developing reference service lists that will address criteria such as inclusion of MPC codes, RUC validated codes, a range of values, codes in the same family as the surveyed code, and codes with the same global period as the surveyed code.**
- **Add the following question to the summary form: "Is the reference service list consistent with the RUC guidelines? If not please explain."**

Inclusion of MPC codes to Summary of Recommendation Form

The Subcommittee reviewed a recommendation that was forwarded from the RUC MPC workgroup. Specifically, the RUC MPC Workgroup determined that all new/revised codes that the RUC reviews should be compared to codes on the MPC. The Research Subcommittee discussed the pros and cons of adding MPC codes to the Summary of Recommendation Form. A number of Subcommittee members felt that it would not be appropriate to impose a mandate on specialties to include MPC codes, when there may not be appropriate MPC comparisons for every new/revised code. Other committee

members felt that the change in the summary form would not be a mandate, but would be a request for specialties to include MPC codes if the specialty felt that a comparison would be appropriate. The consensus of the subcommittee was that the recommended change in the Summary of Recommendation Form would be the option of the specialty society to add codes from the MPC. Additionally it was requested that the MPC lists be sorted according to the specialty society that placed the code on the MPC list. It was explained that the MPC lists is provided on the RUC agenda book CD that allows sorting the list according to any variable.

Some committee members felt that since the MPC list is available to all RUC members, it is not necessary to add a question to the summary form since RUC members can perform their own comparisons of MPC codes. A motion was introduced to approve the MPC committee recommendation with the addition of the term "if appropriate" since it was the sense of the committee that this should not be a requirement.

The Subcommittee voted on the following motion to change the summary of recommendation form. The vote was a tie vote that was broken by the chair resulting in the subcommittee to **recommend the following additions to the RUC documents**:

Addition to Instructions

The specialty committee, if appropriate, may compare the relative value recommendations for the newly surveyed code to existing relative values for codes on the RUC's Multi-Specialty Points of Comparison (MPC). The Summary of Recommendation form would allow the specialty to include comparisons of the relative value unit recommendations for new codes against codes with the same global periods from the MPC list. If possible, at least two reference codes from the MPC list may be chosen that have relative values higher and lower (i.e. to book-end your recommendation and show proper rank order) than the requested relative values for the code under review.

Addition to Summary of Recommendation Form

Compare the Surveyed Code to Codes on the RUC's MPC

Reference codes from the MPC list may be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

Code	**Descriptor**	**Work RVU**

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
April 22, 2004

The Practice Expense Subcommittee met during the April 2004 RUC meeting to discuss the allocation of physician time components, and hear an update in the AMA's plans for practice expense data collection. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Przybylski, Siegel, Strate, and Wiersema.

Physician Time & Visit Allocations

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes, which have only total physician time within CMS's database. The PEAC has assigned post operative practice expense through RUC and CMS physician time components. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide all the necessary time components for each of the identified codes. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

1) If the specialty society agrees with the total Harvard physician time, specialty societies are asked to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post-operative hospital and office visits.

2) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is higher, specialty societies are required to conduct a full RUC physician time survey for the code.

3) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is lower, the predominate specialty who performs the service may provide a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel to develop the physician time components.

The Subcommittee and the RUC have expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs and should have no bearing on physician work. With this in mind, the RUC has directed AMA staff to clearly identify these codes within the RUC database to indicate to RUC members that the physician time from this exercise is not to be considered when making work recommendations.

For this meeting, AMA staff obtained physician time allocations for 12 CPT codes. Subcommittee members first reviewed 8 physician time allocations presented by the American Society for Therapeutic and Radiology and Oncology (ASTRO). Subcommittee members accepted 7 of these recommendations as submitted, and altered one. The Subcommittee reviewed the time components for code 77778 *Interstitial*

radiation source application; complex rejected the time components as recommended by the specialty society. The subcommittee did not agree with the number of post operative visits presented (four level 2 post operative visits), but agreed with the total physician time of 200 minutes. Members of the subcommittee agreed that one of the post operative visits should be dropped and that the time from that visit be allocated to the pre-service time for the code. The pre-service time was then changed from 20 minutes to 35 minutes and the four level 2 office visits were changed to three visits. The attached spreadsheet reflects the change made by the subcommittee.

The Subcommittee then reviewed four physician time allocations submitted by the American Academy of Orthopaedic Surgery (AAOS). Three of the codes submitted were reallocations of previous RUC practice expense time-only survey data, and one code reflected an allocation of CMS time. Subcommittee members reviewed all four codes carefully, and agreed with the physician time and visit allocation as presented. **The Practice Expense Subcommittee recommends the attached physician time and visit components to be used for practice expense purposes, these times will be flagged in the RUC database as not to be used for physician work purposes by the RUC or by CMS.**

Update on AMA's Plans for Practice Expense Data Collection

Sarah Thran from the AMA's survey research area came to this subcommittee to provide an update on the SMS survey. Ms. Thran announced that the AMA is in the planning stage of conducting another physician survey similar to the old SMS survey. The survey could potentially be conducted early in 2005 and end later in the year, with delivery to CMS early in 2006. Ms. Thran explained that there is a significant need for more current data as CMS is currently using data from the 1999 SMS survey. The survey is still in the planning stage, and a draft survey has been developed that is shorter than the 1999 survey but contains all the detail to calculate the practice expense per hour. In addition, the AMA will add questions requested by CMS to differentiate separately billable supplies and services provided by clinical staff. The survey topics will potentially include; practice expenses, practice characteristics, professional liability, charity care, bad debt, EMTALA, and managed care.

The SMS plans on having about the same number of observations and responses as the previous 1999 survey did. The AMA expects approximately 3,300 responses, without any over sampling. Ms. Thran mentioned that those specialties who want to have more observations collected would be allowed to purchase over samples in the 2005 survey. The cost would be $20,000 per 100 additional interviews. AMA will meet with specialty societies once more definite plans are made. There will not be an opportunity to add questions to the survey.

It was also explained by Ms. Thran that the physicians' selected for the survey are planned to be non-federal government employees who are involved in at least 20 hours of patient care hours per week. In addition, the physician would need to be a full or part owner of a practice. Subcommittee members believed that the physician would most likely not know the true practice expense items and it would be more appropriate to

survey the practice manager. It was explained that the instructions direct the surveyed physician to obtain the necessary information to complete the survey and provide the most accurate data, using staff and other resources in their practice. The physician should obtain the information from their practice manager or other personnel under his or her direction.

Updated Physician Time allocation submissions - Practice Expense Subcommittee April 22, 2004

CPT Code	Subcommittee Review Date	Glob	Specialty Who Submitted Time	Pre-serv time	Intra-Serv time	Post Time, Same Day of Surgery	99231@ 19 min	99232@ 30 min	99233@ 41 min	99238@ 36 min	99239@ 57 min	99212@ 15 min	99213@ 23 min	99214@ 38 min	99215@ 59 min	Total Time REC	Method	total time cms	Time change	2002 top Site of Service	Percent Site of Serv	IWPUT
77750		090	ASTRO	8	40	20						2				98	Allocation	98		Outpatient Hospital	65%	0.123
77761		090	ASTRO	11	45	10						1				81	Allocation	81		Inpatient Hospital	48%	0.084
77762		090	ASTRO	18	60	19						1				112	Allocation	112		Inpatient Hospital	63%	0.095
77763		090	ASTRO	20	80	28						2				158	Allocation	158		Inpatient Hospital	46%	0.107
77776		090	ASTRO	10	60	15						1				100	Allocation	100		Outpatient Hospital	50%	
77777		090	ASTRO	18	60	19						1				112	Allocation	112		Inpatient Hospital	50%	0.125
77778		090	ASTRO	35	90	30						3				200	Allocation	200		Outpatient Hospital	73%	0.124
77781		090	ASTRO	6	15	10						1				46	Allocation	46		Outpatient Hospital	43%	0.111
20690		090	AAOS	5	6	3	1			1		2				99	Allocation	99		Inpatient Hospital	47%	0.092
27193	April 04	090	AAOS	25	40	10	1			1		2	1			183	Survey reallocation			Inpatient Hospital	65%	
27501	April 04	090	AAOS	25	21	10	1			1		2	1			164	Survey reallocation	174		Inpatient Hospital	58%	
27824	April 04	090	AAOS	25	47	10						2	1			135	Survey reallocation			Physician's Office	55%	

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
April 22, 2004

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Michael Bishop, John Derr, David F. Hitzeman, Peter A. Hollmann, Charles Mick, J. Baldwin Smith, III, Peter Smith, Arthur Traugott and Robert Fifer, PhD

Overview of Internal Medicine Rotating Seat Election Process-
At the suggestion of AMA Staff, the Administrative Subcommittee agreed that there was a need for clarification within the RUC's Rotating Seat Policies and Election Rules. Currently, the Election Rules state:

> Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle.

AMA staff noted that there was some confusion as to the length of a cycle for a society to be eligible for nomination. **Therefore to clarify any confusion, the Administrative Subcommittee recommends the following language:**

> **Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle. (i.e., two years)**

RUC Database Distribution-
At the request of the Administrative Subcommittee, AMA staff met with AMA Legal Council to discuss various issues involving distribution of the RUC database to Carrier Medical Directors (CMD) including modifications to the database, restrictions on its use and CPT licensing. Legal Council recommended that for the RUC to consider this issue, the Centers for Medicare and Medicaid Services (CMS) would need to write a letter to the Chair of the RUC to request that the databases be distributed to their Carrier Medical Directors, because the Carrier Medical Directors are licensed for CPT through CMS. The Administrative Subcommittee discussed this recommendation and made the following motion:

> **The Centers for Medicare and Medicaid Services (CMS) needs to write a letter to the Chair of the RUC to request that the databases be distributed to their Carrier Medical Directors for further RUC database distribution discussion.**

Because Doctors Richard Whitten and William Mangold initially raised this question to the Administrative Subcommittee, they will be notified of this motion. The Administrative Subcommittee working under the presumption that CMS will write this letter, has also decided to form a workgroup. This workgroup will closely study this issue and ultimately will write a report and give a presentation to RUC, pending approval

of the Administrative Subcommittee, detailing their findings regarding the distribution of the RUC database to the Carrier Medical Directors. The RUC Database Distribution Workgroup members will include Doctors J. Baldwin Smith III, John Derr and chaired by Peter Hollmann. Their report will be scheduled for presentation at the September 2004 Administrative Subcommittee Meeting.

AMA Staff also noted that CPT Editorial Panel members have requested the RUC database. In the past, the database has been supplied to them with the restriction that all of the information
contained is confidential and/or proprietary and should only be used pursuant to participation in the AMA/Specialty Society RUC and CPT Processes. The Administrative Subcommittee agreed to continue to supply the CPT Editorial Panel Members with the RUC database.

