

**AMA/Specialty RVS Update Committee
February 6-7, 1998**

**The Pointe Hilton Resort at Squaw Peak
Phoenix, Arizona**

I. Call to Order and Opening Remarks.

Doctor Hoehn called the meeting to order at 3:00 p.m. The following RUC members were in attendance:

James Hoehn, MD	James S. Maloney, MD
David Berland, MD	John Mayer, MD
Melvin Britton, MD	David McCaffree, MD
Robert Florin, MD	Clay Molstad, MD
John O. Gage, MD	William Rich, MD
William Gee, MD	Peter Sawchuck, MD*
Tracy R. Gordy, MD	Chester Schmidt, MD
Larry P. Griffin, MD*	Paul Schnur, MD
Kay K. Hanley, MD	Bruce Sigsbee, MD
Alexander Hannenberg, MD	Sheldon B. Taubman, MD
W. Benson Harer, MD	William Thorwarth, Jr., MD*
James Hayes, MD	Laura Tosi, MD
Richard J. Haynes, MD	John Tudor, MD
Emily Hill, PA-C	Charles Vanchiere, MD
David F. Hitzeman, DO	Richard Whitten, MD*
Charles Koopmann Jr. MD	William L. Winters, MD
J. Leonard Lichtenfeld, MD	

(*Indicates alternate member)

The following individuals also attended and were introduced by Doctor Hoehn: Terry Kay, Health Care Financing Administration (HCFA); William Thorwarth, Jr., MD, RUC alternate for American College of Radiology; John Wade, Chair, RBRVS Commission of Ontario, Canada; William Mangold, MD Medicare Carrier Director of Arizona and Nevada, and Jill Zanutto, new AMA staff to the RUC.

Doctor Hoehn appointed the following facilitation committees:

- Doctors Charles Koopman (Chair), Clay Molstad, John O.Gage, Sheldon Taubman, Emil Paganini, and Eileen Sullivan-Marx, PhD.

- Doctors Charles Vanchiere (Chair), James Haynes, Peter Sawchuck, Chester Schmidt, John Mayer, Allan Plummer, David I. Berland, and Steve Levine, PT.

- Doctors W. Benson Harer (Chair), George Hill, James Hayes, Melvin Britton, William Gee, J. Leonard Lichtenfeld, and Boyd Buser.

II. Approval of September 27, 1997 Minutes

The minutes of the September 27, 1997 RUC meeting were approved after the following revisions were noted:

- The third sentence of paragraph 6, on page 5, to read: “*The workgroup further observes that since ~~all~~ most formulas for the calculation of IWPUT use imputed values, there is no preferable formula.*”

- Insert on page 6, Practice Expense Subcommittee Report: Doctor Mayer asked staff to seek advice from AMA legal staff regarding the antitrust or legal issues involved should the RUC review practice expense issues.

- The third sentence of paragraph 7, on page 8, to read: “*These workgroups met in February after the conclusion of the RUC meeting and ~~validated~~ reviewed and commented on the single system exams (after presentation by each specialty society).*”

The minutes were approved as amended.

II. Calendar of Meeting Dates

The RUC was informed that the April 30-May 3, 1998 RUC meeting will be held at the JW Marriott in Washington D.C. Doctor Hoehn also announced that AMA meeting services staff had not yet located a site for the September 25-27, 1998 meeting. *Staff Note: The September 25-27, 1998 RUC meeting will be located in Orlando, Florida at the Walt Disney World Hilton.* The RUC participants were asked for input regarding future sites and possible long-term commitments to specific locations. Doctor Hoehn asked the RUC to provide their preferences to Doctor Rich (Chair) of the Administrative Subcommittee.

IV. CPT Update

Doctor Tracy Gordy reported that among several issues to be discussed at the February 13-15 CPT Editorial Panel meeting of particular interest to the RUC includes several coding changes, documentation guidelines and specialty specific exams. Doctor Gordy specified that CPT 1999 will most likely include definitions but not the actual documentation guidelines.

