

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING
February 9-11, 1996

Stouffer Renaissance Cottonwoods Resort
Scottsdale, Arizona

MINUTES

I. Call to Order and Opening Remarks

Doctor Rodkey called the meeting to order at 9:00 a.m. The following RUC members were in attendance:

Grant V. Rodkey, MD, Chair	David McCaffree, MD
James Fanale, MD	James Moorefield, MD
Robert E. Florin, MD	Alan Morris, MD
John O. Gage, MD	L. Charles Novak, MD
Timothy Gardner, MD	Neil Powe, MD
Tracy Gordy, MD	William Rich, MD
Kay K. Hanley, MD	Peter Sawchuk, MD*
W. Benson Harer, MD	Chester Schmidt, MD
James E. Hayes, MD	Paul Schnur, MD*
David F. Hitzeman, DO	Ray E. Stowers, DO
James G. Hoehn, MD	Richard Tuck, MD
H. Logan Holtgrewe, MD	Charles Vanchiere, MD
Emily Hill, PA-C	John Tudor, Jr., MD
Dudley D. Jones, MD	Richard Whitten, MD*
Charles F. Koopmann, MD	Eugene Wiener, MD
J. Leonard Lichtenfeld, MD	William L. Winters, MD
Michael D. Maves, MD	

(* indicates alternate member)

Grant Bagley, MD, from the Health Care Financing Administration (HCFA) also attended, as did several physicians from British Columbia.

The following facilitation committees were appointed by Doctor Rodkey:






Doctor McCaffree (Chair)	Doctor Hanley (Chair)
Doctor Schmidt	Doctor Hitzeman
Doctor Wiener	Doctor Fanale
Doctor Maloney	Doctor Novak
Doctor Hayes	
Doctor Harer (Chair)	
Doctor Jones	
Doctor Mabry	
Doctor Florin	
Doctor Powe	

II. Introduction of New Members

Doctor Rodkey introduced new RUC members: Doctors Dudley Jones, David Hitzeman, Charles Koopmann, and Charles Vanchiere. He also introduced several new RUC alternates and Advisory Committee members for whom the February RUC meeting was their first introduction to the RUC. It was announced that Doctor Hoehn has been appointed by the AMA Board of Trustees to succeed Doctor Rodkey as RUC Chair at the conclusion of his term in mid-1997. Until that time, Doctor Hoehn will continue to hold the plastic surgery seat on the RUC.

RUC Subcommittees

Doctor Rodkey appointed Doctor Rich to succeed Doctor Kwass as Chair of the Research Subcommittee (Doctor Kwass will continue as the RUC Advisor for the College of American Pathologists). Doctor Rodkey announced several other changes in RUC subcommittees and subcommittee procedures based on consultation with several members of the RUC:

-  To increase the participation of members of the Advisory Committee and the HCPAC in the RUC process, Advisors and HCPAC members will be added to RUC subcommittees and facilitation committees.
-  To improve the efficiency of subcommittee meetings, in general, subcommittee meetings will be open to all other members of the RUC, but closed to specialty staff contacts, except for those who may be presenting information to the subcommittee. Subcommittee Chairs will continue to have discretion on this point, however, if they wish to have an open meeting or arrange for a portion of a meeting to be open to other attendees.
-  Research Subcommittee: Doctor Rodkey announced the following appointments to the Research Subcommittee for the second term: Doctors Rich (Chair), Britton, Florin, Gee, Gerety, Hoehn, Kwass, Tudor, and Sullivan-Marx. He also referred to the Research Subcommittee the question of whether the workgroup review process used in the five-year review might be expanded for use in the annual update process. Three issues have already been referred to the Research Subcommittee: development of a revised RUC survey instrument incorporating features of the five-year review questionnaire, exploration of the idea of "intensity," and "add-on codes." The Research Subcommittee will meet in April.
-  Five-Year Review and Cross-Specialty Reference List Subcommittees: The work of these subcommittees has been concluded, so they will be discontinued. Doctor Rodkey asked Doctor Tudor to develop, with input from the other members of the Subcommittee on the Five-Year Review, a report for the RUC on the lessons learned from the first five-year review and any suggestions for the next time around.
-  Practice Cost Subcommittee: Doctor Rodkey announced the establishment of a new RUC subcommittee focusing on practice costs. Doctor Powe questioned the charge to this new subcommittee. There was also considerable discussion about the ongoing Abt study, other studies funded by HCFA, and potential roles for the RUC related to practice cost relative values (*see item IX, page 11*). The subcommittee was charged with monitoring HCFA's efforts to develop new practice cost relative values, making a report to the RUC at its April 1996 meeting and possibly updating the practice cost component of new and revised CPT codes. The subcommittee, at its discretion, may also explore potential next steps on this issue. Any identified