Other Issues
AMA Staff announced that at the April/May 2004 CPT meeting, the Panel Members will be discussing the motion of changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. If this motion is approved, the Administrative Subcommittee may want to discuss the dates of future RUC meetings.

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
April 21, 2004

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Dale Blasier, MD
Mirean Coleman, MSW, LICSW, CT
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
Christoper Quinn, OD
Arthur Traugott, MD
Jane White, PhD, RD, FADA

On April 21st, the RUC HCPAC Review Board met to discuss several administrative issues and assess the recommendations for Acupuncture/Electroacupuncture (977X1-977X4), Evaluation of Central Auditory Function (926X4 & 926X5) and Comprehensive Tinnitus Assessment (926XX).

I. Administrative Issues

The RUC HCPAC Review Board reviewed several administrative issues including the Financial Disclosure and Conflict of Interest Policies. The members were instructed that the Conflict of Interest forms needed to be signed by all members and all forms need to be received by AMA staff before the end of the meeting. In addition, the HCPAC discussed several issues involving HCPAC alternates and decided they would be discussed further in the 'Other Issues' item on this meeting's agenda.

II. CMS Update

Carolyn Mullen provided a CMS update and announced that a new CMS Administrator, Mark McClellan, MD and Director of the Center for Medicare Management, Herb Kuhn have been appointed. In addition, CMS is currently working on the Proposed Rule which is scheduled to be published in late June/early July.

III. Relative Value Recommendations for CPT 2005

Acupuncture/Electroacupuncture (977X1-977X4)

Dr. Hamm presented the American Chiropractic Association, the American Association of Oriental Medicine and the American Academy of Medical Acupuncture joint relative value recommendations for the Acupuncture/Electroacupuncture codes. After an extensive discussion of the original relative value recommendation for 977X1- 977X4, an alternate methodology was selected. The key reference code *98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions* (0.65 RVU), was used to support the recommendation for 977X3 and rank order was applied to the remaining codes. Service times for 977X1 and 977X3 were modified by the specialties to include 3 minutes pre-service, 15 minutes intra-service and 3 minutes post-service. 977X2 and 977X4 service times

were modified to only capture the 15 minutes of intra-service time. The HCPAC understands that a patient is typically in the office 35 minutes for 15 minutes of face-to-face time. The HCPAC then approved the society recommended 0.60 work RVU recommendation for 977X1, 0.50 work RVU recommendation for 977X2, 0.65 work RVU recommendation for 977X3 and 0.55 work RVU recommended for 977X4. The recommended RVUs were accepted based on the assumption that the CPT descriptor will include the clarification that the 977X2 and 977X4 codes are only applied when new needles are inserted. Additionally, supplies and equipment for all of the codes were assessed, modified and approved by the HCPAC. The PLI crosswalk was modified to be 98941.

Evaluation of Central Auditory Function (926X4 & 9926X5)
Dr. Fifer of the American Speech, Language and Hearing Association presented the practice expense recommendations for the Evaluation of Central Auditory Function codes. In the extensive discussion of the practice expense for 926X4 and 926X5, it was determined that some clinical services (i.e., gowning the patient and cleaning the room) are below PEAC standard because the HCPAC determined that these specific standards do not apply because a gown is not usually worn by the patient for these services and there is little to clean. Additionally, the intra-service for 926X5 was dropped from 23 minutes to 15 minutes to appropriately represent the work specified in the descriptor. The HCPAC deemed this was appropriate and approved the Practice Expense for these new codes.

Comprehensive Tinnitus Assessment (926XX)
Dr. Fifer presented the practice expense recommendations for the Comprehensive Tinnitus Assessment. The society explained that audiology forms needed to be added to their supplies. With this revision, the HCPAC approved the clinical labor time, supplies and equipment for 926XX.

IV. Approval of PEAC recommendations from January and March 2004 meetings

The HCPAC reviewed and approved the PEAC recommendations from the January and March 2004 meetings.

V. National Provider ID

Emily H. Hill, PA-C, of the National Uniform Claim Committee (NUCC) announced that any code standardization transactions, provider taxonomy or Medicare issues regarding National Provider IDs, may be sent to her and she will present any questions to the NUCC and in turn provide feedback regarding these issues.

VI. Other Issues

HCPAC Alternate Co-Chair
Mary Foto, OTR announced that Nelda Spyres, LCSW regretfully had to step down as the HCPAC Alternate Co-Chair. Therefore, a new HCPAC Alternate Co-Chair must be elected. Nominations along with a one-page curriculum vitae should be sent

to AMA staff by September 1, 2004, in order to conduct an election at the September 2004 RUC HCPAC meeting. Ms. Spyers' term began in September 2003, therefore the Alternate Co-Chair elected at the September 2004 meeting will finish Ms. Spyers' two-year term.

HCPAC Alternates
Doctor Whitten indicated that currently ten out of the twelve societies on the HCPAC have nominated permanent alternate members. Each specialty is encouraged to identify its permanent member and alternate member, which may be any member it chooses, including a staff person if that person meets all membership criteria and any other criteria that the society has set for its representatives. Mary Foto, OTR, spoke to the two societies without alternates nominated and they agreed to nominate an alternate and provide AMA staff with the appropriate letter and curriculum vitae.

The HCPAC proposed and approved the motion that the HCPAC Review Board Structure and Functions Manual should be amended to read, "Members <u>and Alternate Members</u> of the RUC HCPAC Review Board shall hold terms of three (3) years. The HCPAC organization will appoint these representatives."

Insert Dr. Rich's slide show presentation.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
April 22, 2004

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Michael Bishop, John Derr, David F. Hitzeman, Peter A. Hollmann, Charles Mick, J. Baldwin Smith, III, Peter Smith, Arthur Traugott and Robert Fifer, PhD

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> **The Centers for Medicare and Medicaid Services (CMS) needs to write a letter to the Chair of the RUC to request that the databases be distributed to their Carrier Medical Directors for further RUC database distribution discussion.**

Because Doctors Richard Whitten and William Mangold initially raised this question to the Administrative Subcommittee, they will be notified of this motion. The Administrative Subcommittee working under the presumption that CMS will write this letter, has also decided to form a workgroup. This workgroup will closely study this issue and ultimately will write a report and give a presentation to RUC, pending approval of the Administrative Subcommittee, detailing their findings regarding the distribution of the RUC database to the Carrier Medical Directors. The RUC Database Distribution Workgroup members will include Doctors J. Baldwin Smith III, John Derr and chaired by Peter Hollmann. Their report will be scheduled for presentation at the September 2004 Administrative Subcommittee Meeting.

AMA Staff also noted that CPT Editorial Panel members have requested the RUC database. In the past, the database has been supplied to them with the restriction that all of the information

contained is confidential and/or proprietary and should only be used pursuant to participation in the AMA/Specialty Society RUC and CPT Processes. The Administrative Subcommittee agreed to continue to supply the CPT Editorial Panel Members with the RUC database.

Other Issues

AMA Staff announced that at the April/May 2004 CPT meeting, the Panel Members will be discussing the motion of changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. If this motion is approved, the Administrative Subcommittee may want to discuss the dates of future RUC meetings.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW
PROCEDURES FOR THE AUGUST WORKGROUP AND SEPT/OCT RUC MEETINGS

April 24, 2004

The August 25-28, 2005 meetings of the eight multidisciplinary workgroups and the September 29-October 2, 2005 meeting of the full RUC will be the only opportunity for the RUC to evaluate and finalize its recommendations for the RBRVS five-year review.

This document originated from the previous five-year review and has been revised to reflect actions taken by the five-year review workgroup and the RUC at the April 2004 RUC meeting.

AUGUST 2005 WORKGROUP MEETINGS

At the August 25-28 meetings, each of the eight workgroups will meet to discuss its designated codes. Agendas will be prepared for each topic and the agenda books for all eight workgroups will be distributed to all RUC members, Advisory Committee members, and staff contacts.

Just like at the full RUC meetings, Advisory Committee members attending the workgroup meetings should provide a brief oral presentation to the workgroup about their specialty society's recommendations. Presentations should follow the order of the codes on the agenda. Workgroups must cover all the codes assigned to them in the time scheduled for their meeting, and they may continue their meetings into the evening hours or begin earlier in the morning to accomplish this if necessary. Conference calls prior to the face-to-face meetings may also be appropriate. Comments should be reviewed and some action taken even if no one has submitted any recommendation for the code.

Following the presentation for each code or issue, the workgroup members will ask questions of the presenters. Time permitting, other RUC members, specialty advisors, or staff who are present should also feel free to make comments or ask questions about the codes. The entire workgroup process will be open to presenters, and all other RUC participants who wish to attend, including the decision making process regarding the codes under review.

All specialty societies will have equal opportunity to collect and present data to the workgroup meetings in August 2005. Specialty societies will not be provided with additional opportunity to collect new data following these meetings.

For each code, the workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

The workgroup may want to suggest a new RVU (action #4) if, for example, it agrees with the commenter and/or specialty society that the RVUs should be increased or decreased, but believes that

a different key reference service is more equivalent to the service under review than the one initially presented by the commenter or specialty.

For all of the above actions, the workgroup should have a reason for the actions that it takes. Recommended increases and decreases should only be adopted if compelling evidence has been provided by either the specialty society or the commenter that the current RVUs are incorrect. Rationale must also be provided for referrals to the CPT Editorial Panel and for decisions to maintain the current RVUs. The only situation in which a detailed discussion and rationale may not be necessary is if the specialty society originally recommended a change and now believes that it has not developed sufficient evidence to support the change and agrees that the current RVUs should be maintained.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five-Year Review.

In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus. In other words, if four workgroup members believe the specialty's recommendation should be adopted and one member does not, that member must offer some rationale for not adopting the recommendation.

An AMA staff member will attend each workgroup's meeting to record the discussion and decisions at the meeting and draft a report from each group to the RUC. These reports will include the nature of the group discussion, the action taken and rationale for it, and other expressed opinions about the action. Workgroup members will have an (brief) opportunity to review and comment on these drafts before they are disseminated to the full RUC.

It is critical that members of the workgroup read their group's agenda material prior to their August workgroup meeting. The list on the following page is a checklist of the questions and issues that the workgroup members should consider for each code assigned to them. Each of these questions should have been considered by each workgroup member in reviewing their group's materials and/or explicitly by the group in its discussion in August **prior to** a recommendation being made to the full RUC. By having the major evaluation of each code done by a workgroup, the RUC is essentially delegating responsibility for the rigorous review that usually takes place at RUC meetings to the workgroups. The groups need to anticipate and consider all the questions, therefore, that would have been asked if the codes were being evaluated by the full RUC.