Barry Eisenberg discussed an action plan that the Board of Trustees put forth to evaluate the evaluation and management documentation guidelines. The plan is focused around three strategies: 1) Advocacy, 2) Technical corrections, and 3) Education. Mr. Eisenberg also announced that the AMA is inviting all specialty societies to a working meeting in Chicago on April 27, to discuss improvements to the documentation guidelines. Meeting

participants will also develop a plan to assist physicians with tools/templates to comply with future documentation requirements. Mr. Eisenberg also provided RUC participants with background information on the documentation guidelines Saturday morning at 8:00am.

V. HCFA Update

Terry Kay, Director of the Division of Practitioner and Ambulatory Care provided an update on HCFA's recent activities relating to the RBRVS. Mr. Kay announced that HCFA is working on several issues of particular interest to the RUC including: Details of the Balanced Budget Act (BBA) including the preventive medicine benefits and mandates such as the Hospital Outpatient Prospective Payment Schedule and the Practice Expense Relative Values. Both the Hospital Outpatient Prospective Payment Schedule, and the Practice Expense Relative Values are scheduled to be implemented January 1, 1999. In addition, several benefits scheduled to go in effect July 1, 1998 such as the coverage of Bone Density and Diabetes education have required HCFA to specifically define the nature of the service and who may provide the service. The May 1, 1998 Notice of Proposed Rule Making will outline all of the details to the aforementioned issues.

Mr. Kay also stated that due to strong opposition by numerous organizations, HCFA has delayed implementation of the physician supervision of diagnostic test regulations.

VI. Washington Update

Sharon McIlrath, from the AMA's Washington Office, reviewed a number of legislative and regulatory initiatives of interest to medicine. On the legislative side, she discussed the status of proposals to set quality and patient protection standards for health plans. She also updated members on HCFA's implementation of and congressional attempts to amend a law that would provide physicians limited opportunities to engage in private contracting with Medicare patients. Ms. McIlrath's major focus was the Clinton Administration's 1999 budget proposal, which includes a variety of user fees and so-called anti-fraud provisions that the AMA will seek to defeat.

VII. Relative Value Recommendations for New or Revised Codes

Breast Reconstruction with Free Flap (Tab 6)

Presentation: John W. Derr, Jr., MD, & Steven Keller, MD, American Society of Plastic and Reconstructive Surgeons

A revised CPT code 19364 (for CPT 1999) was proposed that would bundle CPT 1998 codes 19364 and 15756 into one code to correct nomenclature confusion and to eliminate the necessity for reporting a separate free flap correct. The correct reporting for *unrevised* CPT 19364 includes multiple code reporting-CPT 15756 and 19364. Using the multiple procedure payment rule, this equates to 49.75 rvus [35.23 + 50%(29.04)]. The American Academy of Plastic and Reconstructive Surgeons proposed the work RVU for

the revised CPT code 19364 to be 41.00 based on their survey median. The RUC argued that this proposed work RVU would create a rank order anomaly with other codes, such as 20802, *Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation* (work RVU 41.14).

A facilitation committee, Doctors Koopman (Chair), Moorefield, Gage, Taubman and Eileen Sullivan-Marx, Ph.D., met to consider this issue. The facilitation committee proposed two alternative recommendations to the RUC including: 1) the first was built upon CPT code 19368 *Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including, closure of donor site; with microvascular anastomosis, (supercharging)*(work RVU=32.42) plus the average of the difference between CPT Codes 19367 *Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site* (work RVU 25.73) and CPT code 19369 *Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site* (work RVU 29.82) [(32.42-25.73=6.69, 32.42 - 29.82 = 2.6, 6.69 + 2.6 / 2 = 4.65) + 32.42] for a recommendation of 37.07. 2) The alternative recommendation is work RVU of 39.36, which is the 25th percentile of the survey data.

The American Society of Plastic and Reconstructive Surgeons withdrew this issue and would like to resurvey the code and bring a new recommendation to the April 30-May 3, 1998 RUC meeting.

