

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

Scottsdale Hilton Resort and Villas  
Scottsdale, Arizona  
February 10-11, 1995

**I. Call to Order**

Doctor Rodkey opened the meeting at 2:15 p.m. The following RUC members were in attendance.

Grant V. Rodkey, MD, Chair  
James Fanale, MD  
Robert E. Florin, MD  
John O. Gage, MD  
Timothy Gardner, MD  
Tracy Gordy, MD  
Kay K. Hanley, MD  
W. Benson Harer, MD  
Emily Hill, PA-C  
George F. Kwass, MD  
Charles F. Koopman, MD\*  
J. Leonard Lichtenfeld, MD  
Michael Maves, MD  
David McCaffree, MD

James Moorefield, MD  
Alan Morris, MD  
L. Charles Novak, MD  
Arvin I. Philippart, MD\*  
Neil Powe, MD  
William Rich, MD  
Peter Sawchuk, MD\*  
Chester Schmidt, MD  
Paul Schnur, MD\*  
Gregory A. Slachta, MD  
Ray E. Stowers, DO  
John Tudor, Jr., MD  
Richard Whitten, MD\*  
William L. Winters, MD

(\* indicates alternate member)

Thomas Ault, Terence Kay, Kay Jewell, MD and James Holloway, MD from the Health Care Financing Administration (HCFA) also attended.

The following facilitation committee was formed by Doctor Rodkey:

Doctor Novak (Chair)  
Doctor Lichtenfeld  
Doctor Koopman  
Doctor Fanale  
Doctor Sawchuk

Doctor Rodkey introduced Doctor Arvin Philippart, alternate RUC member from the American Pediatric Surgical Association, and Doctor James Fanale, RUC representative for the American Geriatrics Association.

Doctor Rodkey added two items to the agenda: a presentation by the American Society of Anesthesiologists and a draft section on the five-year review process for the Physician Payment Review Commission's Annual Report to Congress.

## **II. Approval of September 30 - October 2, 1994 Minutes**

Doctor Jewell noted that the HCFA organization chart had changed and distributed copies of the new one.

Doctor Tuck noted that the minutes for Neurology [Tab 17] should be revised to reflect the recommendation submitted to HCFA. The minutes of the September RUC meeting were approved as amended.

## **III. Calendar of Meeting Dates**

The RUC was reminded that the April 27-30 and the August 24-27 meetings will be held in Chicago.

## **IV. Roster of RUC Participants**

A roster was distributed including information on RUC members, advisors and specialty society staff contacts.

## **V. CPT Update**

Doctor Gordy reported that the CPT Editorial Panel will be considering a large number of issues at their next meeting, which will be held in Miami, Florida at the end of the month. He noted that he is unsure how many of these issues will be presented to the RUC at the April meeting.

Doctor Rodkey asked Doctor Gordy if any progress had been made on the issue of specialty societies using the same vignettes for the CPT and RUC processes. Doctor Gordy reported that at this point the specialty societies should be using the same vignettes for CPT and RUC. Sandy Sherman noted that in certain situations, a specialty society will have to alter a vignette for the RUC process to better reflect the physician work component of a procedure.

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

Doctor Tudor presented an oral report of the Subcommittee on the Five-Year Review. He reported that in addition to the meeting this morning, the subcommittee met on January 7 in Chicago to develop the survey instrument and review the timetable of the five-year review.

A proposed survey instrument for use by specialties in gathering information on the codes to be reviewed during the five-year review had been disseminated to RUC members, advisors, and staff contacts for review. Sherry Smith summarized the comments received on the survey instrument, and explained the changes that were made in response to those comments. Doctor Florin summarized his letter of January 22 to the subcommittee in which he suggested that the survey instrument should precisely define time periods. Doctor Gage suggested that the survey instrument be made sensitive enough to catch all of the components of physician work with respect to time. Sandy Sherman expressed concern that such a change would create an "illusion of precision."