Because preliminary review of the materials is so important, no substitutions for attendance by workgroup members at meetings will be permitted.

Doctors Rich, Gerety, and Moran will attend the workgroup meetings for the whole time but, since they are not members of a particular group, they will circulate to the various group meetings and try to help with any problems that may arise.

Potential Discussion Points

1. Has a RUC survey or other approved methodology been conducted for the code?

2. Review the survey instrument and results:

   Is the survey instrument and any cover letter and/or supplemental materials provided to respondents appropriate for a RUC survey, or does it contain leading or misleading information? (Staff will have copies of survey instruments available at the August meetings)

   Does the vignette describe the typical patient and service for the code?

   How many physicians responded to the survey?

   Were the survey responses tightly clustered around the median value or was there a large spread?

   What was the level of agreement or disagreement between the different specialties or professions surveyed?

3. Compare the work of the service being rated to the work of the key reference services. Did the specialty society and/or commenter select appropriate key reference services?

4. Compare the work, time, and work per unit time of the service to similar codes on the Multispecialty Points of Comparison (MPC).

5. Assess whether the specialty recommendation and rationale is pertinent to the comment, relevant, and includes valid data.

6. Evaluate and compare the pre-and post-work and time of the services under review, key reference services, MPC codes, noting the global periods.

7. How do the data provided and arguments made by the specialty compare to the Harvard and Medicare claims data for the code:

8. What is the nature of the compelling argument that the current RVUs are wrong? What evidence is there that the current RVUs or Harvard data for the service is currently incorrect? For example, has evidence been provided that the technology of providing the service has changed, the patient population has changed, or the providers have changed? See the RUC's Standards for Compelling Evidence and make certain that at least one of these standards are met.

9. How would the recommendation affect closely related codes? Would it create rank order anomalies?

Other Issues

- There are no predetermined limits on changes. If a 1%, 5% or 10% change is warranted, the change should be recommended.

- Along the same lines, workgroups should exercise caution in reviewing specialty society recommendations for which a survey of a small number of people is being used to justify a large increase when the original comment requested a small increase.

- If a specialty society identifies a service as potentially misvalued in the course of reviewing other codes, the code should not be included in the workgroup recommendations. The range of specialty societies on the Advisory Committee would not have had the opportunity to consider these services. If the workgroup thinks that the specialty society's recommendations warrant adding the service to the list of codes under review, it should make this recommendation to the RUC. Subject to the workgroup's recommendation to include these services and RUC and CMS agreement with this recommendation, they would be considered at the February RUC 2006 meeting.

SEPTEMBER/OCTOBER 2005 RUC MEETING

At the September 29-October 2, 2005 RUC meeting, the recommended actions of each workgroup will be presented in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, therefore, with recommendations stating, for example, "For the following codes, Group X recommends that the RUC adopt the recommended increase in RVUs." Codes for which the workgroup does not reach consensus will be listed individually.

Codes on the consent calendars may be extracted by any RUC member or specialty society advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. After the workgroup reports are made available in September, advisors and RUC members should attempt to inform workgroup chairs in writing of the codes they wish to have extracted and provide a reason for the extraction. A copy of this correspondence should be provided to AMA staff.

A lunch meeting will be arranged for each workgroup on Thursday, September 29. At that time, the groups will meet in executive session to discuss the extracted codes, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and September/October meetings.

An order of business will be developed for the September/October meeting to allow each workgroup's recommendations to be considered in a timely manner. A certain time period will be allotted for each workgroup, and when that period ends, the RUC will move on to the next group. Any codes that are not completed by the end of the day for the workgroups scheduled on that day will be considered in a prolonged or evening session on that day. If, on the other hand, the RUC is ahead of schedule on a day, it will move on to the next workgroup and not adjourn.

If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value to be voted upon.

If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the society, the workgroup, or the RUC chair.

AMA/Specialty Society RVS Update Committee
Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to CMS, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
  - technique
  - knowledge/technology
  - patient population
  - site-of-service
  - length of hospital stay
  - physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:
  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;
  - a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and/or
  - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

AMA/Specialty Society RVS Update Committee

Five-Year Review of the Work Component of the RBRVS
Proposed Process, Work Plan, and Timetable
April 24, 2004

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) played an instrumental role in both the 1997 and 2002 Five-Year Review processes to review the physician work component of the Resource-Based Relative Value Scale (RBRVS). This review is required according to Section 1848(C)2(B) of the Omnibus Budge Reconciliation Act of 1990, which requires the Centers for Medicare and Medicaid Services (CMS) to comprehensively review all relative values at least every five years and make any needed adjustments. CMS is expected to announce the initiation of the 2007 Five-Year Review in the November 2004 *Final Rule* and call for comments on the physician work relative values. The RUC submits this proposed process, work plan, and timetable for CMS to consider in its planning for this upcoming review.

This proposal will use the framework and ground rules from the previous Five-year review to outline a process, work plan, and timeframe for the upcoming Five-Year Review to begin in February 2005 and conclude with the implementation of the values on January 1, 2007. It should be noted that the time for this Five-Year Review will be similar to the previous processes, as the RUC will have approximately seven months to complete its review.

Historical Overview of Previous Five-Year Review Processes:

On February 23, 1995, the Health Care Financing Administration (HCFA) sent 70 comments on approximately 700 codes to the AMA/Specialty Society RVS Update Committee (RUC) to review and develop specific work relative value unit (RVU) recommendations for submission back to HCFA by September 1995. HCFA also forwarded comments from Medicare Carrier Medical Directors (CMDs) for 300 codes. In addition, large studies from the American Society of Anesthesiology and the American Academy of Orthopaedic Surgeons were sent for review. The American Academy of Pediatrics had also requested more than 1,500 new CPT codes to identify varying levels of work from different age groups. The RUC took on the challenge of reviewing this magnitude of codes and delivered the recommendations to HCFA, on time, seven months after receiving notice of the specific codes to be reviewed.

The RUC accomplished this task by developing a detailed process, work plan, and timetable prior to the submission of the codes to HCFA. The RUC's efforts were successful, as more than 93% of the RUC recommendations were accepted by HCFA, with a greater number accepted after a refinement panel review. Many anomalies in the RBRVS were corrected, including gynecological and neurosurgical services. In addition,

the work relative values for the Evaluation and Management services were increased, both for the individual codes and all of the codes with global surgical periods. The 1997 Five-Year Review did not result in increases for all codes as the RUC also recommended decreases for more than 100 codes.

In the November 2, 1999 *Final Rule*, HCFA announced the second, Five-Year Review (2002) and stated its intention to share comments the agency received with the RUC. HCFA noted that the RUC process used during the 1997 Five-Year Review was "beneficial" and further states:

> *The RUC's perspective will be helpful because of its experience in recommending relative values for codes that have been added to, or revised by, the CPT Editorial panel since we implemented the physician fee schedule in 1992. Furthermore, the RUC, by virtue of its multi-specialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process. We emphasize, however, as we reiterated for the first Five-Year Review, that we retain the responsibility for analyzing the comments in the 2000 physician fee schedule, developing the proposed rule for 2001, evaluating the comments on the proposed rule, and deciding whether to revise relative value units. We are not delegating this responsibility to the RUC or any other organization.*

CMS received only 30 public comments in response to its solicitation of misvalued codes to be reviewed in the second, Five-Year Review. However, 870 codes were identified for review as several specialties (general surgery, vascular surgery and cardiothoracic surgery) commented that nearly all of the services performed by their specialty were misvalued. The process that the RUC utilized in the 2002 Five-Year Review was very similar to the process utilized in the 1997 Five-Year Review. Multidisciplinary workgroups were utilized to review the large number of codes. The entire RUC then reviewed and discussed the reports of these workgroups.

In October 2000, the RUC submitted recommendations to: increase the work relative values for 469 CPT codes; decrease the work relative values for 27 CPT codes; and maintain the work relative values for 311 CPT codes. As in the 1997 Five-Year Review, the RUC also referred 63 codes to the CPT Editorial Panel to consider coding changes. In addition, the RUC reviewed a comment from the American Society of Anesthesiologists that the anesthesia conversion factor was too low. The RUC was able to review a simulated work relative value for 19 anesthesia services and made specific recommendations related to these codes to CMS. The CMS published a Proposed Rule on June 8, 2001, and a Final Rule on November 1, 2001, announcing the agency's intention

to accept and implement more than 95% of the RUC's recommendations on January 1, 2002.

Potential Scope of the 2007 Five-Year Review

The scope of the 2007 Five-Year Review is unknown at this time, as CMS comment period will not be initiated until November 2004. AMA RUC staff asked specialty societies to share their intentions regarding the next five-year review. Thirty specialties responded to this query, indicating that as many as 500 CPT codes could be identified. Therefore, it will be prudent, and realistic, to assume that CMS will receive comments on a large number of codes and a special process will need to be developed to review these codes.

Final Rule Comment Process

In the past, CMS has announced at least a 60 day comment period for the public to identify any misvalued code for review and clarified that the scope of the review will be limited to the work relative values. The practice expense relative values were not fully transitioned until 2002 and are currently undergoing refinement. The professional liability insurance (PLI) relative values were implemented on January 1, 2000 and will be refined for January 1, 2005. The RUC has discussed this issue and has agreed that the 2007 Five-Year Review should be restricted to the review physician work relative values. While it is expected that certain elements of the direct practice expense inputs will be modified due to changes in physician time and/or number of follow-up visits, the RUC considers any independent review of practice expense to be unnecessary at this time.

In the previous comment processes, CMS has stated that their preferred format for submitting a code for review is to include the following:

- CPT code
- Clinical description of the service
- Discussion of how the work of that service is analogous to one or more reference services
- Additional information for services with global periods:
    - physician time - on the same date as the service
    - whether the patient goes home, to a hospital bed, or to an ICU on the same day
    - number, time, type of physician visits after the day of procedure until the end of the global period (distinguish between outpatient and inpatient visits).
    - CMS requests that commenters provide nationally representative data from operating room logs, reports, or medical charts to explain this post-service time.

The RUC has extensively discussed measures to ensure that each specialty society, carrier medical director, or any member of the general public has equal opportunity to comment on misvalued codes and present their argument in a uniform manner. The RUC has developed compelling evidence standards and proposes that these standards be utilized throughout the process. The RUC recommends that the existing work relative value for a code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.