next steps will be forwarded to the full RUC for discussion and consideration. Doctor Rodkey announced the following appointments to this subcommittee: Doctors Lichtenfeld (Chair), Gage, Gardner, Lenet, Moorefield, Novak, Powe, Runowitz, and Sigsbee.

III. Approval of Minutes

Doctor Novak requested that the third sentence of paragraph 7, on page 3, of the April 1995 minutes be changed to read: *The intensity values were defined as the work per minute of four services: established patient office visits, epidural injection, critical care, and a group of very high intensity services such as aortic valve repair.* Doctor Tuck requested that the third sentence of paragraph 4, on page 7, of the April 1995, minutes be changed to read: *In their comments on this Rule, the American Academy of Pediatrics identified 480 codes for which they believe physician work is significantly different when the services are provided to pediatric patients than to adult patients.* Doctor Harer requested that the last sentence of the discussion on Medical Liability Reform on page 9, of the April 1995, minutes be deleted. After some discussion of this issue, AMA staff was directed by the RUC to obtain a legal opinion on the "discoverability" of RUC minutes. The minutes of the April 1995 RUC meeting were approved as amended.

Doctor Morris noted that the RUC's action on CPT code 27052 was recorded twice in the August minutes, and was incorrect in one instance. Doctor Gage requested that the discussion in the minutes of the implementation of the five-year review reflect that the five-year review issues that were referred to CPT will be implemented January 1, 1997. Doctor Powe requested that the discussion of impact analyses include information on the number of CPT codes that had RVUs that were increased or decreased as a result of the five-year review, as Doctor Berenson had inquired at the August meeting. The minutes were approved as amended.

IV. Amendments to Structure and Functions

The RUC adopted an amendment to its Structure and Functions document (Tab A, III(A), 4(c)) changing the terms of the AMA representative and alternative representative to three years with a limit of six years, since the specialty representatives to the RUC have three-year terms.

V. Calendar of Meeting Dates

The RUC was informed that the April 25-28 RUC meeting will be held in Chicago at the Marriott on Michigan Avenue. Sandy Sherman reported that this year's annual CPT Symposium may be expanded to include a one-day optional seminar on forthcoming changes in Medicare's RBRVS as a result of the five-year review. Sandy also explained that only a limited number of RUC participants have been using the RUC conference on the electronic network, while use of the Internet seems to be growing exponentially. She requested that the RUC attendees provide AMA staff with their e-mail addresses if they have one. She also reported that AMA staff is working closely with those who maintain the AMA Home Page on the World Wide Web to develop a Coding and Payment Programs site as part of the AMA Home Page.

AMA staff reported that the AMA sent a comment letter to HCFA on the interim relative value units for Medicare's 1996 RBRVS physician payment schedule. Copies of this letter were made available at the meeting.

VI. CPT Update

Doctor Gordy reported to the RUC that the CPT Editorial will be considering 68 issues at its February 1996 meeting.

VII. RUC HCPAC Review Board Report

The RUC HCPAC Review Board met on Thursday, February 8. The Review Board Co-Chair, Emily Hill, PA-C, reported that the RUC HCPAC plans to reconsider the physical and occupational therapy codes (CPT codes 97010-97770) referred back by HCFA. HCFA believes that the RVUs assigned to the therapeutic procedures are too high relative to other services on the fee schedule. A workgroup chaired by Doctor Whitten was formed to discuss this issue and the RUC will receive a report of the Review Board response at the April meeting.