Chielectomy (Tab 7), Tracking Number: O1

Hallux Rigidus Correction for Presentation: Laura Tosi, MD, American Academy of Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society and Richard Viehe, DPM, American Podiatric Medical Association.

A new CPT code 2828X was established to report the work involved in a distal first metatarsal Cheilectomy to remove bone at the distal first metatarsal and proximal phalanx, debride the joint and reconstruct the capsule. This procedure has been most commonly reported by CPT codes, 28290, *Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)* and 28122, *Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or talar bossing), talus or calcaneus* which do not adequately describe the procedure. The RUC questioned the recommended work RVU of 7.29 when comparing codes with similar intensity, eg 54161, *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn* with a work RVU of 3.27. This raised the issue that there is no standardization with IWPUT.

A facilitation committee: Doctors Vanchiere (Chair), Haynes, Sawchuck, Schmidt, Mayer, Plummer, Berland and Steve Levine, PT met to discuss this issue.

The facilitation committee recommended and the RUC accepted a RVU of 7.04 for CPT code 2828X *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metaatarsophalangeal joint*. The facilitation committee questioned the

appropriateness of the reference codes used in the survey as well as the rationale of building discharge day management into the value of 2828X when the survey respondents determined this was not applicable. Therefore, the facilitation committee subtracted the middle level subsequent hospital care (code 99232) RVU of 1.06 from the lowest level discharge day management (code 99238) of 1.28 to arrive at a difference of .22. The work value recommendation of 7.29 was then reduced by .22 to arrive at an RVU of 7.07. The 7.07 work RVU was then compared to a new reference code, not on the original reference list, CPT code 28292 *Simple resection of the base of the proximal phalanx with removal of the medial eminence, A hemi implant is optional* with a work RVU of 7.04. In reviewing the Five Year review time data for CPT code 28292, the pre, intra, post service times of 30, 60, and 45 minutes and 6 office visits were very similar to the survey data collected by the American Podiatric Medical Association for 2828X. The RUC therefore recommends that the •2828X be valued equivalent to 28292, a work RVU of 7.04.

Psychotherapy (Tab 8) Tracking Numbers RR3-RR30

Presentation: Ronald Shallow, MD, American Psychiatric Association, Sherry Barron –Seabrook, MD, American Academy of Child and Adolescent Psychiatry, Mirean Coleman, ACSE,LICSW, National Association of Social Workers, Eileen Sullivan Marx, PhD, American Nurses Association and James Georgoulakus, Ph.D., American Psychological Association. Al Dobson and Margaret Harrison from the Lewin Group.

A series of 24 new Psychotherapy codes (CPT Codes 90804-90829) have been established that will replace HCPCS codes G0071-G0094 for CPT 1998 and the 1998 Medicare Fee Schedule. A joint proposal was presented based on survey data from all providers and a work neutral regression technique to eliminate inconsistencies among practice patterns. The RUC recommendation on the 24 psychotherapy services represents an acceptance of a base value of 1.30 for 90804 and a method of adding the additional work of other codes, derived from a regression analysis, to this code. The estimated work effects that are applied to the base code 90804, work RVU of 1.30, are as follow:

Type of Effect	Estimated Work Effect
E/M	0.17
Time (45-50)	0.69
Time (75-80)	1.00
Inpatient	0.04
Interactive	0.12

The base code is 90804, *individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.* 90804 is currently valued by HCFA at 1.11 RVUs. The survey found a median work RVU of 1.25 and the regression analysis indicated a work RUV of 1.40. The work neutrality analysis comparing the total pool of survey RVUs to the pool of regression derived RVUs showed that the base RVU from the regression should be reduced by 0.10 work RVUs to 1.30. Therefore, the organizations recommended and the RUC has accepted

1.30 work RVUs for 90804. The current HCFA RVU for 90805 of 1.47 further supports this recommendation. The only difference between 90804 and 90805 is the provision of E/M. If the estimated work effect for E/M (0.17) is removed from 90805 the result is 1.30 the recommended work RVU for 90804.