These compelling evidence standards have been reviewed by the specialty societies who participate in the RUC process. The RUC believes that these standards should be reviewed by the carrier medical directors and the public prior to their use in the comment period. Therefore, the RUC requests that CMS publish these standards in the *Proposed Rule* this spring and review comments before publishing final compelling evidence standards in the *Final Rule* in November 2004. The RUC envisions that CMS would specify the format of comment letters to include documentation of compelling evidence. The RUC also requests that CMS review and screen comment letters to make sure that they meet the minimal standards regarding compelling evidence prior to sharing with the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted. The compelling evidence standards developed by the RUC are as follows:

Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to CMS, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
    - technique
    - knowledge/technology
    - patient population
    - site-of-service
    - length of hospital stay
    - physician time

- An anomalous relationship between the code being valued and multiple key reference services. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

    - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

    - a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and/or

    - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

Timetable

April 2004	Submission of RUC Proposal on Five-Year Review to CMS
December 30, 2004	Comment period closes on public solicitation of codes to be reviewed. *Assumes publication date of CMS Final Rule of November 1, 2004*
February 1, 2005	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
February 3-6, 2005	Research Subcommittee to review any changes to the existing RUC survey instrument.

February 15, 2005	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1.
March 15, 2005	Responses to the LOI due to the AMA.
March 2005	Five-Year Review Workgroup to Review Comment Letters for codes in which there is no interest expressed to determine next steps for the review of these services.
April 28 – May 1, 2005	Summary of codes under review and specialty society assignments Research Subcommittee to review any alternative methodologies introduced.
May 9, 2005	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.
August 2, 2005	Recommendations due to the AMA from specialty societies.
August 25-28, 2005	Five-year review workgroups meet and review recommendations.
September 14, 2005	Workgroup recommendations and consent calendars sent to the RUC.
September 29 – October 2, 2005	RUC meeting to review workgroup recommendations and consent calendars
October 31, 2005	RUC recommendations submitted to CMS.
November 2005-February 2006	CMS Review
March 2006	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2006	Final Rule on Five-Year Review
January 1, 2007	Implementation of new work relative value units.

Process, Work Plan, and Policies

Drawing on the ground rules and policies from the previous five-year reviews, the following proposed process should provide the framework for the 2007 Five-Year Review.

CMS Submission and Level of Interest Process

CMS has shared the comments received within three weeks of receipt in both the 1997 and 2002 Five-Year Review processes. Therefore, we would request to receive the comments by February 1, 2005. It would also be preferable to receive the comments and list of codes in a similar format as the previous five-year reviews. This format is illustrated in attachment A and included the following fields:

1. CPT Code
2. Ref Set? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
3. Short or Medium CPT Descriptor
4. Control Number - linked the code back to a comment letter where the specific comment was identified.
5. Commenter - the specialty society or individual commented on the code (a key was provided to define acronyms).
6. Current RVU - the 2005 work RVU would be included here.
7. Rec RVU - the recommended RVU - or a note that the presenter requested an increase or decrease.
8. 1 Ref Code - Code number for a reference code identified
9. Ref Set? - an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
10. 2 Ref Code - Code number for second reference code identified
11. Ref Set ? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
12. Source - the source of the current RVU, for example, Harvard, RUC surveyed, etc (a key was included for this field).
13. Year - the year the current value was determined
14. Freq – 2004 frequency of claims for the code
15. Dif. - the difference between work RVU requested and the current work RVU.
16. % Dif. - the percentage difference between the work RVU requested and the current work RVU
17. Impact - difference in work RVU x conversion factor x frequency

The inclusion of this information in the material to the RUC was very important and crucial in the compressed schedule to review these services. The RUC will request that CMS follow this same format.

The specialty societies were extremely responsive in the previous five-year reviews in coordinating the Level of Interest process in a few weeks. The same timeframe will be necessary for this five-year review.

Initial Screen of Codes

In the 1997 and 2002 Five-Year Review processes, the RUC applied a series of initial screens to the potentially misvalued codes identified through the comment process. For example, the RUC had decided that due to the number of codes to be reviewed, it could not review low volume codes (ie, less than 1,000 per Medicare utilization). The RUC has reviewed these previous screens and agreed that they are not necessary for the 2007 Five-Year Review. The RUC believes that since the RBRVS will be fifteen years old, an opportunity should be provided to review any code. All codes that are identified should be reviewed based on the merit of the data and adherence to the compelling evidence standards.

Although the RUC agreed that an automated screening process should not be used in the 2007 Five-Year Review, the RUC is also concerned that codes not be excluded from the review if an interest has not been expressed in reviewing the code(s). Therefore, the Five-Year Review Workgroup will convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.

Surveys and Alternative Methodologies

The Research Subcommittee will review the current RUC survey used to develop work RVU recommendations at the February 2005 RUC meeting to determine if any changes need to be incorporated for the five-year review. During the previous five-year reviews, the survey instrument was substantially improved and used for the new and revised code review process after these five-year reviews were completed. However, there may be relevant questions that should be added to the current survey. For example, questions that solicits information on how the service has changed in past five years.

The Research Subcommittee will also be charged with reviewing any alternative methodologies introduced for this five-year review. At this time, it is not known whether any specialty society will be submitting any such study or request the RUC to review a specialty methodology for their services. However, if this does occur, the Research Subcommittee will be prepared to discuss these issues in April and the RUC will

determine the appropriateness of any such study/methodology at their April 2005 meeting. Previously approved methodologies are acceptable and will not require a new review by the Research Subcommittee (eg, mini-survey methodology previously utilized by the Society for Vascular Surgery).

The surveys for the five-year review will be mailed to the specialty societies immediately following the April RUC meeting. As in the past, specialty societies may, if they choose, share their vignettes with the workgroup who will be reviewing their codes to receive feedback prior to the release of their surveys. Copies of all final survey instruments, including vignettes and cover letters, must be provided to the AMA for filing. The completed summary of recommendation forms will be submitted to the AMA RUC staff by August 2, 2005.

Workgroups

The previous five-year refinement processes incorporated workgroups to review the recommendations. Eight workgroups were utilized with four RUC members or RUC alternate members on each workgroup. For planning purposes, a similar structure will be implemented in the 2007 Five-Year Review process. The assignment of the workgroup Chairs, composition, and topics to be addressed will be done prior to the April 2005 RUC meeting. The RUC Chair will assign individuals to these workgroups. The workgroups will meet for organizational purposes at the April RUC meeting and for 1 and 1/2 days in August 2005 to review their assigned codes.

It should be noted that for services performed only by non-MDs/DOs, the Health Care Professionals Review Board would meet in April and September 2005 to discuss these issues.

Workgroup Rules and Policies

The attached document, *Procedures for August Workgroup and September/October RUC Meetings* was developed to guide the workgroups and to ensure consistency in the rules used by each workgroup. The Workgroup on the Five-Year Review agrees that principles in this document were appropriate and recommends that an update version of this document be forwarded as instructions for the August 2005 workgroup meetings. A few key points from this document are as follows:

- All specialty societies will have equal opportunity to collect and present data to the Workgroup meetings in August 2005. Specialty societies will not be provided with additional opportunity to collect new data following these meetings.

- Following the presentation of each code or issue, the workgroup members will ask questions of the presenters. Time permitting, other RUC members, specialty society advisors, or staff who are present should also feel free to make comments about the codes. The workgroup on the five-year review also recommends that it be explicitly stated that the entire workgroup process will be open to the presenters, and all other RUC participants who wish to attend, including the decision-making process regarding the codes under review.

For each code, the workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

For each of the above actions, the workgroup should have a reason for the action it takes. Recommended increases or decreases should only be adopted if compelling evidence has been provided by either the specialty society or those commenting that the current relative values are incorrect. Rationale must also be provided for referrals to CPT and for decisions to maintain the current relative values. In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five-Year Review.

- Because preliminary review of the materials is so important, no substitutions for attendance by workgroup members at meetings will be permitted.

RUC Review/Consent Calendar Process

At the September 29 - October 2, 2005 RUC meeting, the recommendations from each workgroup will be presented to the RUC in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, following each of the first five action keys. Codes for which the workgroup does not reach consensus will be listed individually. During the previous five-year review, there were not significant issues concerning the ability to reach consensus within the workgroups.

The workgroups will meet in executive session to discuss the codes to be extracted, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and September/October meetings.

Appeals Process

Codes on the consent calendar may be extracted by any RUC member or specialty society advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value voted upon. As required by the RUC's Structure and Functions document, a vote by two-thirds of the representatives present at the RUC meeting shall constitute passage of each RVS recommendation.

If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the specialty society, the workgroup, or the RUC chair.

The RUC also has a formal appeals (re-consideration) process included in the RUC's Rules and Procedures document. This formal appeal would occur after the September/October 2005 RUC meeting and any re-consideration would occur at a future RUC meeting. These appeals process is outlined as follows:

II. **Appeals Process for Reconsideration of RUC Recommendations**

A. If a specialty requests an appeal of a RUC recommendation, the Chair will appoint an Ad Hoc Facilitation Committee as in I.F.1. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

B. The Ad Hoc Facilitation Committee shall meet in person or by telephone conference within two weeks of receipt of a written request for an appeal.

C. All appeals of RUC decisions shall be in writing.

D. The Ad Hoc Facilitation Committee shall invite appellants to meet with the Ad Hoc Facilitation Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

E. The Ad Hoc Facilitation Committee will notify anyone who previously commented on an issue under appeal and elicit further comments.

F. The Ad Hoc Facilitation Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC.

G. The Ad Hoc Facilitation Committee shall provide its recommendation to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner.

H. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

Submission to CMS

AMA staff will develop detailed recommendations to be submitted to HCFA immediately following the September/October 2005 RUC meeting. These recommendations will be circulated to the RUC for comment prior to their submission to HCFA in October 2005.

CMS Review of RUC recommendations

The RUC will request to be invited to any Carrier Medical Director or other committee meetings convened by CMS to review the RUC recommendations. The RUC believes that this participation is necessary to clarify any questions that may arise regarding the RUC recommendations. CMS will publish a *Proposed Rule* in spring of 2006 announcing its review of the RUC's recommendation.

AMA.Specialty Society RVS Update Committee
Five-Year Review Workgroup Report (Tab I)
April 22, 2004

The following Five-Year Review Workgroup members met via conference call on March 24, 2004 (refer to report on page 1471 of the RUC agenda book) and then face-to-face on April 22, 2004, to review and propose final documents for the five-year review including: the compelling evidence standards; Process, Work Plan, and Timetable Submission to CMS; and the Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, James Maloney, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Compelling Evidence Standards

The Workgroup recommends approval of the Compelling Evidence Standards document (page 1474 of RUC agenda book) with the following modification:

- An anomalous relationship between the code being valued and other codes. ~~multiple key reference services.~~ For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

The workgroup suggests this revision to remove any perception that these codes must be on the Multi-Specialty Points of Comparison (MPC) or any other specialty reference service list.