During the five-year review, the American Psychological Association (APA), the American Speech-Hearing and Language Association (ASHA), and the American Audiological Association (AAA) submitted comments to HCFA for the five-year review on codes that currently have zero work relative value units. They commented that HCFA's decision not to assign work RVUs to these services is inconsistent with other Codes on the fee schedule, including other services that are principally provided by non-MD/DOs. Doctor Grant Bagley agreed that inconsistencies exist in the current RBRVS and suggested that the Review Board develop a proposal to persuade HCFA to review certain codes with zero work RVUs and proposals for addressing codes with a physician work value of zero for which comments were submitted during the five-year review.

There was considerable discussion regarding potential changes in the structure and procedures for the HCPAC. The Review Board will continue to discuss the process of reviewing work relative value recommendations for non-MD/DO services and will direct any changes proposals for change to the Chair of the RUC. Doctor Rodkey asked the RUC to consider whether the HCPAC co-chair should have a voting seat on the RUC, but the RUC deferred consideration of this question until the AMA General Counsel's office could evaluate it.

The RUC accepted Emily Hill's Report.

VIII. Five-Year Review of the RBRVS

HCFA Review of RUC Recommendations

HCFA has completed its review of the RUC's recommendations for the five-year review which were submitted in September and anticipates an acceptance rate of greater than 90%. Doctor Bagley reported that the quality of the recommendations was very high, but he also noted that the Notice of Proposed Rulemaking will identify several areas where HCFA has questions and concerns that they would like the RUC to consider or reconsider.

Doctor Bagley raised the question of whether and how the relative values for global surgical procedures may be affected by changes in evaluation and management (E/M) services. Several members expressed the opinion that any change in E/M work values should be matched by corresponding increases in surgical global fees since many E/M services provided by surgeons are bundled into the 90-day global packages. Other members cited the need for current data on the components of global surgical packages to be collected before this issue can be more fully addressed. Later in the meeting, Doctor Rodkey indicated that Doctor Gage would be working with the American College of Surgeons to initiate a project to collect these data. He appointed a workgroup including Doctors Florin, Koopmann, Kwass, Lichtenfeld, and Moorefield to advise Doctor Gage in this effort and report at the April RUC meeting.

Relative Value Recommendations for Interim Recommendations from the Five-Year Review:

Appendectomy[Tab 10]

CPT Codes: 44950 and 56315

Presentation: John O. Gage, MD, American College of Surgery

After the five-year review recommendations had been submitted to HCFA, it was brought to the attention of staff and the workgroup that considered general surgery codes that the recommendations for the appendectomy codes were in error. Since the discrepancy could not be resolved, HCFA agreed to take no action on the appendectomy recommendations until the issue was revisited at the February RUC meeting.

The RUC recommends that the work relative value for 44950 *Appendectomy* and 56315 *Laparoscopy, surgical; appendectomy* be increased from 6.06 to 8.25. Compelling evidence was presented that the Harvard survey was flawed and incorrectly valued this service. For example, the survey included a different vignette for family physicians than was used to survey general surgeons which resulted in a 45% difference in intra-service work estimates between the two groups. The RUC was also convinced by the objective data provided by the American College of Surgeons that the intra-service time for the appendectomy was at least 50 minutes, which is significantly higher than the 37 minutes estimated by Harvard.

In addition, a rank order anomaly currently exists between the relative value for these codes in comparison to 44900 *Incision and drainage of appendiceal abscess, transabdominal* (work rvu=7.86) and 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* (work rvu=9.78). Code 44900 is used for percutaneous or open drainage of postoperative abscesses after the appendix has been removed and involves less physician work than an appendectomy. Code 44950 involves somewhat less work than 44960, and it is clearly an emergent procedure performed under highly urgent conditions.