The RUC's recommendation is for an acceptance of 1.30 work RVUs for 90804 as the base and the additive methodology derived from the regression analysis. The addition of the estimated work effect to the base code allows the creation of a consistent work scale across all 24-psychotherapy codes. The RUC recommendation for this issue is attached and was sent to HCFA on February 20, 1998 as a late comment on the October 31, 1997 Final Rule.

Cytogenetic Studies (Tab 9) Tracking Number L1

Presentation: David Flannery, MD, American College of Medical Genetics

A new CPT code 8829X was added to describe the work involved in chromosome analysis, which can be used for both acquired disease testing and constitutional disease testing. This procedure requires a physician to review microscopic images of chromosomes and use his or her expertise and experience to determine if the chromosomes are normal in structure and number. If an abnormality is identified, the physician's expertise is called into play to determine if the abnormality is pathological or a benign variant. If the abnormality is pathological, the physician will determine either from her/his experience and knowledge, or from literature review, what the implications of the abnormality are for the patient and the genetic implications for family members. A report must be prepared enumerating the physician's assessment and recommendations. The work involved in this procedure is similar to the reference services 83912 *Molecular Diagnostics; Interpretation and Report* (work RVU = .37) and 88104 *Cytopathology; Fluids, washings or brushings, except cervical or vaginal; Smears with interpretation* (work RVU = .56). Based on a survey median of 21 physicians, the RUC recommended an RVU of .52 for this service.

VIII. Administrative Subcommittee Report

On February 7, the Administrative Subcommittee (Doctors Rich (Chair), Kay Hanley, James Hayes, David F. Hitzeman, Paul Schnur, Charles Vanchiere, Frank Opelka, and Steven Levine, PT met to discuss the rotating seat terms, meeting dates/locations and specialty requests for the review of RVUs.

Rotating Seat Terms

In order to be consistent with the Structure and Functions Document, which calls for the rotating seat terms to end upon submission of RUC recommendations to HCFA in May each year, the Administrative Subcommittee made the following recommendation that was accepted by the RUC:

Doctors Berland and Britton will complete their terms on the RUC at the May 1999 RUC meeting, at which time the RUC will hold an election for these two seats.

The subcommittee clarified that the American Geriatric Society would be eligible for a rotating seat at the May 2001 election.

Meeting Dates & Locations

The subcommittee made the following recommendations for the meeting dates and locations through the year 2000.

February 5-7, 1999 - Phoenix
April 29-May 2, 1999 - Chicago
September 24-26, 1999 - San Diego/Seattle

February 4-6, 2000 - Phoenix
May 4-7, 2000 - Chicago
September 28-October 1, 2000 - Boston/Charleston

The location for the September 1998 RUC meeting is pending. AMA meeting services is coordinating efforts and will provide location information to AMA staff as soon as possible (*staff note-the September 25-27, 1998 will be held at the Walt Disney World Hilton, Orlando, Florida*). It was noted that advance meeting planning (5-year) would be beneficial in terms of competitive housing prices and securing optimal locations.

Specialty Requests for Review of RVUs

Terry Kay, HCFA clarified that requests from specialty societies to review existing relative values should be submitted directly to HCFA. Sherry Smith requested that a copy be sent to the AMA RUC staff.

The following is a proposed timetable for the next 5-Year Review

- Final Rule (October/November 1999)- HCFA solicits comments for services to be reviewed in the next 5-Year Review
- September 2000- RUC submits recommendations
- January 1, 2002- Revised relative values are implemented

The Subcommittee discussed with Terry Kay the potential for reviewing these issues on an ongoing basis rather than in the aggregate during the 5-Year Review. In response, Terry Kay indicated that HCFA staff had been unable to devote resources to review specific issues due to their work on practice expense. In addition, HCFA has some concern regarding the ongoing budget neutrality adjustment other than that all at once in a Five-Year Review. He did indicate however, that HCFA needs greater specificity regarding the scope of the review and may consider suggestions to request comments in the Final Rule for the 1999 Medicare Payment Schedule. This earlier request for

comments would give the RUC two years to review the comments and submit recommendations to HCFA..