Doctor Gage suggested that time be estimated in terms of intensity for each phase of work. He made a motion that the survey instrument be changed so that pre-service and post-service periods of work are rated for intensity and intensity is defined in Appendix A of the survey instructions. Doctor Kwass was concerned that this could flaw the data since most services were originally surveyed globally without intensity breakdowns for each phase of work.

The survey instrument was finalized and adopted.

AMA staff summarized the format of recommendations to be submitted to the RUC for the five-year review. This format will be different than the format of recommendations for new and revised codes. The new survey instrument will provide information that allows comparison of characteristics of services under review to characteristics of key reference services.

Objective data will be available on each of the codes under review and key reference services, including data being prepared by the AMA and data to be supplied by the specialties such as operative reports. The AMA will also develop a detailed profile of each service on the MPC and each service under review based on data provided by HCFA. This profile will provide information on frequency, site of service, length of stay, patient characteristics, diagnosis codes, average anesthesia time, specialties providing the service, other physicians involved in treatment, and other CPT codes reported during the same episode of care.

The summary of recommendation form was reviewed and approved by the subcommittee with the addition of a header over median time to differentiate time spent with a patient from the actual number of patient visits. This change was suggested by ACP staff.

HCFA staff provided a summary of the public comment process. There are 666 public comments. HCFA will deliver the comments to the AMA on February 24. The level of interest process will occur between February 28 and March 16. Responses to the level of interest process will be considered at the March 24-25 meeting of the subcommittee.

HCFA provided a sample of about 200 comments from the carrier medical directors (CMDs) for review. The subcommittee discussed a series of questions posed by HCFA staff about the identification of codes for review and potential approaches to the review of these codes:

1. How will the RUC prioritize its work since HCFA expects to refer approximately 1,000 codes to the five-year review process? The discussion for this issue focused on the type of information that HCFA could provide to assist the RUC in organizing its workload.
2. How will the RUC deal with recommendations for changes in the value of reference procedures? HCFA plans to refer all comments on "unstable" reference procedures to the RUC. Also, HCFA will refer comments to the RUC which are dependent on the unstable reference services.
3. How will the RUC deal with recommendations to change the value of an E/M service?
4. How will the RUC evaluate recommendations for a small change in relative value for a high frequency code? HCFA recommended that changes of 5% or less in RVUs not be considered.
5. Does the RUC want to evaluate comments on low volume codes?
6. Does the RUC want to evaluate undeveloped comments on significant issues? For example, gender specific codes that are comparable procedures have lower RVUs for females than males.
7. How will the RUC deal with recommendations to change relative values because coding conventions or rules create anomalies?

8. How will the RUC evaluate recommendations to create fixed relationships across families of codes for similar additional work?
9. How will the RUC deal with recommendations that are limited in scope? Will the RUC only deal with the comments received, or should HCFA or the RUC identify other codes that present the same issue?
10. How will the RUC evaluate comments which identify instances in which established rules are violated? Should review of these codes be more rigorous? If so, would the RUC or HCFA correct the problem?
11. HCFA asked that the RUC provide detailed rationale and information to evaluate RUC recommendations, including facilitation committee deliberations.

There was discussion of a regression analysis conducted by HCFA staff of the entire RBRVS and the reference set to identify codes that may be under or overvalued according to a number of factors. This analysis was provided to selected CMDs, who were asked to review it in a structured way, identify codes to be referred to the five-year review, and provide rationale for the inclusion of those codes in the process. Daniel Dunn, PhD, provided his analysis of the information on codes that had been provided to the CMDs by HCFA. Dr. Dunn noted in his analysis that HCFA's methodology was focused on the ability of the CMDs to compare relative work, time, and intensity estimates across services in the RBRVS. Dr. Dunn suggested that the analysis and data provided by HCFA for the review of the RBRVS physician work values could be used as one approach for the identification of misvalued services. However, the process for evaluating intraservice work and intensity, two important components of the five-year review process, were not correct and may not have allowed the CMDs to make valid assessments about the current RVUs for certain procedures.