Revision of Hip and Knee Arthroplasty[Tab 11]

CPT Codes: 27137, 27138, and 27487

Presentation: Richard Haynes, MD, American Academy of Orthopaedic Surgeons

At the August meeting, the RUC adopted increased work relative values for CPT codes 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* and 27486 *Revision of total knee arthroplasty, with or without allograft; one component*, but did not accept increases for the other codes in the same family (27137, 27138, and 27487). This action created an anomaly in the relationship between the work relative values in these groups of codes, which the RUC recommends be corrected with the following final recommendations:

Code	Short Descriptor	1996 RVU	Interim Final RUC Rec.	RUC Rec.
27134	Revise hip joint replacement	24.54	27.00	27.00
27137	Revise hip joint replacement	18.67	18.67	20.00
27138	Revise hip joint replacement	18.93	18.93	21.00
27486	Revise knee joint replacement	16.63	18.00	18.00
27487	Revise knee joint replacement	21.69	21.69	24.00

The RUC was convinced that the patient population receiving these services has become more complex since the Harvard study, with increasing numbers of patients receiving re-revisions.

Other Orthopaedic Surgery[Tab 12]

CPT Codes: 25810, 27052, 28002

Presentation: Richard Haynes, MD, American Academy of Orthopaedic Surgeons

At its August meeting, the RUC found no compelling evidence to recommend an increase to the relative values for CPT codes 25810, 27052, and 28002 and recommended maintaining the current values of these codes on an interim basis. The specialty society was given the opportunity to present additional evidence at the February meeting. Based on the new evidence, the RUC reaffirmed its earlier work RVU recommendations for the following services:

Code	Short Descriptor	1996 RVU	Interim Final RUC Rec.	RUC Rec.
25810	Fusion/graft of wrist joint	9.79	9.79	9.79
27052	Biopsy of hip joint	5.45	5.45	5.45
28002	Treatment of foot infection	3.76	3.76	3.76

Oral and Maxillofacial Surgery[Tab 13]

CPT Codes: 21125 and 21270

Presentation: Lewis Estabrooks, DMD, American Association of Oral and Maxillofacial Surgeons

As an interim recommendation, the RUC had recommended no change in the current work RVU for these services until all interested organizations were given the opportunity to survey and comment. The American Association of Oral and Maxillofacial Surgeons (AAOMS) surveyed 30 members and presented the survey median to the RUC. The American Academy of Orthopaedic Surgeons and the American Academy of Otolaryngology - Head and Neck Surgery, Inc. did not comment on the AAOMS recommendations. The American Society of Plastic and Reconstructive Surgeons agreed with the recommendations.

The RUC agreed that the current rank order between these services is incorrect. CPT codes 21270 *Malar augmentation, prosthetic material (1996 work RVU = 12.10)* and 21125 *Augmentation, mandibular body or angle; prosthetic material (1996 work RVU = 6.22)* are similar in work to codes 21208 *Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant (1996 work RVU = 9.56)* and 21210 *Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) (1996 work RVU = 9.56)*. Each of these codes involve the placement of prosthetic materials. Although 21125 is similar to 21270, it is more difficult in work, stress and effort and requires longer intra-service time due to the location of the incision and augmentation. The RUC recommends that 21270 be reduced to 9.56 and 21125 be increased to 10.00.

Podiatry[Tab 14]

CPT Codes: 28114 and 28010

Presentation: Richard Lee, DPM, American Podiatric Medical Association

At its August meeting, the RUC found no compelling evidence to recommend an increase to the relative values for CPT codes 28114 and 28010. The specialty society was given the opportunity to present additional evidence at the February RUC meeting. CPT code 28114 was referred to the facilitation committee chaired by Doctor Harer. The facilitation committee agreed with the specialty that the code was undervalued based on the following new information that was reported: a survey of 66 podiatrists which suggests that the current work RVU of 7.16 for 28114 *Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)* is too low and resulted in a median of 10.60. APMA also calculated an RVU for this service using the multiple surgery rules as follows:

28112 (4.23)	x	100%	4.230
28112 (4.23)	x	50%	2.145
28112 (4.23)	x	50%	2.145
28113 (4.09)	x	50%	<u>2.045</u>
Computed Work RVU			10.52

This would still not recognize the additional work associated with performing the partial phalangectomies of the metatarsophalangeal joint. 28114 is also comparable in work to 28725 *Subtalar arthrodesis* (rvu = 10.86) as both have similar intra-service time.

