

**AMA/Specialty RVS Update Committee
February 5-7, 1999**

**Lowes Ventana Canyon Resort
Tucson, AZ**

I. Call to Order:

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

James Hoehn, MD
David Berland, MD
Joel Bradley, MD*
Melvin Britton, MD
Thomas P. Cooper, MD*
Peter Dempsey, MD*
John O. Gage, MD
William Gee, MD
Tracy R. Gordy, MD
Kay K. Hanley, MD
W. Benson Harer, MD
James Hayes, MD
Richard J. Haynes, MD
Emily Hill, PA-C
Charles Koopmann Jr., MD
George F. Kwass, MD
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
William T. Maloney, MD*

David L. Massanari, MD ~~John Mayer,~~
MD
John Mayer, MD
~~MD~~
David L. McCaffree, MD
Clay Molstad, MD
James Moorefield, MD
Willard B. Moran, Jr., MD*
Eugene Ogrod, MD
Thomas G. Olsen, MD*
William Rich, MD
Peter Sawchuck, MD*
Chester Schmidt, MD
Paul Schnur, MD
Daniel M. Seigle, MD*
Bruce Sigsbee, MD
Sheldon B. Taubman, MD
Charles Vanchiere, MD
Richard Whitten, MD*
William L. Winters, MD

***Alternate**

The following individuals attended and were introduced by Doctor Hoehn: Eugene Ogrod, MD, Chair of the Practice Expense Advisory Committee (PEAC); Carolyn Mullen & Thomas Marciniak, MD, Health Care Financing Administration (HCFA); John Wade, RBRVS Commission of Ontario; Kevin Hayes, MedPAC, and William Mangold, MD, Carrier Medical Director of Arizona and Nevada.

II. Chairman's Report:

Doctor Hoehn introduced Eugene R. Ogrod, MD, as the new non-voting RUC member and Chair of the PEAC. Doctor Hoehn invited all RUC, HCPAC and PEAC members and participants to a reception welcoming PEAC members following the conclusion of Thursday's activities.

Doctor Hoehn announced that the Administrative Subcommittee Report would be discussed at 3:00 pm Friday while the remaining Subcommittee Reports would be discussed Saturday morning. Doctor Hoehn also highlighted several items in the agenda book that deserve careful reading including: 1) Tab 3-contains the November 21, 1998 RUC meeting minutes that provide an extremely clear definition of the responsibilities of PEAC, Practice Expense Subcommittee, and Research Subcommittee and 2) Tab 15-The KPMG review of HCFA's practice expense methodology.

Lastly, Doctor Hoehn acknowledged that Doctor W. Benson Harer was recently appointed as President-Elect for ACOG and Doctor Paul Schnur is now President of ASPRS. Doctor Hoehn also strongly encouraged the RUC to read a few articles from the *New England Journal of Medicine* on Health Policy and socioeconomic issues. RUC members may obtain a copy from Dawn K.Gonzalez.

III. Director's Report:

A Director's Report was presented by Sherry Smith, who introduced Letisha Miller as the new administrative secretary for the Department of Relative Value Systems at the AMA. She also announced that the AMA is currently recruiting a Policy Associate to primarily work on the practice expense issue. Ms. Smith informed participants that the RUC will meet in the future at the following locations: April 29 - May 2, 1999-Chicago Hilton; September 1999-Seattle; February 2000-Phoenix; and April 2000-Chicago. Several RUC members and participants expressed concern over the AMA's choice of meeting locations noting the high cost of the hotel rooms that have a significant impact on a specialty society's budget. Ms. Smith assured RUC members and participants that AMA meeting services staff will be more sensitive to hotel costs in the future.

Ms. Smith also stated that the AMA's publication, *Medicare RBRVS: The Physicians Guide 1999* is ready to go to print and that all RUC members, Advisory Committee members, and RUC HCPAC members were acknowledged in the foreword for their significant contribution to the RUC process. As a token of appreciation, the AMA will provide a complimentary copy of *The Physicians Guide* to each RUC member, RUC Advisor and RUC HCPAC member. It is expected that copies will be available by the next RUC meeting.