Kurt Gillis, PhD, presented information on an AMA Trends Analysis of BMAD data. Dr. Gillis presented six tables that identified changes in utilization, site of service, and specialty mix. RUC members were asked to review the tables and identify additional codes for review.





Doctor Rodkey presented a list of eight multidisciplinary workgroups that include all 26 members of the RUC. These workgroups will advise the specialty societies conducting surveys and the full RUC. Once the codes to be reviewed are known, the subcommittee will determine assignments of codes to workgroups. Doctor Tudor noted that the workgroups will act as pre-facilitation committees and will be a way for the RUC to expedite the review process. Doctor Tudor also noted that at the March 24-25 meeting of the subcommittee a detailed workplan will be developed for reviewing comments on codes referred to the five-year review.

The RUC accepted Doctor Tudor's oral report.

## **VII. RBRVS Practice Cost Component**

Sandy Sherman summarized the staff note on the RBRVS Practice Cost Component. In October, Congress passed legislation requiring HCFA to develop "resource-based" practice expense relative values for implementation in 1998. In November, HCFA published a Request for Proposals seeking a contractor to collect data on physicians' resource costs. Next, HCFA will award contracts to multiple researchers who will consider various methods to collect data that could be used to develop new relative values. Finally, HCFA will select a preferred methodology and develop new practice expense relative values.

At the December AMA Interim Meeting, AMA staff met with the RUC Chair and AMA representatives to discuss potential involvement in this study. On December 21, a conference call was convened of interested RUC members to discuss this suggestion. Of the 26 RUC members, 22 of them indicated an interest in participating in the conference call and 20 participated. At the conclusion of the call it was determined that:

-  staff should attempt to gather more information about the study;
-  staff should use this information to develop options for potential RUC involvement that can be discussed at the full RUC;
-  time should allocated at the February meeting to discuss this issue; and
-  there should be no expression of RUC interest in becoming involved in the practice expense study until after this more informed discussion has occurred and unless there is some agreement by the RUC on a specific plan of action.

Sandy also stressed that the role of the RUC would be strictly advisory. The RUC would not conduct a survey process nor would the RUC hinder the participation of other medical specialty societies in this process. The RUC participation would be similar to the participation of the AMA in the Harvard study which was advisory.

Thomas Ault from HCFA provided an update on the practice expense issue for the RUC. He reported that HCFA was currently in the process of reviewing proposals that were received in response to the November Request for Proposals.

Doctor Rodkey asked the RUC what role if any they should play in this process. In response, Doctor Powe stated that ACP opposes any role for the RUC in this process. The ACP feels strongly that the mission of the RUC is to focus on work relative values. Doctor Tudor stated that AAFP feels that the RUC should confine its scope to work relative values. Conversely, Doctor Gage felt that the role of the RUC should not be limited to only one aspect of reimbursement. Doctor Sigsbee urged the RUC to get involved in this process since the RUC understands the RBRVS better than any other physicians. He feels that the RUC should have a strong monitoring role with participants on the panel. Doctor Florin pointed out that the RUC is the Relative Value Scale Update Committee, not just the physician work update committee, and if HCFA is offering an opportunity for RUC involvement we should take advantage of it. Doctor Gardner stated that he was in favor of RUC involvement in this issue because of past experience in dealing with the RBRVS. He stated further that he felt that the process that Mr. Ault described would not allow any particular group to have a dominant role except for HCFA. Doctors Maves and Winters also support RUC involvement in this process.

Doctor Lichtenfeld stated support for a RUC liaison role that would be advisory in nature, much like the RUC members' role in the HCFA refinement panels. Doctor Tuck shared Doctor Lichtenfeld's view but said that the RUC should be sensitive to "primary care paranoia" on this issue. He agreed that the RUC should have a limited role on this issue and involve RUC alternates and advisors. Doctor Tudor agreed with Doctor Tuck's perception of "primary care paranoia."