The RUC reviewed this service in relationship to 28113 *Ostectomy, complete excision; fifth metatarsal head* (rvu =4.09) and determined that the intra-service intensity of the two services should be equal. The RUC calculated a new RVU as follows:

1996 RVU for 28114	7.16
- Intra-service work	<u>3.64</u>
Pre-, post-service work	3.52
Intra-service intensity for 28113	.057
Intra-service time for 28114	<u>90</u> minutes
Intra-service Work for 28114	5.13
+ Pre, post-service work	<u>3.52</u>
RUC Recommendation	8.65

The RUC accepted the facilitation committee recommendation for this procedure.

28010 *Tenotomy, subcutaneous, toe: single* (rvu = 2.97) was identified by the RUC as a potentially overvalued service. The RUC recommends that the relative value be reduced to 2.71 as it is similar in work to 26060 *Tenotomy, subcutaneous, single, each digit* (rvu = 2.71). All four components of physician work (time, mental effort and judgement, technical skill, and physical effort and stress) are the same for these soft tissue operations.

Intra-aortic Balloon Insertion and Removal[Tab 15]

CPT Codes: 33970 and 33971

Presentation: Sidney Levitsky, MD, Society of Thoracic Surgeons

33970 *Insertion of intra-aortic balloon assist device through femoral artery, open approach* (rvu = 8.05) was identified by the RUC as a potentially overvalued service. The RUC determined that there are rank order anomalies in the intra-aortic balloon insertion and removal codes and recommends a decrease in 33970 to 6.75. The recommendation for CPT code 33971 failed and was referred to the facilitation committee chaired by Doctor McCaffree. Doctor McCaffree reported that comparison of 33971 *Removal of intra-aortic balloon assist device through including repair of the femoral artery, with or without the graft* (rvu = 4.04) to the family of codes identifies it as currently undervalued, so it should be increased to 8.40. 33971 is more work than 33970 and 35226 *Repair blood vessel, direct; lower extremity* (rvu = 8.17) and the relationship should be similar to that between 33973 and 33974.

Bypass Grafts[Tab 16]

CPT Codes: 35556, 35566, 35583, and 35585

Presentation: Robert Zwolak, MD, Society for Vascular Surgery

At the August RUC meeting, the RUC adopted the workgroup recommended increases for 35556 and 35583, but not for 35566 and 35585. All four workgroup recommended values were below those requested by the specialty. The RUC agreed to accepted the recommended values for all four codes on an interim basis, however, so that an rational explanation could be provided for the family of codes. At the February meeting, the RUC agreed to make its interim recommendations final.

Ophthalmology[Tab 17]

CPT Code: 66825

At the August meeting, the RUC recommended that the current value of CPT code 66825 be maintained on an interim basis. The RUC reaffirmed the interim recommendation for this service.

Weekly Radiation Treatment Management[Tab 18]

CPT Codes: 77420, 77425, and 77430

Presentation: W. Max Cloud, MD, Paul Wallner, MD, Theodore Brickner, MD, American College of Radiology, American Society for Therapeutic Radiology and Oncology

The RUC recommends the current values be maintained on an interim basis until the issue has been reviewed by the CPT Editorial Panel. The assignment of complexity levels of weekly radiation treatment currently requires the consideration of equipment that is used for treatment setup (eg, beam arrangement, number of ports, use of blocks, wedges, and other beam attenuation devices). The descriptors should be revised to adequately reflect different levels of complexity in managing the treatment of these patients. The current global period of XXX should also be considered because weekly treatment management includes evaluation and management services during treatment and 90 days post-treatment, the interpretation of port-films, and continuous supervision and management of physics and technical factors.