Finally, Ms. Smith encouraged the RUC and participants to view the newly updated RBRVS page on the AMA web site at www.ama-assn.org/med-sci/cpt/payment.htm. This site is updated monthly and aims to continuously improve its content. Ms. Smith asked RUC members and participants to forward any comments or suggestions for the RBRVS page on the web site to Dawn K.Gonzalez, AMA staff.

IV. Approval of the September and November 1998 Minutes:

The minutes of the September 25-26, 1998 RUC meeting were approved after the following revisions were noted:

- Doctor Sheldon B. Taubman should be deleted to the list of RUC member attendees.
- Page Two, Directors Report – the last sentence should read “Sherry reported that the RBRVS page on the AMA web site would be available for viewing on the Internet by mid-October.”
- The third sentence of the second paragraph on page 7 under the Laparoscopic Procedures (Adrenalectomy, Splenectomy, Jejuostomy)(Tab 6) should read “The laparoscopic suturing is made more difficult because of the three-dimensional vision.”

The minutes were approved as amended.

The minutes of the November 21, 1998 RUC meeting were approved without revision.

V. CPT Update:

Doctor Tracy Gordy, CPT representative to the RUC, provided the RUC with an update on two upcoming meetings including the CPT Editorial Panel meeting to be held in mid-February 1999 and the CPT-5 meeting scheduled for March 3-5, 1999. The February Panel meeting is expected to be very busy as it needs to review two large agenda books of material. The Panel also expects to review the E/M Guidelines by its May meeting. Doctor Gordy anticipates that this issue will conclude by the end of the year.

Doctor Gordy provided the RUC with an overview of the CPT-5 project. The CPT-5 workgroups are expected to meet through November 1999. Doctor Gordy explained that the AMA and the Executive Project Advisory Group (PAG) have taken the position that CPT-4 needs to be updated to reflect the coding needs of physicians, non-MD providers, researchers, and third party payers. The PAG is expected to make its first recommendation to the CPT Editorial Panel this May. The Panel will have all of the PAG’s final recommendations by the Editorial Panel’s February 2000 meeting. At this point, it is unclear how substantially different CPT-5 will be from CPT-4. Doctor Gordy did acknowledge that the PAG is considering cross-referencing CPT-5 with SNOMED and other coding systems. It is clear that the PAG and ultimately the Editorial Panel, will try to achieve the ideal coding system to meet the needs of many, which may or may not include interfacing with another coding system. Lastly, Doctor Gordy reiterated that the participation of each RUC member involved in the workgroups will play a significant role in the CPT-5 project by contributing to each issue from their perspective of the RUC process, and to assist in developing workable solutions to the CPT-5 Project.

Correct Coding Initiative Update:

Doctor Kenneth McKusick, Chair of the Correct Coding Policy Committee (CCPC) gave an overview of the Committee, Phase IV Edits and the Commercial Claims Editing Software. Doctor McKusick reported that last fall, HCFA asked the CCPC to review 200 edits purchased from HBOC. Following an extensive review, the CCPC delivered a report to HCFA in January 1999. HCFA is currently reviewing this report.

Since last November, the CCPC has coordinated the review of several series of CCI edits which include: Phase IV edits which related primarily to E & M; over 1300 edits mostly concerning HCFA's foot care policy; 32 edits recommended by Carrier Medical Directors; and finally, the review of nearly 300 edits which are expected to be forwarded with comments to HCFA by mid-March.

HCFA has subsequently informed the CCPC that it will not implement the coding edits related to minor services or diagnostic tests performed on the same date as an E/M service. A December 21, 1998 letter from Doctor Robert Berenson to Doctor McKusick was distributed at the meeting.

Sherry Smith also updated the RUC on AMA advocacy efforts related to proprietary claims editing software projects. In January 1999, a packet was sent to the AMA Federation soliciting information on claims rejections in their states and specialties. Included in this packet, which was also made available to RUC participants at this meeting, was the following:

- June 29 and September 24, 1998 letters to Nancy-Ann Min DeParle protesting HCFA's implementation of black box edits.
- AMA Board of Trustees Report 35 outlining all of the AMA advocacy efforts relating to correct coding edits and claims editing software.
- Example of the November 3, 1998 letter sent from Doctor Anderson to all Medical Directors in the United States advocating appropriate recognition of CPT codes, modifiers, and guidelines.
- Example of the December 21, 1998 letter sent from Doctor Anderson to all vendors of claims editing software.