The RUC decided to study the methodology from the past Five-Year Review. In addition, the RUC will request that specialty societies forward a list of codes they consider misvalued to the AMA before the September 1998 RUC meeting. This list will be used for planning purposes only.

Doctor Koopman made several comments regarding the Five-Year Review that he would like addressed by HCFA before the next Five-Year Review. During the last review, the American Urological Association (AUA) and the American College of Radiology (ACR) were challenged by Carrier Medical Directors (CMDs) which required the associations to devote all their efforts into defending a majority of their codes. Devoting a great deal of resources to defend their services limited their ability to bring their undervalued codes to the RUC during the 5-Year Review. Doctors Koopman and Gee both requested that HCFA work directly with the CMD's to coordinate a more appropriate and diverse agenda to ensure fairness throughout the process.

Throughout this meeting, RUC members identified issues with the Multi-Specialty Points of Comparison (MPC). The RUC agreed that anomalies that exist within this list must be addressed before the next Five-Year Review.

A motion was passed that the Research Subcommittee will review the MPC at the next RUC meeting in April

IX. Rules and Procedures Subcommittee Report

On February 7, the Rules and Procedures Subcommittee members (Doctors Tudor (Chair), David Berland, Richard J. Haynes, W. Benson Harer, Chester Schmidt, Richard Whitten, William Winters, Paul Collicott, and Emily Hill, PA-C) reviewed and suggested several changes to the RUC's Rules and Procedures document; considered the RUC chair term; and began discussions regarding the practice expense issue.

Revisions to Rules and Procedures

Doctor Tudor reported that the Subcommittee suggests the following recommendations to the Rules and Procedures document:

- Remove all gender reference throughout the document (eg, Chairman)
- Section I. B.-Rewrite mechanism for coordinating CPT proposal to make the language more specific
- Section I. E.4D-Editorial change should read "*in a timely fashion*"
- Section I. F.-Add Subsection 5. The Facilitation Committee will present a summary report to the RUC for decision
- Section I.I.- 4. In absence of direction from the RUC, staff & chair will choose which option to report.
- Section II. Renamed to Appeal Process

- Section II. Replace all references to “reconsideration” with “appeal”
- Section II. A. Revised to read: *If a specialty requests an appeal after conclusion of the RUC, the Chairman will appoint an Ad Hoc Facilitation Committee as in I.F.3.*
- Section IV.A. should be revised to clarify permission for distribution of RUC information and materials.

These revisions will be summarized by staff, reviewed by AMA legal counsel and considered at the April 30-May 3 RUC meeting.

RUC Chair Term

- The subcommittee recommends that the Chair’s tenure be extended to three, two year terms for a total of six years from the current maximum tenure of four years (two, two year terms)
- The RUC agreed that the maximum number of terms should be increased. This action will be forwarded to the AMA for final approval.

Incorporation of Non-MD/Dos into Practice Expense Issue

The subcommittee discussed the following issues:

- In reviewing the options for creation of a subcommittee to review practice expenses, it was noted that organizations representing individuals with expertise in accounting, management, and clinical staff inputs need to be identified and included in the process.
- It was also noted that the HCPAC should not be utilized as the practice expense subcommittee, as it would conflict with its review of work RVUs. The subcommittee further suggested that the HCPAC organization structure and function document be reviewed and offered to work with the HCPAC on this issue.

X. Research Subcommittee Report

On February 6, the Research Subcommittee met to discuss the following: 1) Report from the Add-on Code Workgroup; 2) Review of Regression Analysis Methodology Utilized for Psychotherapy; 3) Review of Multi-Specialty Points of Comparison; 4) Review of Worksheet on Closed vs. Open Analogous Codes; and 5) Assessment of ICD-10-PCS. The following members attended: Doctors Robert Florin, (Chair), Melvin Britton, William Gee, Charles Koopman, Jr., David McAffree, Sheldon Taubman, and Eileen Sullivan-Marx, PhD.