Diagnostic Interview[Tab 19]

CPT Code: 90820

Presentation: David Berland, MD, American Academy of Child and Adolescent Psychiatry

In September, the RUC recommended that the current value of 2.27 be maintained for 90820 *Interactive medical psychiatric diagnostic interview examination* until the American Academy of Child and Adolescent Psychiatry had an opportunity to survey. A survey of nearly 40 child psychiatrists resulted in a median of 3.25 work RVUs. 90820 requires more work than 90801 *Psychiatric diagnostic interview examination including history, mental status, and disposition* (5-year RUC rec = 2.80). The survey indicates 170 minutes of total time for this service, compared to 135 min minutes for 90801. The pre-service time is greater for 90820 because the psychiatrist must contact not only the child's pediatrician, but also their school. The intra-service time is longer and requires more work to develop a relationship with the child using non-verbal technique and to collect and interpret data. Drawing inferences from the data requires the child psychiatrist to generate and test of series of developmental and dynamic hypothesis. For example, the child's loss of control reflects a wish that an adult control him versus the aggressive outburst reflecting the child's enacting what he has seen at this father's home. There is also increased technical skill required to use the play equipment during this interactive interview. The post-service time is greater than 90801 because the psychiatrist must again contact the non-custodial parent and school.

The RUC agreed that 90820 required more work than 90801 *Psychiatric Interview* (2.80) and recommends 3.01. This is consistent with the relationship between the RUC recommendations for 90855 *Interactive individual medical psychotherapy* (2.15) and 98044 *Psychotherapy, 45-50 minutes* (2.00).

Outpatient Consultations[Tab 20]

CPT Codes: 99241-99245

Presentation: Bruce Sigsbee, MD, American Academy of Neurology, The Society of Thoracic Surgeons, American Academy of Physical Medicine and Rehabilitation, American College of Rheumatology, American Academy of Ophthalmology, American College of Cardiology, American Society of Internal Medicine, American Association of Clinical Endocrinology, American Society of Clinical Oncology, American Academy of Pain Medicine, American Society of Hematology, American College of Physicians, and American College of Surgeons

At the August 1995 RUC meeting, the RUC decided that these codes should be resurveyed for discussion at the February 1996 RUC meeting. In the letter of January 18, 1996 to Doctor Tudor, the survey method was explained in detail. There were four steps to the process: 1) development of a commonly used set of reference services consisting of both E/M and procedure codes; 2) re-scaling of relative value units to eliminate economic bias and simplify the process of magnitude estimation; 3) development of a method to rank order outpatient consultation codes within their own family of codes; and 4) development of a re-scale ratio to rank order outpatient consultation codes among all of the E/M services. This issue was referred to the facilitation committee that was chaired by Doctor Harer. The facilitation Committee recommended that the interim values for those codes be retained. The RUC reaffirmed the interim recommendation for these services.

Inpatient Consultations[Tab 21]

CPT Codes: 99251-99255

Presentation: Sidney Levitsky, MD, The Society of Thoracic Surgeons, American Academy of Physical Medicine and Rehabilitation, American College of Rheumatology, American Academy of Ophthalmology, American College of Cardiology, American Society of Internal Medicine, American Association of Clinical Endocrinology, American Society of Clinical Oncology, American Academy of Pain Medicine, American Academy of Neurology, American Society of Hematology, American College of Physicians, and American College of Surgeons

At the August 1995 RUC meeting, the RUC decided that these codes should be resurveyed for discussion at the February 1996 RUC meeting. This issue was referred to the facilitation committee that was chaired by Doctor Harer. The facilitation Committee recommended that because of anomalies that need to be corrected in the intensity factors of the inpatient consultation codes, that the intensity factors for the hospital visit codes be used to develop relative value units for these codes. The RUC reaffirmed the interim recommendation for these services.

A March 9 letter (attached) noted an error in the preparation of the Summary of Recommendation form for CPT code 99255. Data from an earlier version of the survey analysis was mistakenly entered in the survey data portion of the summary sheet. The data on the median, 25th percentile, 75th percentile, and low and high RVUs were at lower levels than the final survey, as were data on pre-, intra-, and post-service times. As a result of this, the specialty societies felt that a misunderstanding occurred during the discussion for increasing the value of code 99255 because of these errors. The argument for increasing the RVU for CPT code 99255 was based on three factors: 1) The proportionately greater intensity of the work related to this code, because the patients represented by this code tend to critically ill; 2) The existing intensity anomaly of this code and the other inpatient consultation codes, specifically the hospital inpatient codes; and 3) Data from the specialty society surveys, especially from the Society of Thoracic Surgery.