Barry Eisenberg made the following points:

1. Page 1, Tab A of the RUC structure and function document states: "Relative value recommendations will initially focus on the physician work component of the Medicare RVS. In the future the Process may be used to establish overhead and professional liability components of the RBRVS."

2. There has never been a clear distinction between work and the practice cost components of the RBRVS.

In response to Barry Eisenberg's comments, Doctor Philippart observed that in some cases work and practice costs have been folded together, and the problem with the practice cost component is that nobody really understands it. Emily Hill noted that in some cases non-physician providers are the practice expense. She also asked the RUC to include the HCPAC if they become involved in this issue.

Doctor Novak made a motion that the RUC express its interest to HCFA in participating in a liaison role in the resource-based practice expense study. Doctor Powe asked that the vote be recorded. He also restated ACP's objection to RUC involvement in this issue. The view of ACP is that the RUC was set up to comment on relative work values of the RBRVS only. Further, if the RUC decides to get involved in the evaluation of other components of the RBRVS, then the set-up of the RUC should be re-evaluated.

In response to Doctor Powe, Doctor Gage pointed out that, until now, Congress/HCFA would not allow the RUC to evaluate other components of the RBRVS, and since the RUC now has the opportunity to be involved in evaluating other RBRVS components that we should take advantage of it.

Doctor Novak's motion was restated and the RUC voted 22 to 2 to adopt the motion. Doctors Hanley, Gage, Tuck, Slachta, Gardner, Morris, Stowers, Novak, Maves, Fanale, Schmidt, Philippart, McCaffree, Schnur, Florin, Harer, Kwass, Rich, Lichtenfeld, Moorefield, Winters, and Sawchuk voted in favor of the motion. Doctors Powe and Tudor voted against the motion.

### **VIII. Definition of Internal Medicine Subspecialty**

The RUC discussed concerns raised by the American College of Rheumatology (ACR<sub>h</sub>) regarding the recent election of two RUC rotating seats. At the September RUC meeting, the American Geriatrics Society and the American Pediatric Surgical Association were elected. A short time after the meeting, it was brought to the attention of AMA staff that the ACR<sub>h</sub> was disappointed in the results of the election and questioned the election process. Correspondence between AMA and ACR<sub>h</sub> was included in the agenda book.

Doctor Rodkey stated that, when the RUC was first formed, geriatrics was considered an internal medicine subspecialty and, prior to the vote at the September RUC meeting, the RUC determined that geriatric medicine would be considered an internal medicine subspecialty. Doctor Tudor commented that there was no prior notice regarding how the seats would be defined before the September election and that it is his understanding that geriatricians must be board certified in family practice or internal medicine; however, board certification does not determine what specialties are elected to seats on the RUC. Doctor Fanale, who represents the American Geriatrics Society on the RUC, stated that it is crucial that geriatrics be represented on the RUC since over 90% of geriatric patients are Medicare recipients.

Since no formal motion was offered on this issue, Doctor Rodkey told the representatives of ACR<sub>h</sub> that this issue would be revisited before the next RUC election. Until then, rheumatology will still be able to fully participate in the RUC process through its membership on the RUC Advisory Committee.

### **IX. Report of the HCPAC Review Board**

The RUC HCPAC Review Board met on February 9. Emily Hill reported that the Review Board adopted a cross-profession reference list of 100 codes. The list represents services that are commonly performed by the nine non-MD/DO specialties represented on the HCPAC. The HCPAC also reviewed and adopted recommendations for four physical therapy codes presented by the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA). The Review Board also discussed the involvement of APTA in the survey of consensus recommendations with the American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, and the American Association of Electrodiagnostic Medicine for electrodiagnostic medicine services. APTA noted the cooperation and involvement of the MD organizations in developing appropriate relative values. Each of the nine organizations represented on the HCPAC briefly discussed their comments to HCFA on the five-year review of the RBRVS. Of the nine organizations, only four organizations AOTA, the American Psychological Association, the American Podiatric Medical Association, and the American Speech-Language Hearing Association commented on specific codes. The report was accepted by the RUC.