Add-on Codes Workgroup

Doctor Florin reported the Add-on Code Workgroups discussion on the recent CPT coding changes regarding add-on codes and codes where the –51 modifier is not appropriate (Appendices E & F). After extensive discussion of add-on codes, the subcommittee made the following recommendation, which the RUC accepted:

AMA staff should circulate Appendix E and F to the RUC advisory Committee for review. If a specialty society believes that a code on these lists should be revalued as a result of the CPT changes, they should present their recommendation to the RUC at the May 1998 RUC meeting.

Staff noted that the RUC would also need to follow up more closely on codes where global periods of 010 and 090 days currently exist and will be changed to a ZZZ global period.

Re-operation and Microsurgery Add-on Codes

Doctor Florin informed the RUC that the CPT Editorial Panel is continuing efforts to develop new add-on codes for services involving altered surgical fields and to describe microsurgery codes. A comment was made these issues should be addressed prior to the next five-year review. Doctor Zwolak noted that budget neutrality would also be an issue, as HCFA did adjust a family of vascular surgery codes to achieve budget neutrality for new re-operation codes.

Low Birth Weight/Extreme Weight Modifiers

The Research Subcommittee (with recommendations from the American Academy of Pediatrics (AAP) and American Pediatric Surgical Association (APSA)) reviewed three extreme weight categories to determine if it was possible to determine work relative values for codes or a percentage adjustment for modifiers. The Research Subcommittee agrees that code specific solutions are preferable and recommended the following recommendation, which was adopted by the RUC:

CPT should adopt the low birth weight/extreme age modifiers on an interim basis, which allows physicians to petition their payor to consider an increase in payment when these modifiers are appended to codes. These modifiers will be disseminated to the RUC Advisory Committee for their review. If a specialty society believes that codes should be developed for services for which low birth weight is an issue, the may ask the RUC to review the service with the modifier and use the survey evidence as a part of the CPT proposal for new codes.

Review of Regression Analysis Methodology Utilized for Psychotherapy

The specialties involved in the development of relative value recommendations for the 24 new psychotherapy codes asked the Research Subcommittee to review the regression methodology. The subcommittee agreed that regression analysis methodology is extremely useful in reviewing very complex, and sometimes inconsistent, survey data for code series.

Review of Multi-Specialty Points of Comparison

Doctor Florin presented spreadsheets with the IWPUT calculations for codes included on the Multi-Specialty Points of Comparison (MPC). He illustrated that IWPUT calculations are useful within families of codes but when used to compare codes across specialties, IWPUT produced anomalies. The RUC referred this issue for further discussion at the April 30 Research Subcommittee meeting.

Review of Worksheet on Closed and Analogous Codes

The worksheet in Tab 12 was the result of the closed vs. open workgroup. The worksheet is a useful tool in making decisions as to new CPT codes. The Research Subcommittee agreed that the worksheet is a starting point when reviewing open/closed procedures.

Applied Medical Data, Inc. Assessment of ICD-10-PCS

Doctor Florin noted that the report may be found in Tab 12 and was included for the information of the Research Subcommittee and the RUC. Doctor Florin also explained that he had been unable to crosswalk existing CPT codes to the ICD-10-PCS system and recommended that others attempt this exercise. The RUC also heard from members who had been contacted to serve as “consultants” to the system, but were never asked to review material. Doctors Haynes asked Terry Kay to explain HCFA’s perspective of this coding system. Terry Kay responded that HCFA was in a preliminary stage of reviewing this system, with a staff looking at a few options to come to a single coding system. Currently, CPT is used to report outpatient and physicians services, while ICD-9 volume 3 is used to report hospital services. Barry Eisenberg informed the RUC that the ICD-10-PCS system has a potential for 200,000 codes.

The full Research Subcommittee Report is attached to these minutes.