Home Visits[Tab 22]

CPT Codes: 99341-99535

Presentation: Dennis Stone, MD, Eileen Sullivan-Marx, PhD, Richard Viehe, DPM, American Academy of Home Care Physicians, American Academy of Pediatrics, American Nurses Association, American Podiatric Medical Association

These codes were discussed at the August RUC meeting and the RUC recommended maintaining the current values of these codes pending the review of new survey data at the February meeting.

The specialty societies reported that it is difficult to examine a patient at home, and that usually an attempt is made to manage the patient from the office before a home visit is initiated. It was also noted that BMAD frequency data shows that mainly podiatrists report the new patient home visit codes 99431 (77%) and 99432 (64%). This issue was referred to the facilitation committee chaired by Doctor Hanley. The RUC adopted the values of the new patient home visit codes 99341-99343. The established patient home visit codes were referred to a facilitation committee that will report on this issue at the April RUC meeting (Doctors Hanley (Chair), Rich, Tudor, Novak, and Gage).

Requests for Reconsideration of RUC Recommendations from the Five-Year Review

Anesthesiology[Tab 23]

Presentation: Karl Becker, Jr., MD, American Society of Anesthesiologists

In December 1995, the American Society of Anesthesiologists (ASA) requested that the RUC reconsider its five-year review recommendation adopted at the August RUC meeting and submitted to HCFA. Doctor Rodkey appointed the following facilitation committee to evaluate this request and make a recommendation to the RUC: Doctors Gardner (Chair), Lichtenfeld, Rich, Moorefield, Novak, Tudor, Gordy, and Koopmann. This committee met on February 8 to examine new evidence and detailed analysis presented by the ASA.

The anesthesiologists reported that they were satisfied with the report of the facilitation committee. The following recommendations made by the facilitation committee were accepted as motions by the RUC, and both motions were adopted:

- 1) The RUC should reconsider its previous recommendation for anesthesiology services.
- 2) The average work per unit time value for the maintenance or base period of anesthesia work should be .017.

Doctor Rodkey congratulated the facilitation committee, ASA and ASA staff. The full report of the facilitation committee is attached.

Discussion of Recommendations and Revisions in MPC Rank Order

The RUC discussed its overall impressions of the five-year review recommendations and the changes in the Multispecialty Points of Comparison (MPC). In general, members noted that the MPC seemed relatively stable except for changes in rank order for evaluation and management services, gynecology, and vascular surgery, and a few other services. It was also noted that many more services on the RBRVS can now be considered to be valued correctly (assuming HCFA adoption of the RUC's recommendations), so that more codes should be added to the MPC. Based on information that was presented by the American Academy of Orthopaedic Surgeons, the RUC approved as an editorial correction a change in rank order on the MPC of CPT codes 27001, 27003, and 64763.

IX. RBRVS Practice Cost Study

There was considerable discussion of the ongoing HCFA/Abt study of physicians' practice expenses and perceived problems with its methodology and timeframe. Staff explained plans for the study and observations from the first expert panel meeting, noting that comments have been provided to HCFA and Abt suggesting corrections in this process. In particular, staff noted that discussion of this issue should not focus solely on the practice cost component, but, ultimately, on the validity of the total relative values for each service. Many members and advisors cited problems attempting to collect data to support the study's expert panel process and a few suggested a delay be sought to allow more time for data collection. Several members, however, underscored the primary care community's continuing strong support for 1998 implementation of resource-based practice expense values.

X. Correct Coding Initiative

Staff explained the history and current status of HCFA's correct coding initiative, also known as the AdminaStar rebundling project. This project now involves 80,000+ code edits which were implemented effective January 1, 20,000 proposed code edits which are expected to be made available for comment February 29, and 1,000 code edits which were set aside for further review after the specialties made comments on them last year. The AMA is establishing a new AMA committee, the Correct Coding Policy Committee, which will work with the specialties, the CPT Editorial Panel, the RUC, and HCFA to resolve the 1,000 disputed code edits over the next couple months. Doctor McKusick has been appointed by the CPT Editorial Panel Chair as Chair of the new committee, and he will provide a report at the April RUC meeting.