**X. Relative Value Recommendations**

1. **Transperineal Radioactive Substance Insertion of the Prostate[Tab 9]  
RUC Tracking Numbers: K1 and K2**

This issue was withdrawn by the specialty society.

2. **Infusion Pump Insertion[Tab 10]  
RUC Tracking Numbers: L2, L3, L4, L5, L6, L7, L8, L9, and L10  
Presentation: Harry Van Loveren, MD, Richard Penn, MD, and Brian Gwartz, MD,  
American Association of Neurosurgeons, American Society of Anesthesiology**

This issue was referred back to the specialty society.

3. **Newborn Discharge[Tab 11]  
RUC Tracking Number: O1**

This issue was withdrawn by the specialty society.

4. **Electrodiagnostic Medicine[Tab 12]  
RUC Tracking Numbers: M3, M5, M6, M7, M9, and M10  
Presentation: Neil Busis, MD, Stephen Ribaud, MD, and Bruce Sigsbee, MD, American  
Academy of Neurology, American Academy of Physical Medicine and Rehabilitation,  
American Association of Electrodiagnostic Medicine, and American Physical Therapy  
Association**

Tracking numbers M9 and M10 passed, while numbers M3, M5, M6 and M7 were referred to the facilitation committee chaired by Doctor Novak. The committee will convene a conference call prior to the April RUC meeting and will present a report at this meeting.

5. **Group Preventive Medicine Counseling  
CPT Codes: 99411 and 99412  
Presentation: Anthony Hirsch, MD, American Academy of Family Physicians, American  
Academy of Pediatrics, American College of Obstetrics and Gynecologists, and American  
College of Preventive Medicine**

At the September RUC meeting in Seattle, the Group Preventive Medicine Counseling codes were referred back to the specialty societies for further review. Since these codes had been previously surveyed on two occasions, the specialty societies contacted the RUC Research Subcommittee for assistance in determining the appropriate methodology to value these procedures.

The RUC advisors for AAFP, AAP, ACOG, ACPM, staff from those specialty societies, Doctors Lichtenfeld, Gordy, and Sandy Sherman participated in a conference call to discuss how to value preventive medicine groups counseling services. The major concern of the RUC was that the values that were sought for the preventive medicine group counseling codes seemed too high when compared to psychotherapy codes 90849 [Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated] and 90853 [Group Medical Psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated.]. In addition the RUC expressed concern that the work per unit of time for the codes was too high. It was determined that the methodology to value these procedures should be the same as what was used to value the multiple-family group psychotherapy code, 90849. The ratio between the values for individual and group medical psychotherapy was used to compute the relative value for 99411 [Preventive Medicine group counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.] The calculations were as follows:

[99411] Assume the relationship between the physician work for individual vs. group psychotherapy is consistent with the relationship between physician work for individual vs. group preventive medicine counseling.  $90842/90853 = 99402/99411$ ,  $2.74/4.3 = 0.98/99411$  therefore,  $99411 = 0.15$

[99412] Assume the relationship between the physician work for individual vs. group psychotherapy identified in the latest survey is appropriate.  $99411/99412 = 0.6$ ,  $0.15/99412 = 0.6$ , therefore,  $99412 = 0.25$  The ratio calculation for 99412 was based on a survey of approximately 150 physicians the results of which were presented at the September RUC meeting.

Using these calculations it was determined that the use of the comparison to the difference between individual and group psychotherapy was the most accurate measure of the difference between individual and group preventive medicine counseling. It was also determined that the most accurate measure of the difference in physician work between 99411 and 99412 was the ration applied by survey respondents to the difference between 30 to 60 minutes of preventive medicine group counseling.