XI. Practice Expense Subcommittee Report

On February 6, the Practice Cost Subcommittee (Doctors J. Leonard Lichenfeld (Chair), Gage, Hannenberg, Lenet, Mayer, Molstad, Thorworth, Sigsbee and Zwolak met and discussed the following issues:

Reports on Practice Expense Panels

Several RUC members, who directly observed or participated on the October 5-8 practice expense panels and the December 15-16 Multi-Specialty Panel conducted by the HCFA, discussed their observations of these processes. The participants unanimously agreed that the December 15-16 Panel did not meet its objectives. Many RUC members, however, complimented Bart McCann, MD on his performance in facilitating the meeting. The RUC concluded that a concise framework must be developed in order for participants to reach a thorough and fair consensus regarding practice expense inputs and relative values.

HCFA Update

Terry Kay from HCFA agreed that the multi-specialty panel did not achieve the intended results. However, HCFA has not completely disregarded this method for refining practice expense inputs. Mr. Kay reported that the May 1, Proposed Rule will present several options for practice expense relative values. These options may include: the inclusion of some or all of administrative staff time in the indirect component; standardizing data across broad CPT groups; and the use of AMA SMS data to develop specialty specific indirect expenses. Each of these options would have different effects on the ratio of direct to indirect and the type of data collected in a refinement or update process.

Discussion of the RUC's Involvement

Doctor Lichtenfeld reported that the majority of the subcommittee members agreed that the RUC is the only multispecialty group that has the skill, expertise, and an established process to assist in the refinement of practice expense relative values. The subcommittee recommended and the RUC agreed that it is imperative for the RUC to take a proactive stance and begin the process of developing a plan for the refinement. However, concerns were raised about developing a plan and signing on at this time. Doctor Gee presented a list of pros and cons, which was augmented by other RUC members about developing a plan for the refinement of practice expense relative values at this time. These suggested pros and cons include:

Pros:

1. HCFA has a significant degree of trust in the RUC.
2. RUC constitutes representation from a cross-section of American Medicine.
3. RUC members are motivated and dedicated to this process.
4. Most RUC members have also been deeply involved with their respective specialty societies, practice expense studies, CPEPs, and HCFA validation panels.
5. The development of a plan now prepares the RUC to respond and comment in a timely fashion (within a 90 day comment period) without committing to anything.
6. It is critical that the RUC make a strong statement that we must have a seat at the table on the practice expense issue.
7. Physicians know more about their practice than businessmen or practice managers and the RUC should not abdicate its responsibility on this issue.
8. The RUC has a responsibility to develop a process that is fair, reliable and validated where organized medicine can address this issue.
9. There are few physicians who can contribute to the complexities of determining work or costing out direct inputs like the RUC.

Cons:

1. RUC participation in refining or developing the methodology to refine may imply support of HCFA's methodology and data.
2. RUC participation in developing a plan now may imply some degree of support of the as of yet unseen May 1 Notice of Proposed Rule Making (NPRM).

3. Participation may put RUC members in the difficult position of judging many things they know little about (eg, general accounting principles and practice costs of specialties other than their own).
4. RUC participation will require hours of future education and work for the AMA staff, specialty society staff, and RUC members with absolutely no assurance that HCFA's process will be altered.
5. The implementation of resource based practice expense RVUs will result in massive shifts of relative values between specialties. RUC participation, at this time, may imply that the RUC supports payment shifts between major groups of physicians.
6. Legal or antitrust concerns have been expressed by some RUC members.
7. Public perception issues-some may feel that the RUC would have too much input into the RBRVS, expanding its role beyond the 54% of the total RVUs of the total RVUs incorporating both work and practice expense. Also noted was that a large percentage of other payors are also using the RBRVS as the mechanism for determining physicians payment.
8. No advantage of developing plan now, the RUC should monitor what HCFA is doing and wait 11 weeks until the proposed rule comes to react and decide whether to develop a plan.
9. Workload and financial consideration in developing a new process must be considered for the AMA and specialty societies.

After an extensive debate, the RUC adopted the following subcommittee recommendation:

The RUC will begin the process of developing a plan for the refinement of practice expense relative values.

The Practice Expense Subcommittee report is attached.

Doctor Hoehn thanked Doctor Gee and others for defining the issues that spurred an extensive debate and focused the RUC's discussion.