The Workgroup also would like to clarify that when this document is sent to CMS, the RUC intended to ask CMS to publish this list of Compelling Evidence Standards as information for those preparing comments on codes for the Five-Year Review. .

The Workgroup discussed the RUC's prior recommendation that the Standards for Compelling Evidence be published by CMS in the Notice of Proposed Rule Making (NPRM). By requesting this, the RUC intended to widely disseminate its Standards so that all commenters would have early access to the standards and, hopefully, formulate their comments using these standards. By publishing these in the NPRM, public comments would be invited about the standards, requiring CMS to comment on them and forward comments to the RUC for potential revision. The workgroup believes that the RUC's intention was to provide these standards for information only. The Workgroup recommends that the RUC convey this intention to CMS and refrain from making any formal recommendation regarding publication in the NPRM.

Approved by the RUC at the April 24, 2004 Meeting.

Process, Work Plan, and Timetable Document for Submission to CMS

The Workgroup recommends approval of the Process, Work Plan, and Timetable document (page 1479 of the RUC agenda book) with the following modification:

Modification to page ten of the document (page 1488 of the RUC agenda book):

For each code, the Workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

For each of the above actions, the Workgroup should have a reason for the action it takes. Recommended increases or decreases should only be adopted if compelling evidence has been provided by either the specialty society or those commenting that the current relative values are incorrect. Rationale must also be provided for referrals to CPT and for decisions to maintain the current relative values. In order to report "no consensus" (action #6) to the RUC, the individual(s) who are in the minority must offer a rationale for the lack of consensus.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five Year Review.

- ~~Codes cannot be withdrawn from the five-year review by a specialty society or a workgroup. The withdrawal of a recommended change is an action to accept the lower of the current work RVU or the recommended decrease.~~

The Workgroup discussed the issue of withdrawn codes in great detail. There was overall consensus that any commenter may withdraw its original comment/codes. Further, the withdrawal action should not be considered to be a comment about the code's current valuation. Therefore, the Workgroup recommends the creation of an additional action key to reflect withdrawal by the original commenter. Proposed action key # 7 reads, "Accept withdrawal by commenter, without prejudice."

Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings

The Workgroup recommends approval of the Procedures for the August 2005 Workgroup and September/October 2005 RUC Meeting (page 1492 of the RUC agenda book) with the following modification:

Modification to page two of the document (page 1493 of the RUC agenda book):

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five Year Review.

~~Codes cannot be withdrawn from the five-year review by a specialty society or a workgroup. The RUC will take an action on each code included in the submission from CMS. Therefore, if a specialty requests to withdraw a code, an action key must be recommended (eg, #2 - Maintain the current RVUs).~~

The Workgroup recommends this change to be consistent with the modification suggested in the Proposed Process, Work Plan, and Timetable document.

AMA/Specialty Society RVS Update Committee
Five-Year Review Workgroup
March 23, 2004 Conference Call Meeting

The following Five-Year Review Workgroup met via conference call on March 23, 2004: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, J. Leonard Lichtenfeld, Trexler Topping, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C. The workgroup considered specialty society comments on the *Compelling Evidence Standards*; the draft proposal to CMS; and the draft Five-Year Review Procedures document.

Compelling Evidence Standards

AMA staff indicated that twenty specialty societies responded that the draft *Compelling Evidence Standards* were fine as presented. The American College of Surgeons and the Society of Thoracic surgeons offered comments on this document. The Workgroup considered these comments and made the following revisions:

Removal of the adjectives "significant" and "seriously" as these terms may not be defined. A new sentence will be added to the preamble of the *Compelling Evidence Standards* document to reflect the sentiment that the evidence must be substantial and meet the compelling arguments.

Revision to second bullet, last sentence to read "These reference services ~~should~~ may be both inter- and intra-specialty." The Workgroup understands that specialty societies will include comparison of codes under review to codes on the MPC on the RUC *Summary of Recommendation Form*,. However, specialties are not required to include inter-specialty reference services on their surveys or to use in the formulation of their recommendation.

The Workgroup also agreed to clarify the preamble to indicate that the compelling evidence argument must be provided in the comment letter to CMS and then later to the RUC in writing on the Summary of Recommendation form.

The Society of Thoracic Surgeons (STS) requested a modification to the first and fourth bullets. The Workgroup believes that "other reliable data" incorporates the STS recommendation to add "national and other representative databases" and therefore, does not recommend an addition of this phrase in the first bullet. The Workgroup does agree that the language should be added to the fourth bullet to now read: "Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

Review of Draft Five-Year Review Proposed Process, Work Plan, and Timetable for Submission to CMS

The Workgroup reviewed the draft proposal to CMS on the Five-Year Review. This document will be submitted to CMS following the April 2004 RUC meeting. AMA staff

indicated that the appeals process section from the RUC's *Rules and Procedures* document has been included per the request in the ACS letter.

The Workgroup made a few changes to this document, including:

- Clarification regarding the initial screen of codes to indicate that a screening process will not be utilized in this Five-Year Review as the RBRVS is now fifteen years old and opportunity should be provided to review any code.

- An additional sentence was included in the surveys and alternative methodologies sections to indicate that previously approved methodologies will be considered appropriate for this Five-Year Review (eg, SVS mini-survey methodology).

- Clarification to the appeals process section to specify that a formal appeal would occur after the September/October 2005 RUC meeting and any re-consideration would be discussed at a future RUC meeting.

Review of Draft Five-Year Review Procedures for the August 2005 Workgroup and September/October 2005 RUC Meetings

The Workgroup also reviewed the draft *Procedures for the August 2005 and September/October 2005 RUC Meetings*. This document will be attached to the proposal to CMS and serves as a tool for the workgroups and RUC to use in these meetings next year.

The Workgroup made a few revisions to this document, including:

- Re-wording of sentence regarding the issue of code withdrawal from the Five-Year Review on page Two of the document to be more concise.

- Re-titled the "Discussion Checklist" to "Potential Discussion Points."

- Clarified the first bullet in this list on page three to include a RUC survey or "other approved methodology."

The Workgroup will circulate these documents to all RUC participants via the RUC agenda book and CD prior to the April 22 meeting. The Workgroup, and then the RUC, will review the documents and finalize them at the April 2004 RUC meeting for submission to CMS in late April.

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
April 21, 2004

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Dale Blasier, MD
Mirean Coleman, MSW, LICSW, CT
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
Christoper Quinn, OD
Arthur Traugott, MD
Jane White, PhD, RD, FADA

On April 21st, the RUC HCPAC Review Board met to discuss several administrative issues and assess the recommendations for Acupuncture/Electroacupuncture (977X1-977X4), Evaluation of Central Auditory Function (926X4 & 926X5) and Comprehensive Tinnitus Assessment (926XX).

I. Administrative Issues

The RUC HCPAC Review Board reviewed several administrative issues including the Financial Disclosure and Conflict of Interest Policies. The members were instructed that the Conflict of Interest forms needed to be signed by all members and all forms need to be received by AMA staff before the end of the meeting. In addition, the HCPAC discussed several issues involving HCPAC alternates and decided they would be discussed further in the 'Other Issues' item on this meeting's agenda.

II. CMS Update

Carolyn Mullen provided a CMS update and announced that a new CMS Administrator, Mark McClellan, MD and Director of the Center for Medicare Management, Herb Kuhn have been appointed. In addition, CMS is currently working on the Proposed Rule which is scheduled to be published in late June/early July.

III. Relative Value Recommendations for CPT 2005

Acupuncture/Electroacupuncture (977X1-977X4)

Dr. Hamm presented the American Chiropractic Association, the American Association of Oriental Medicine and the American Academy of Medical Acupuncture joint relative value recommendations for the Acupuncture/Electroacupuncture codes. After an extensive discussion of the original relative value recommendation for 977X1- 977X4, an alternate methodology was selected. The key reference code *98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions* (0.65 RVU), was used to support the recommendation for 977X3 and rank order was applied to the remaining codes. Service times for 977X1 and 977X3 were modified by the specialties to include 3 minutes pre-service, 15 minutes intra-service and 3 minutes post-service. 977X2 and 977X4 service times were modified to only capture the 15 minutes of intra-service time. The HCPAC understands that a patient is typically in the office 35 minutes for 15 minutes of face-to-face time. The HCPAC then approved the society recommended 0.60 work RVU recommendation for 977X1, 0.50 work RVU recommendation for 977X2, 0.65 work RVU recommendation for 977X3 and 0.55 work RVU recommended for 977X4. The recommended RVUs were accepted based on the assumption that the CPT descriptor will include the clarification that the 977X2 and 977X4 codes are only applied when new needles are inserted. Additionally, supplies and equipment for all of the codes were assessed, modified and approved by the HCPAC. The PLI crosswalk was modified to be 98941.

Evaluation of Central Auditory Function (926X4 & 9926X5)
Dr. Fifer of the American Speech, Language and Hearing Association presented the practice expense recommendations for the Evaluation of Central Auditory Function codes. In the extensive discussion of the practice expense for 926X4 and 926X5, it was determined that some clinical services (i.e., gowning the patient and cleaning the room) are below PEAC standard because the HCPAC determined that these specific standards do not apply because a gown is not usually worn by the patient for these services and there is little to clean. Additionally, the intra-service for 926X5 was dropped from 23 minutes to 15 minutes to appropriately represent the work specified in the descriptor. The HCPAC deemed this was appropriate and approved the Practice Expense for these new codes.

Comprehensive Tinnitus Assessment (926XX)
Dr. Fifer presented the practice expense recommendations for the Comprehensive Tinnitus Assessment. The society explained that audiology forms needed to be added to their supplies. With this revision, the HCPAC approved the clinical labor time, supplies and equipment for 926XX.

IV. Approval of PEAC recommendations from January and March 2004 meetings
The HCPAC reviewed and approved the PEAC recommendations from the January and March 2004 meetings.

V. National Provider ID
Emily H. Hill, PA-C, of the National Uniform Claim Committee (NUCC) announced that any code standardization transactions, provider taxonomy or Medicare issues regarding National Provider IDs, may be sent to her and she will present any questions to the NUCC and in turn provide feedback regarding these issues.

VI. Other Issues
HCPAC Alternate Co-Chair
Mary Foto, OTR announced that Nelda Spyres, LCSW regretfully had to step down as the HCPAC Alternate Co-Chair. Therefore, a new HCPAC Alternate Co-Chair must be elected. Nominations along with a one-page curriculum vitae should be sent to AMA staff by September 1, 2004, in order to conduct an election at the September 2004 RUC HCPAC meeting. Ms. Spyers' term began in September 2003, therefore the Alternate Co-Chair elected at the September 2004 meeting will finish Ms. Spyers' two-year term.