During the presentation, Doctor Hirsch stressed that the purpose of these codes are not to lecture to patients on the "ills of the world". These services are interactive and require participation from both the patient and physician. He also noted that the presumed number of patients that would be receiving the services described by 99411 is five, and 99412 assumes that six patients are receiving services.

In response to questions raised during the discussion that pertained to potential abuse of these codes, Sandy Sherman noted that it is not the job of the RUC to police potential abuse.



The RUC accepted the specialties' recommended value of 0.15 RVUs for 99411 and 0.25 RVUs for 99412.

6. **End Stage Renal Disease[Tab 14]**

**CPT Code: 90921**

**Presentation: Emil Paganini, MD, Richard Hamburger, MD and Louis Diamond, MD, Renal Physicians Association**

The building block method previously utilized by both the RUC and the HCFA CMD panel was used to develop the current RUC recommendation of 5.06 for 90921 [End stage renal disease (ESRD) related services per full month; for patients twenty years of age and over]. The building block method incorporates various levels of evaluation and management services determined by previous studies conducted to evaluate the services rendered to dialysis patients. Oversight care is also included in the calculation of the work value.

The 1983 study undertaken by the University of Southern California, Division of Research in Medical Education under contract from HCFA and DHHS entitled "Physicians who care for End Stage Renal Disease Patients: A National Study of their Practices, Patients and Patient Care" (Mendenhall Study) was utilized as a description of physician work. In an effort to update this data, the Renal Physicians Association (RPA) utilized a 1991 RPA physician activity survey, as well as the responses from the RUC survey completed in 1994.

Mendenhall Study

The Mendenhall study found that patients are seen an average of **1.7 times per week** by their nephrologist. The activity of the physician regarding "other encounters" was also studied. The study found that the amount of activities such as phone encounters with the patient and other health care providers (nurse, dialysis technician, social worker, dietician, nursing home, etc.) increased with age and complexity of the patient.

RPA 1991 MCP Survey

This survey, conducted by the RPA, was sent to 1000 randomly chosen nephrologist in practice during 1991. The survey instrument consisted of a series of questions regarding the frequency of visits in the dialysis unit, the level of activity as judged by the assessment of diagnostic tests, therapeutic procedures, and the occurrence of patient care conferences, patient family meetings and patient/family telephone encounters and non-renal patient care activity rendered to dialysis patients. The survey results found that physicians typically visited their patients **5.7 times per month** in the dialysis unit and **1.2 times per month** in the office. The survey also found that physician interventions in dialysis (eg, dialysis prescription changes or medication changes) occurred **3.3 times per month**.

RPA-RUC Survey

The RUC survey was distributed to 104 nephrologists randomly chosen from the Renal Physician Association Nephrology Database. The cited services used by the majority of the survey respondents included Evaluation and Management services related to an established patient outpatient visit: 99215 was utilized by 98% of the survey participants; other E/M services (in

descending order) included 99213 (69.7%), 99214 (60%), 99211 (58%), and 99205 (39.5%). These responses indicate that the level of physician service delivered to the patient has increased in complexity compared to the Mendenhall study.

Care Plan Oversight Services

The ESRD program has functioned with a multidisciplinary approach to patient care. As part of the quality review process, all patients must have at least yearly "long-term care plans" and at least biannual "short term care plans," these latter frequently developed in the more complicated patient at monthly intervals. A significant amount of time is spent in direct meetings with other health care providers (dietary, social service, nursing, administration) in an attempt to help these chronic patients through the rigors of dialytic supports, and the complications of both their renal-related conditions as well as other underlying entities which may have influence on overall patient well-being and outcome. The renal physician acts as the team leader in these discussions and is actively involved in the implementation. This activity has been documented both in the Mendenhall Study, and in the RPA 1991 MCP survey.