Discussion of Next Steps:

Doctor Hoehn asked the RUC to spend some time discussing options for each subcommittee to consider in developing an agenda for May. The following issues were discussed:

Structure/Composition of a Committee to Review Practice Expense

The RUC agreed that getting involved in the refinement of practice expense relative values would require a tremendous amount of time and work. Therefore, the RUC discussed several options in sharing the practice expense workload with an advisory

committee of the RUC. The discussion of this issue included the structure, composition, and reporting mechanism of the committee to review practice expense.

Doctor Hoehn commented that the structure of the practice expense advisory committee could take one of three forms including: a separate body reporting directly to HCFA, 2) committee or subcommittee that would be separate from any other subcommittees and report directly to the RUC; or lastly, 3) a work group that would report to the practice expense subcommittee.

The RUC discussed the possibility of utilizing RUC alternates, RUC advisors, nurse practitioners, physician assistants, other individuals that work for physician practices, and with expertise in a variety of different areas that relate to the practice expense issue. Doctor Hoehn announced that it is clear that we have not made full use of our advisors and alternates that know the process. Doctor Schnur added that the advisors and alternates are already attending the RUC meetings for their societies and should be used in the practice expense advisory committee or an additional committee if necessary. Don Williamson, OD commented that the RUC should include representation of the HCPAC on this committee.

The RUC also discussed the practice expense advisory committee's reporting mechanism. Such considerations include: Reporting directly to the RUC; reporting directly to HCFA similar to the HCPAC; or a workgroup that would report directly to the Practice Expense Subcommittee who would then report to the RUC.

Doctor Mayer again raised the question of the legal issues involved if the advisory committee were to report to the RUC and or even the Practice Expense Subcommittee.

Scope of Refinement/Nature of Input to HCFA:

The RUC also discussed the scope of the RUC's involvement and the nature of its input to HCFA. Comments focused on whether the RUC should move forward with the process and methodology developed by HCFA (ie, determining direct inputs) or review other potential methodologies. Several members argued that the RUC should not replicate what HCFA has done to date, but should develop a uniform, universal framework of definitions and consider alternate methodologies. Others argued that the GAO report due out this month will determine whether other methodologies will be considered or not. Others noted that in determining practice expenses, data is needed to compute direct practice expense RVUs and methodology is needed for indirect practice expense RVUs.

Doctor Sigsbee commented that the RUC's first step should be to develop a survey over this summer that specialty societies may use to collect consistent data on direct inputs to use in the refinement process. The next step should be to develop a process for review new and revised codes and for future five-year reviews.

At the conclusion of this discussion, Doctor Hoehn charged the Subcommittees with the following issues:

RUC Subcommittee Assignments:

Administration Subcommittee:

- Potential meetings dates
- Nominations for physician representatives on the Practice Expense Advisory Committee (PEAC)

Rules and Procedures Subcommittee:

- Structure and Composition of the PEAC
- Reporting Mechanism

Research Subcommittee:

- Establish the ground rules in determining direct inputs (eg, clinical staff time)
- Development of a survey to determine direct inputs
- Review alternative methodologies

Practice Expense Subcommittee

- Provide oversight over the development of the proposed plan
- Nature of Inputs (eg, direct inputs or direct RVUs or all elements of practice expense)
- Scope of Involvement (eg, refinement or updating)
- Review of General Accounting Office (GAO) Report
- Review of HCFA Report to Congress

XII. Other Issues

• Pending Five-Year Review Issues

A table listing the pending CPT issues for the Five-Year Review was included in tab 14 of the agenda book for the RUC to review. These issues include CPT codes 54100, 77420, 77425, and 77430. CPT Code 54100, will be submitted to delete the code in time for the August 1998 Editorial Panel Meeting. CPT codes 77420, 77425 and 77430 will be addressed again at the May CPT Editorial Panel meeting, as requested by the American College of Radiology and the American Society for Therapeutic Radiology and Oncology.

- Doctor Hanley and Emily Hill noted that the RUC HCPAC Review Board held its first meeting four years ago today and that the members of the HCPAC have been making important contributions to the process ever since.

The meeting adjourned at 5:50 p.m.