HCPAC Alternates
Doctor Whitten indicated that currently ten out of the twelve societies on the HCPAC have nominated permanent alternate members. Each specialty is encouraged to identify its permanent member and alternate member, which may be any member it chooses, including a staff person if that person meets all membership criteria and any other criteria that the society has set for its representatives. Mary Foto, OTR, spoke to the two societies without alternates nominated and they agreed to nominate an alternate and provide AMA staff with the appropriate letter and curriculum vitae.

The HCPAC proposed and approved the motion that the HCPAC Review Board Structure and Functions Manual should be amended to read, "Members <u>and Alternate Members</u> of the RUC HCPAC Review Board shall hold terms of three (3) years. The HCPAC organization will appoint these representatives."

June 1, 2004

Stephen Phillips
Director
Division of Practitioner Services
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard, C4-03-06
Baltimore, Maryland 21244

Dear Mr. Phillips:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) has reviewed the methodology to compute the professional liability insurance (PLI) relative value component of the Resource-Based Relative Value Scale (RBRVS). We offer a number of recommendations for the Centers for Medicare and Medicaid Services (CMS) to consider as you develop the Notice of Proposed Rulemaking (NPRM) for the 2005 Medicare Physician Payment Schedule.

In our September 30, 2003 comment letter regarding the August 15, 2003 NPRM for the 2004 Medicare Physician Payment Schedule, the RUC offered a number of recommendations, including:

- **CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict the 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years.** The RUC urges CMS to use the most recent data available for PLI payments. We also oppose weight averaging of multiple years of data. As recent PLI premiums have increased significantly, it would be unfair to dilute these increases with data from earlier year(s), which are no longer reflective of today's costs.

- **CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.** The inclusion of these costs is critical as insurance carriers have left the market, requiring increasingly more physicians to change PLI coverage and therefore incur the costs of tail coverage. We understand that CMS has not included these costs in the past.

- **In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least**

50% of the time, then a weighted average of the specialties (with the greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to assistant at surgery services should be removed from this analysis. The RUC is supportive of the letter submitted to CMS in May 2003 from a group of medical societies. This letter outlines a methodology for CMS to employ in considering this recommendation. The RUC is concerned that the weighted averaging reduces the potential payment to higher-risk specialties and increases the potential payment to lower-risk specialties.

- **The RUC recommends that PLI data for all specialties should be considered rather than the data from the 20 specialties with the highest volume.** The RUC does not agree with the current CMS approach, which used national average premium data from twenty specialties, and uses crosswalk assumptions for the remaining medical specialties and other health care professionals. The RUC is also concerned that the 20 specialties with the highest volume used in the prior updates include only three high-risk specialties (orthopaedic surgery, general surgery, and emergency medicine).

- **The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.** Several RUC members urged the PLI Workgroup to "think outside the box" and work with CMS to develop a different methodology for paying physicians for their share of the individual physician's professional liability insurance premium. This is a concept that we will explore at future RUC meetings and would welcome dialogue with CMS on this concept.

- **The RUC recommends that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable.** That is, any CMS budget neutrality adjustments should <u>not</u> be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

The RUC considered the Bearing Point Proposal and specialty society comments received on the technical proposal. In general, the RUC would reaffirm its earlier recommendations made to CMS regarding PLI as many of these recommendations were not incorporated into this technical proposal. For example, the technical proposal mentions that the dominant specialty recommendation will be considered as one option. However, this proposal does not reflect the complete recommendation on this

issue and does not address the removal of the assistant-at-surgery claims from the utilization data.

In addition, a number of observations were made by specialty societies resulting in the following new RUC recommendations:

- **The exceptions for the surgical risk factor should be modified to include coding changes since the initiation of the resource-based PLI relative values in 2000.** The RUC recommends revision to the following exception:

  Invasive Cardiology Procedures. The following codes will receive the greater of their actual average risk factor or the risk factor for Cardiac Catheterization (3.16): ~~92980-92998~~ 92973-92974, 93501-~~9355~~93533, 93580-93581, 93600-~~9361~~93613, ~~93617-93641~~ and ~~93643~~ 93650-93652.

- **Any budget neutrality adjustments deemed necessary in the Five-Year Review of PLI relative values should be made to the conversion factor, rather than the relative value units.** The RUC notes that this would be consistent with the application of budget neutrality in the Five-Year Review of physician work relative values.

- **CMS should evaluate the PLI relative values related to the professional component/ technical component relative values.** For example, CPT code 76092 *Screening mammography* has a global PLI RVU of 0.11, the professional component is allocated .04 and the technical component is allocated .07. The actual PLI risk is related to the physician review and interpretation, not the performance of the mammogram. Therefore, the current breakdown of the PLI relative values is problematic. The RUC recommends that CMS conduct a comprehensive review of this issue during this Five-Year Review of PLI relative values.

- **The RUC expresses concern regarding the proposal's step to "normalize" the data to account for specialty concentration in higher or lower than average risk regions to avoid the purported "double counting."** The RUC would like to review further information regarding this data as it has concern about these assumptions.

- CMS appropriately considers a differential in PLI costs for obstetrical codes. **The RUC recommends that CMS also consider the increased costs for CPT codes provided by other providers for obstetric services, specifically**

anesthesiologists and pediatricians (eg, CPT codes 01958 – 01969 and 99436-99440).

We appreciate your consideration of these recommendations and look forward to reviewing the NPRM this summer. If you have any questions regarding our discussions and recommendations, please contact Sherry Smith at (312) 464-5604.

Sincerely,

William Rich, MD

cc: Edith L Hambrick MD
Carolyn Mullen
Ken Simon, MD
Rick Ensor
RUC Participants

AMA/Specialty Society RV S Update Committee
Professional Liability Insurance Workgroup
April 22, 2004

The following members of the Professional Liability Insurance (PLI) Workgroup met on April 22, 2004 to discuss specialty society comments on the risk classification for individual CPT codes and the Bearing Point proposal for the Five-Year Review of PLI RVUs.: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Stephen A. Kamenetzky, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith.

Background

Doctor Przybylski began the meeting by reviewing the eight recommendations the RUC provided to CMS following the September 2003 RUC meeting, including:

- CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data from pervious years.

- CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.

- In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty society does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provide whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to Assistant at Surgery should be removed from this analysis.

- The RUC requested that CMS share the PLI data used in the formulation of the new 2004 PLI GPCIs.

- The RUC will request a list of all CPT codes with their assigned category of risk (ie, surgical or non-surgical).

- The RUC will comment that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable. That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

- The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume.

Approved by the RUC on April 24, 2004.

- The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.

Doctor Przybylski indicated that CMS has responded positively to only two of these recommendations to date. CMS has provided the PLI data utilized in computing the PLI GPCIs and the risk classifications per CPT code to the RUC.

CMS Update

Mr. Rick Ensor, Health Insurance Specialist at CMS, participated in the meeting via speaker phone. Mr. Ensor had prepared written remarks prior to the meeting and these notes are included in the agenda materials. These remarks clarified that tail coverage was not incorporated into the PLI premium data. Mr. Ensor also indicated that CMS is unable to provide specific guidelines regarding the data requirements necessary for the PLI Workgroup and the RUC to consider in collecting independent PLI premium data. He did indicate that CMS remains very interested in identifying any PLI premium sources.

Risk Factor Classifications for Individual CPT Codes

CMS shared an August 13, 2003 technical proposal prepared by Bearing Point regarding the Five-Year Review of the PLI relative value units. This report indicates that, in general, surgical risk factors will be utilized for CPT codes 10000-60000 and all other codes will be assigned a non-surgical risk factor. A few exceptions are made to this general principal and are included in this report. The RUC provided this technical proposal to all specialty societies and solicited specific comments on the risk factor classification exceptions. The PLI Workgroup received a limited response to this request. The American College of Cardiology did indicate that revisions should be made to the Invasive Cardiology Procedures exception. **The PLI Workgroup agrees with these comments and recommends the following:**

***Invasive Cardiology Procedures*. The following codes will receive the greater of their actual average risk factor or the risk factor for Cardiac Catheterization (3.16): ~~92980-92998~~ 92973-92974, 93501-~~9355~~93533, 93580-93581, 93600-~~9361~~93613, ~~93617-93641~~ and ~~93643~~ 93650-93652.**

The American College of Radiology mentioned that the Workgroup may discuss the creation of a new exception for mammography services. The Workgroup did not agree that this would be appropriate as PLI premium data does not typically vary for radiologists based on whether they read mammograms. It was noted that Florida and Connecticut do reflect these variances in their rates.

Review of Bearing Point Technical Proposal on PLI Five-Year Review

CMS shared the August 13, 2003 Bearing Point Technical Proposal on the Five-Year Review of the PLI relative values with the RUC. The RUC distributed this report to the specialty societies and solicited comments. Mr. Rick Ensor indicated that a more detailed report will be available from Bearing Point in May and this report will be provided to the RUC.

The Workgroup considered the comments received on the technical proposal. In general, **the Workgroup would reaffirm its earlier recommendations made to CMS regarding PLI as many of these recommendations were not incorporated into this technical proposal.** For example, the technical proposal mentions that the dominant specialty recommendation will be considered as one option. However, this proposal does not reflect the complete recommendation on this issue and does not address the removal of the assistant-at-surgery claims from the utilization data.

In addition, a number of observations were made by specialty societies and the PLI workgroup recommends the following new recommendations:

- **Any budget neutrality adjustments deemed necessary in the Five-Year Review of PLI relative values should be made to the conversion factor, rather than the relative value units. The Workgroup notes that this would be consistent with the application of budget neutrality in the Five-Year Review of physician work relative values.**

- **CMS should evaluate the PLI relative values related to the professional component/ technical component relative values. For example, CPT code 76092 *Screening mammography* has a global PLI RVU of 0.11, the professional component is allocated .04 and the technical component is allocated .07. The actual PLI risk is related to the physician review and interpretation, not the performance of the mammogram. Therefore, the current breakdown of the PLI RVUs is problematic. The PLI Workgroup recommends that CMS conduct a comprehensive review of this issue during this Five-Year Review of PLI relative values.**

- **The PLI Workgroup expresses concern regarding the proposal's step to "normalize" the data to account for specialty concentration in higher or lower than average risk regions to avoid the purported "double counting." The Workgroup would like to review further information regarding this data as it has concern about these assumptions.**

- **CMS appropriately considers a differential in PLI costs for obstetrical codes. The Workgroup recommends that CMS also consider the increased costs for CPT codes provided by other providers for obstetric services, specifically anesthesiologists and pediatricians.**

Approved by the RUC on April 24, 2004.