Since HCFA has determined that care plan oversight services eligible for separate payment "include the physician supervision and management of complex or multidisciplinary care modalities involving regular physician development or revision" (Federal Register, vol 59, no 235, p 63419), and further that these services "necessitate a high level of decision-making and go beyond administrative function", this service rendered for the dialysis patient should have value in the composite building of the MCP. Although all patients will receive the mandated team coordinations and discussion, there are increasing numbers of patients with highly complex health care needs which require increasing time from the physician. This patient demographic can be easily extracted from the USRDS database, and substantiated by HCFA BMAD data. It is therefore essential that physician work for care plan oversight (1.06) be incorporated into the work value for 90921, as was done in the original submission from the RUC, but eliminated by the CMD panel during their evaluation of the recommendation.

CALCULATION OF CURRENT RVW RECOMMENDATION

FOR HEMODIALYSIS:

Total number of dialysis per month	13	(Standard - dialysis 3 times per week)
Total number of visits per month	6.9	(Mendenhall = 6.8/1991 RPA Survey = 6.9)
visits in office	1.2	(1991 RPA Survey)
visits in dialysis unit	5.7	(1991 RPA Survey)
interventions	3.3	(1991 RPA Survey)
Translation to Work Values		
Face to Face:		
99215 (1.51) X 1.2	1.812	(1991 RPA Survey and 1994 RUC Survey)
99213 (0.55) X 3.3	1.815	(3.3 interventions per month - 1991 RPA Survey)
99212 (0.38) X <u>2.4</u>	0.912	(remaining dialysis visits per month)
Total Visits	6.9	
Care Plan Oversight:		
99375 (1.06) X 1	<u>1.060</u>	

Hemodialysis Relative Work Value 5.599

FOR PERITONEAL DIALYSIS:

47% of Hemodialysis (5.599 X .47) 2.632 (Ratio used by RUC and CMD panel in previous calculations)

CALCULATION FOR FINAL RVW FOR CPT CODE 90921:

Blend of Hemodialysis (82% of patients, per frequency ratio used by RUC and CMD panel in previous calculations) and Peritoneal Dialysis (18% of patients)

$$(0.82 \times 5.599) + (0.18 \times 2.632) = \mathbf{5.06}$$

**XI. Other Issues**

Anesthesiology Abt Study

The RUC received a report from the Doctor Karl Becker on behalf of the American College of Anesthesiology (ASA) about an evaluation of the anesthesia relative values by Abt Associates. Doctor Becker reported that ASA has felt that the anesthesia codes are undervalued due to the failure of the Harvard study to analyze all of the components of physician work involved in the provision of anesthesia. Instead of separately analyzing the components of anesthesia work, the Harvard study compared the work of anesthesia to medicine. There was also no analysis performed with regard to intra-service time and work intensity in the Harvard study for anesthesia. The Abt study was commissioned to analyze all five components of anesthesia time and looked at fifteen anesthesia services.

A suggestion was made that the RUC deal with this issue as part of the Research Subcommittee meeting that will review that Abt study methodology from the orthopaedic surgeons and the otolaryngologists. After further discussion of this issue the RUC decided that the anesthesiology Abt study as well as the Abt studies for otolaryngology and orthopaedic surgery, will be reviewed by the Research Subcommittee at a full day meeting on April 27. Sandy Sherman clarified that the two issues be considered with regard to these studies are (1) the realignment of work values within orthopaedic surgery and otolaryngology and (2) whether anesthesiology services are over-, under-, or appropriately valued relative to other services. Doctor Kwass suggested that Dr. Dunn be asked to consider these issues.

Physician Payment Review Commission Report

Doctor David Shapiro from the Physician Payment Review Commission had provided a draft to Doctor Rodkey of a section on the five-year review process for the PPRC's Annual Report to Congress which was distributed at the meeting. The RUC made specific comments of the document including: clarification of the section that describes the use of vignettes in the survey process; clarification of the section on feedback to the CPT Editorial Panel; and expanding the documents' discussion of the reference service list. In the next few weeks, Sandy Sherman will draft a response to this document which will be reviewed by the full RUC.

The meeting was adjourned at 2:45 pm on Saturday.