XI. Relative Value Recommendations for New and Revised Codes

Intravascular Ultrasound[Tab 24]

Presentation: Robert Vogelzang, MD, Society of Cardiovascular and Interventional Radiology

Tracking Numbers: A1, A2, A3, A4

The specialty society recommendations failed, and this issue was referred to a facilitation committee which will report at the April RUC meeting (Doctors Powe (Chair), Gardner, Winters, Jones, Moorefield, and Philippart).

Lung Volume Reduction[Tab 25]

Presentation: Sidney Levitsky, MD, Douglas Mathisen, MD, Society of Thoracic Surgeons

Tracking Number: H1

The RUC recommends a work relative value of 21.25 for *324XX Removal of lung, other than pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure* which is based on a survey of 32 thoracic surgeons. The intra-service work is greater than 32550 *Wedge resection, single or multiple* (13.10) and comparable to that of a 32480 *Single lobectomy* (16.84). However, the postoperative management performed by the surgeon is much more intensive. The patient is closely managed postoperatively and requires a longer stay in the ICU. A typical hospital stay is three weeks and then the patient is seen in the office three or four times following rehabilitation for examination, x-ray review, wound care, and prescription management.

Laparoscopy/Peritoneoscopy[Tab 26]

Presentation: George A. Hill, MD, American Society for Reproductive Medicine

CPT Codes: 56300 and 56305

The RUC recommends that the work RVU for 56300 *Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)* be increased from 3.58 to 5.00. The recommendation is based on the survey median of 38 gynecologists. The survey median appears appropriate when confirmed by the following calculation:

Pre-Service Work	99215	1.51
Intra-Service Work	45 min. x .06 intensity	2.70
Post-Service Work	Average of 99213/99214	.74
Total Work		4.95

In addition, 56360 *Peritoneoscopy; without biopsy* (4.04) has been deleted. 56300 requires identical intra-service work but has a 10 day global period and includes a follow-up office visit that would not have been included in 56360.

The recommended increment between 56300 and 56305 *Laparoscopy, surgical; with biopsy (single or multiple)* is .30 which is similar to the current increment between 56360 *Peritoneoscopy; without biopsy* (4.04) and 56361 *Peritoneoscopy; with biopsy* (4.32).

Nasolacrimal Duct Probe[Tab 27]

Tracking Numbers: C2 and C3

This issue was withdrawn by the specialty society until the April RUC meeting.

Indocyanine-Green Angiography (ICG)[Tab28]

Presentation: American Academy of Ophthalmology

Tracking Number: D1

The RUC recommends a work relative value unit of 1.10 for *922XX Indocyanine-green angiography (includes multiframe imaging) with interpretation and report* which represents new technology which is only performed by 15-20% of retinal specialists. ICG and 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* (0.81) both involve the injection of a photochemical dye into the back of the eye, followed by photography of the affected area in order to diagnose the condition of the retina. The work for ICG, however, is more time-consuming and more intense than for fluorescein angiography (FA). ICG requires more pre-service time because a detailed review of a previous FA is performed when the FA was not sufficient for a diagnosis. The intra-service work is more intense and time-consuming because all frames of an ICG are reviewed more closely than for FA and it is more difficult to arrive at a diagnosis. In addition, the images must initially be viewed and manipulated on a computer, in contrast to FA, which may be viewed from individual prints. ICG also generates significantly more psychological stress than FA, because the dye used for ICG is more dangerous, and more likely to cause life-threatening adverse reactions. In contrast, FA rarely produced adverse reactions, and those that occur are almost always mild.

XII. Other Issues

The American College of Emergency Physicians asked that the RUC reconsider its five-year review recommendation that the current relative values for emergency visits be maintained. This issue was referred to the same Facilitation Committee that will address home visits (chaired by Doctor Hanley) and report at the April meeting.

The meeting was adjourned at 10:30 am.