Updated Physician Time allocation submissions - Practice Expense Subcommittee April 22, 2004

CPT Code	Subcommittee Review Date	Glob	Specialty Who Submitted Time	Pre-serv time	Intra-Serv time	Post Time, Same Day of Surgery	99231@19 min	99232@30 min	99233@41 min	99238@36 min	99239@57 min	99212@15 min	99213@23 min	99214@38 min	99215@59 min	Total Time REC	Method	total time cms	Time change	2002 top Site of Service	Percent Site of Serv	IWPUT
77750		090	ASTRO	8	40	20						2				98	Allocation	98		Outpatient Hospital	65%	0.123
77761		090	ASTRO	11	45	10						1				81	Allocation	81		Inpatient Hospital	48%	0.084
77762		090	ASTRO	18	60	19						1				112	Allocation	112		Inpatient Hospital	63%	0.095
77763		090	ASTRO	20	80	28						2				158	Allocation	158		Inpatient Hospital	46%	0.107
77776		090	ASTRO	10	60	15						1				100	Allocation	100		Outpatient Hospital	50%	
77777		090	ASTRO	18	60	19						1				112	Allocation	112		Inpatient Hospital	50%	0.125
77778		090	ASTRO	35	90	30						3				200	Allocation	200		Outpatient Hospital	73%	0.124
77781		090	ASTRO	6	15	10						1				46	Allocation	46		Outpatient Hospital	43%	0.111
20690		090	AAOS	5	6	3	1			1		2				99	Allocation	99		Inpatient Hospital	47%	0.092
27193	April 04	090	AAOS	25	40	10	1			1		2	1			183	Survey reallocation			Inpatient Hospital	65%	
27501	April 04	090	AAOS	25	21	10	1			1		2	1			164	Survey reallocation	174		Inpatient Hospital	58%	
27824	April 04	090	AAOS	25	47	10						2	1			135	Survey reallocation			Physician's Office	55%	

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
April 22, 2004

The Practice Expense Subcommittee met during the April 2004 RUC meeting to discuss the allocation of physician time components, and hear an update in the AMA's plans for practice expense data collection. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Przybylski, Siegel, Strate, and Wiersema.

Physician Time & Visit Allocations

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes, which have only total physician time within CMS's database. The PEAC has assigned post operative practice expense through RUC and CMS physician time components. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide all the necessary time components for each of the identified codes. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

1) If the specialty society agrees with the total Harvard physician time, specialty societies are asked to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post-operative hospital and office visits.

2) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is higher, specialty societies are required to conduct a full RUC physician time survey for the code.

3) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is lower, the predominate specialty who performs the service may provide a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel to develop the physician time components.

The Subcommittee and the RUC have expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs and should have no bearing on physician work. With this in mind, the RUC has directed AMA staff to clearly identify these codes within the RUC database to indicate to RUC members that the physician time from this exercise is not to be considered when making work recommendations.

For this meeting, AMA staff obtained physician time allocations for 12 CPT codes. Subcommittee members first reviewed 8 physician time allocations presented by the American Society for Therapeutic and Radiology and Oncology (ASTRO). Subcommittee members accepted 7 of these recommendations as submitted, and altered one. The Subcommittee reviewed the time components for code 77778 *Interstitial radiation source application; complex* rejected the time components as recommended by the specialty society. The subcommittee did not agree with the number of post operative visits presented (four level 2 post operative visits), but agreed with the total physician time of 200 minutes. Members of the subcommittee agreed that one of the post operative visits should be dropped and that the time from that visit be allocated to the pre-service time for the code. The pre-service time was then changed from 20 minutes to 35 minutes and the four level 2 office

visits were changed to three visits. The attached spreadsheet reflects the change made by the subcommittee.

The Subcommittee then reviewed four physician time allocations submitted by the American Academy of Orthopaedic Surgery (AAOS). Three of the codes submitted were reallocations of previous RUC practice expense time-only survey data, and one code reflected an allocation of CMS time. Subcommittee members reviewed all four codes carefully, and agreed with the physician time and visit allocation as presented. **The Practice Expense Subcommittee recommends the attached physician time and visit components to be used for practice expense purposes, these times will be flagged in the RUC database as not to be used for physician work purposes by the RUC or by CMS.**

Update on AMA's Plans for Practice Expense Data Collection

Sarah Thran from the AMA's survey research area came to this subcommittee to provide an update on the SMS survey. Ms. Thran announced that the AMA is in the planning stage of conducting another physician survey similar to the old SMS survey. The survey could potentially be conducted early in 2005 and end later in the year, with delivery to CMS early in 2006. Ms. Thran explained that there is a significant need for more current data as CMS is currently using data from the 1999 SMS survey. The survey is still in the planning stage, and a draft survey has been developed that is shorter than the 1999 survey but contains all the detail to calculate the practice expense per hour. In addition, the AMA will add questions requested by CMS to differentiate separately billable supplies and services provided by clinical staff. The survey topics will potentially include; practice expenses, practice characteristics, professional liability, charity care, bad debt, EMTALA, and managed care.

The SMS plans on having about the same number of observations and responses as the previous 1999 survey did. The AMA expects approximately 3,300 responses, without any over sampling. Ms. Thran mentioned that those specialties who want to have more observations collected would be allowed to purchase over samples in the 2005 survey. The cost would be $20,000 per 100 additional interviews. AMA will meet with specialty societies once more definite plans are made. There will not be an opportunity to add questions to the survey.

It was also explained by Ms. Thran that the physicians' selected for the survey are planned to be non-federal government employees who are involved in at least 20 hours of patient care hours per week. In addition, the physician would need to be a full or part owner of a practice. Subcommittee members believed that the physician would most likely not know the true practice expense items and it would be more appropriate to survey the practice manager. It was explained that the instructions direct the surveyed physician to obtain the necessary information to complete the survey and provide the most accurate data, using staff and other resources in their practice. The physician should obtain the information from their practice manager or other personnel under his or her direction.

AMA/Specialty Society RVS Update Committee
Research Subcommittee
April 22, 2004

The following members participated in the Research Subcommittee: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Meghan Gerety, Barbara Levy, J. Leonard Lichtenfeld, Bernard Pfeifer, Alan Plummer, Trexler Topping, and Richard Tuck.

Development and Maintenance of Reference Service Lists

The subcommittee continued its discussion regarding reviewing the criteria for establishing and maintaining specialty society reference service lists. The subcommittee was divided on whether anyone other than the individual specialty society should determine the criteria for the reference service lists. The subcommittee examined the existing RUC criteria that provides guidelines for developing reference service lists. The RUC states that the reference service lists should "include a broad range of services and RVW for the specialty. Services on the list should be those which are well understood and commonly provided by physicians in the specialty."

The subcommittee agreed that the specialty societies should determine the composition of their reference service lists used for each new/revised code survey but that a set of guidelines should be established that the specialties would follow in developing their lists.

The subcommittee agreed to develop a set of guidelines for reference service list development. It is the intent of the subcommittee that such an approach would not be overly prescriptive. The subcommittee intends to finalize the criteria at the September RUC meeting after soliciting input from RUC participants.

The subcommittee passed the following recommendation:

- **The reference service list is a specialty society prerogative.**
- **The Research Subcommittee will create guidelines for developing reference service lists that will address criteria such as inclusion of MPC codes, RUC validated codes, a range of values, codes in the same family as the surveyed code, and codes with the same global period as the surveyed code.**
- **Add the following question to the summary form: "Is the reference service list consistent with the RUC guidelines? If not please explain."**

Inclusion of MPC codes to Summary of Recommendation Form

The Subcommittee reviewed a recommendation that was forwarded from the RUC MPC workgroup. Specifically, the RUC MPC Workgroup determined that all new/revised codes that the RUC reviews should be compared to codes on the MPC. The Research Subcommittee discussed the pros and cons of adding MPC codes to the Summary of Recommendation Form. A number of Subcommittee members felt that it would not be appropriate to impose a mandate on specialties to include MPC codes, when there may not be appropriate MPC comparisons for every new/revised code. Other committee

members felt that the change in the summary form would not be a mandate, but would be a request for specialties to include MPC codes if the specialty felt that a comparison would be appropriate. The consensus of the subcommittee was that the recommended change in the Summary of Recommendation Form would be the option of the specialty society to add codes from the MPC. Additionally it was requested that the MPC lists be sorted according to the specialty society that placed the code on the MPC list. It was explained that the MPC lists is provided on the RUC agenda book CD that allows sorting the list according to any variable.

Some committee members felt that since the MPC list is available to all RUC members, it is not necessary to add a question to the summary form since RUC members can perform their own comparisons of MPC codes. A motion was introduced to approve the MPC committee recommendation with the addition of the term "if appropriate" since it was the sense of the committee that this should not be a requirement.

The Subcommittee voted on the following motion to change the summary of recommendation form. The vote was a tie vote that was broken by the chair resulting in the subcommittee to **recommend the following additions to the RUC documents**:

Addition to Instructions

The specialty committee, if appropriate, may compare the relative value recommendations for the newly surveyed code to existing relative values for codes on the RUC's Multi-Specialty Points of Comparison (MPC). The Summary of Recommendation form would allow the specialty to include comparisons of the relative value unit recommendations for new codes against codes with the same global periods from the MPC list. If possible, at least two reference codes from the MPC list may be chosen that have relative values higher and lower (i.e. to book-end your recommendation and show proper rank order) than the requested relative values for the code under review.

Addition to Summary of Recommendation Form

Compare the Surveyed Code to Codes on the RUC's MPC

Reference codes from the MPC list may be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

Code	**Descriptor**	**Work RVU**

Maintaining MFS Viability

The role of the "House of Medicine", Specialty Societies and the RUC

Maintaining MFS Viability

William L. Rich III, MD FACS
Chairman, AMA RUC
April 22, 2004

MFS

- Conversion factor/update formula
- Site of service change
- Threat of marginal technology

MFS Update Formula

- Flawed update formula
- SGR which includes drugs given in physician offices
- Unfair behavioral offset assumption-30%
- Poor calculation of impact of regulatory and legislatively mandated coverage decisions
- Assumes increased intensity of services only economically driven

Drugs in the SGR

- In 1996 drugs accounted for 3.5% of Part B SGR expenditures
- In 2003-10%!!
- Drugs account for 20% of the conversion factor cuts

New coverage decisions

- In 2003, under Congressional pressure, CMS covered 40 PET codes which were not included in the target.
- In MMA a new comprehensive exam for seniors entering Medicare mandated

Legislative Changes

- Medicare Prescription Drug, Improvement and Modernization Act-MMA

Fee fix

- 1.5% increase in 2004 & 2005-a 18% swing in payment when 2003 fix included.
- With no legislative fix for 2006, cuts in the conversion factor of 5% for 2006-2012
- 40% cut over 2005 rates

House of Medicine

- Coordinated, unified approach to the needed regulatory and legislative changes needed to change the SGR

Impediments

- Disjointed DC advocacy efforts
- Republican party desire to shift Medicare from an entitlement to a defined benefit: FFS to Medicare Advantage
- Need to convince Medicare actuary not to impede removal of drugs from SGR

Site of Service

Site of service

- Impact of moving PE$$$ from hospital OPD/ASC to office
- PE $$$ in office and OPD are both paid with Part B dollars
- PE $$$ if office are in SGR; in OPD not in SGR

Gaboikeologist

ASCG

- American Society of Clinical Gaboikeology

ASCG

- 12,000 members
- $1 billion of Medicare revenue
- 60% of revenues office based
- $100 PE/HR
- Supply scaling factor of 1.2

The Demise of the ASCG

Site of service

- Code xxxxx-flying neutrino intralenticular vaporization of cataract, with or without removal of destroyed globe
- Code yyyyy-intradermal thermotherapy of chalzion
- Code zzzzz-microwave destruction of ciliary body for glaucoma with or without provision of low vision aids

Site of service

CODE	WRVU	'01 NFPE Fee	'02 NFPE Fee	Vol.
xxxxx	9	4.7 $560	76 $3,300	2,640
yyyyy	9.4	4.5 $589	93 $3,900	2,500
zzzzz	9.1	4.3 $538	97 $4300	4,300

Disposables

- XXXXX-$595
- YYYYY-$795
- ZZZZZ-$1225

Impact

- $15,853,000 added to PE pool
- $10,112,00 in new disposables added to direct supply inputs to determine NF PERVUs
- $100,000s in equipment for each code

The Problem:

- What is the impact of the move of pricing these three services, performed by a handful of members, on the ASCG "bread and butter" office based code with a volume of 236,000 with a work RVU of 1.4 and NF-PERVU of 4.7?

Impact

- 40% cut in PERVUS!
- Angry members
- Loss of dues
- ASCG-RIP!

Long Term Threats to the MFS

Increased demand for services

- Growth in number of elderly
- Increase in intensity of services per patient delivered annually
- Influence of new technology

Growth in number of elderly

- 20% increase in Medicare beneficiaries by 2010 and a doubling by 2040
- Rate of annual growth is accelerating when compared to the 70s (39%), 80s (20%) and 90s (15.7%)-*Health, United States, 2003, US Dept. of Health and Human Services*

New technology

- New technology, growth in GDP, asymmetric manpower shortages and asymmetric distribution are more important "drivers" medical spending than the aging population. Uwe E. Reinhardt, *Health Affairs. Vol. 22, Number 6, pgs 27-39*
- Aging only accounted for 1% annual increase in health care spending in the 90s. B.C. Strunk and P.B. Ginsburg, Data Bulletin,(*Washington: Center For Studying Health System Change, Nov*. 2002)

Evidence of growth in technology

- IN the last five years the RUC, the number of new diagnostic codes-XXXX-reviewed by the RUC increased by 50% over the first five year period
- Most of the increase in intensity of services driving the SGR are diagnostic codes, not surgical

Diagnostic codes

- Industry gets most of their profit from creating an ongoing revenue stream by charging for disposables
- Most new diagnostic codes include high priced disposables $100-$200
- Creates intra-specialty volatility of payment
- More of revenues go to supplies
- Less profit margin for docs

Diagnostic codes

- In the OPD, a new disposable has a two year pass through and then in bundled into APC payments-pricing pressure
- In the office, the disposable is priced once and there is no further pricing pressure. Great for industry-bad for docs.

Gating of new technology

- FDA
- Specialty societies
- CPT
- CMS
- Role of evidence based medicine

Specialty Societies

- Take an aggressive approach to evidence based technology assessment in the review of codes sent to CPT
- Educate members on the negative consequences of forwarding codes with high priced disposables when done in the office
- Inform staff and governing boards of the impact of new policies
- Understand what your lobbyists are doing in DC!

RUC

- Develop policies and procedures which quantify the impacts of site of service change and the pricing of disposables in the office.
- Develop “look back” mechanisms to ensure that the pricing of disposable doesn’t become a “profit center” for some docs at the detriment of others??

Summary

- In the end, value blind technology coverage leads to value blind payment cuts.

American Medical Association
Physicians dedicated to the health of America

William L. Rich III, MD, FACS
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
Chicago, Illinois 60610

312 464-5604
312 464-5849 Fax

May 3, 2004

Mark McClellan, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Doctor McClellan:

Enclosed for your review and consideration is the American Medical Association (AMA)/Specialty Society RVS Update Committee's (RUC) *Proposed Process, Work Plan, and Timetable for the third, Five-Year Review of the Resource-Based Relative Value Scale (RBRVS).*

The RUC understands that this Five-Year Review will be initiated with a CMS call for comment in the November 2004 *Final Rule* on the 2005 Medicare Physician Payment Schedule. We have proposed a process for review of physician work relative values for codes submitted during this comment period that is similar to processes utilized in the first and second Five-Year Reviews, concluded in 1997 and 2002. It is anticipated that any relative value revisions resulting from this review and CMS consideration, would be implemented on January 1, 2007.

The RUC has recently compiled a list of *Compelling Evidence Standards* that we propose to utilize for both identification of potentially mis-valued codes and for the review of the work relative value recommendations. The RUC recommends that CMS publish this document so all that are commenting may address these issues in their comment letters. We also urge CMS to review and screen comment letters to make sure that they meet minimal standards regarding compelling evidence, prior to submission to the RUC for review.

The RUC remains appreciative of the cooperative relationship between our committee and CMS staff and looks forward to a productive Five-Year Review. If you have any questions regarding our proposal, please contact Sherry Smith, AMA RUC staff, at (312) 464-5604 or Sherry_Smith@ama-assn.org.

Sincerely,

William L. Rich, III, MD, FACS

American Medical Association
Physicians dedicated to the health of America

William L. Rich III, MD, FACS
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
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June 1, 2004

Stephen Phillips
Director
Division of Practitioner Services
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard, C4-03-06
Baltimore, Maryland 21244

Dear Mr. Phillips:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) has reviewed the methodology to compute the professional liability insurance (PLI) relative value component of the Resource-Based Relative Value Scale (RBRVS). We offer a number of recommendations for the Centers for Medicare and Medicaid Services (CMS) to consider as you develop the Notice of Proposed Rulemaking (NPRM) for the 2005 Medicare Physician Payment Schedule.

In our September 30, 2003 comment letter regarding the August 15, 2003 NPRM for the 2004 Medicare Physician Payment Schedule, the RUC offered a number of recommendations, including:

- **CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict the 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years.** The RUC urges CMS to use the most recent data available for PLI payments. We also oppose weight averaging of multiple years of data. As recent PLI premiums have increased significantly, it would be unfair to dilute these increases with data from earlier year(s), which no longer reflect today's costs.

- **CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.** The inclusion of these costs is critical as insurance carriers have left the market, requiring increasingly more physicians to change PLI coverage and therefore incur the costs of tail coverage. We understand that CMS has not included these costs in the past.

- **In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least**

50% of the time, then a weighted average of the specialties (with the greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to assistant at surgery services should be removed from this analysis. The RUC is supportive of the letter submitted to CMS in May 2003 from a group of medical societies. This letter outlines a methodology for CMS to employ in considering this recommendation. The RUC is concerned that the weighted averaging reduces the potential payment to higher-risk specialties and increases the potential payment to lower-risk specialties.

- **The RUC recommends that PLI data for all specialties should be considered rather than the data from the 20 specialties with the highest volume.** The RUC does not agree with the current CMS approach, which used national average premium data from twenty specialties, and uses crosswalk assumptions for the remaining medical specialties and other health care professionals. The RUC is also concerned that the 20 specialties with the highest volume used in the prior updates include only three high-risk specialties (orthopaedic surgery, general surgery, and emergency medicine).

- **The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.** Several RUC members urged the PLI Workgroup to "think outside the box" and work with CMS to develop a different methodology for paying physicians for their share of the individual physician's professional liability insurance premium. This is a concept that we will explore at future RUC meetings and would welcome dialogue with CMS on this concept.

- **The RUC recommends that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable.** That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

The RUC considered the Bearing Point Proposal and specialty society comments received on the technical proposal. In general, the RUC would reaffirm its earlier recommendations made to CMS regarding PLI as many of these recommendations were not incorporated into this technical proposal. For example, the technical proposal mentions that the dominant specialty recommendation will be considered as one option. However, this proposal does not reflect the complete recommendation on this

issue and does not address the removal of the assistant-at-surgery claims from the utilization data.

In addition, a number of observations were made by specialty societies resulting in the following new RUC recommendations:

- **The exceptions for the surgical risk factor should be modified to include coding changes since the initiation of the resource-based PLI relative values in 2000.** The RUC recommends revision to the following exception:

  Invasive Cardiology Procedures. The following codes will receive the greater of their actual average risk factor or the risk factor for Cardiac Catheterization (3.16): ~~92980-92998~~ 92973-92974, 93501-~~9355~~93533, 93580-93581, 93600-~~9361~~493613, ~~93617-93641~~ and ~~93643~~ 93650-93652.

- **Any budget neutrality adjustments deemed necessary in the Five-Year Review of PLI relative values should be made to the conversion factor, rather than the relative value units.** The RUC notes that this would be consistent with the application of budget neutrality in the Five-Year Review of physician work relative values.

- **CMS should evaluate the PLI relative values related to the professional component/ technical component relative values.** For example, CPT code 76092 *Screening mammography* has a global PLI RVU of 0.11, the professional component is allocated .04 and the technical component is allocated .07. The actual PLI risk is related to the physician review and interpretation, not the performance of the mammogram. Therefore, the current breakdown of the PLI relative values is problematic. The RUC recommends that CMS conduct a comprehensive review of this issue during this Five-Year Review of PLI relative values.

- **The RUC expresses concern regarding the proposal's step to "normalize" the data to account for specialty concentration in higher or lower than average risk regions to avoid the purported "double counting."** The RUC would like to review further information regarding this data as it has concern about these assumptions.

- CMS appropriately considers a differential in PLI costs for obstetrical codes. **The RUC recommends that CMS also consider the increased costs for CPT codes provided by other providers for obstetric services, specifically**

anesthesiologists and pediatricians (eg, CPT codes 01958 – 01969 and 99436-99440).

We appreciate your consideration of these recommendations and look forward to reviewing the NPRM this summer. If you have any questions regarding our discussions and recommendations, please contact Sherry Smith at (312) 464-5604.

Sincerely,

William J Rich MD FACS

William Rich, MD

cc: Edith L Hambrick MD
Carolyn Mullen
Ken Simon, MD
Rick Ensor
RUC Participants