VI. HCFA Update:

Doctor Thomas Marciniak provided an update on HCFA's recent activities related to the Year 2000 (Y2K) issue, practice expense, five-year review or work relative values, the development of resource-based malpractice relative values and its ambulatory surgical center regulation. HCFA's biggest priority is to assure that the critical systems are compliant by 2000. It is clear that the fee schedule will not be updated on January 1, 2000 but it will be completed shortly thereafter.

Doctor Marciniak announced that HCFA was very pleased with the RUC and PEAC's plans to review practice expense direct inputs for both new and revised codes, as well as the refinement. Doctor Marciniak asked the RUC to pay close attention to the physician time data, not only in refinement, but also for new and revised codes.

A draft report from Health Economics Research (HER) has been sent to HCFA and suggests five different approaches to the next five-year review, including:

- Expert Panels
- Paired Comparison/Rasch Analysis
- Changes in Length of Stay

- Analysis of Intra-Service Work Per Unit Time (IWPUT)
- Changes in site-of-service, frequency, or specialty mix

A final report from HER is due to HCFA this summer and HCFA will make it available to the RUC. Doctor Marciniak stated that any of these approaches will be complimentary to the RUC and the RUC will be involved in the next five-year review. The RUC will discuss this report and the five-year review at the September 25-26, 1999 RUC meeting. HCFA will be soliciting comments in the Final Rule in the Fall of 1999.

VII. AMA 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, Ms. McIlrath reported that a number of bills are being reintroduced with some variation from last year including the Patient's Bill of Rights, and Bills sponsored by Ganske and Norwood. Ms. McIlrath anticipates that we may see some action on the Patient's Bill of Rights while the Ganske and Norwood may or may not move forward despite several medical specialties' support for the legislation. Although the AMA supports elements of many of these bills, it has yet to endorse any.

Another issue that will be addressed on Capitol Hill is medical necessity. The AMA continues to advocate that physicians and patients (not health plans) should be making decisions about medical necessity. In addition, decisions regarding medical necessity should be based on the needs of an individual patient and not an arbitrary low cost standard set by plans.

Ms. McIlrath highlighted both the 1998 Budget Surplus and the President's 1999 Budget. The Budget Surplus has created tremendous bipartisan disagreements on how the surplus should be spent. President Clinton would like over 62% of the surplus to go to social security and approximately 16% to Medicare. However, the Republicans would like to return the surplus to tax payers via and Health Providers would like the surplus to defray Balanced Budget Act cuts which reduced provider reimbursement or prevent new ones. Several highlights from the President's Budget include:

- 1) Small spending entitlements to help the uninsured specifically;
 - A) Medicare Buy-in for individuals 62 to 65 or displaced workers over 55;
 - B) Medicare for disabled who are unable to work;
 - C) Medicaid Buy in for disabled up to 250% of poverty; and,
 - D) Restore Medicaid for several classes of immigrants;
- 2) Using provider cuts to improve access to health care;
 - A) Cutting payments for outpatient drugs;
 - B) Expand centers of excellence;
 - C) Limit payment for prosthetics; and,
 - D) User fees both paper and duplicate claims application and reapplication.

Although the President's Budget does not currently affect physician fees, there is concern by the medical community about potential reductions in the future. In response, the AMA will be initiating a major campaign to limit the reductions. The campaign will likely include: 1) A clause which eliminates physicians being punished if their spending per Fee For Service benefits rises more than the GDP; 2) A petition for technology add-on as well as adjustments for both changes in site of service and composition of populations; and lastly, 3) The AMA would like HCFA to correct projections as once promised as they were off by \$645 million in 1999. The MedPAC supports the AMA's campaign with the exception of the site of service adjustment.

VIII. HCPAC Report

Emily Hill, PA-C announced the HCPAC approved the following two motions:

The PEAC representative will serve one year and his/her will be renewed by the HCPAC Review Board for the balance of the three-year term.

The HCPAC will elect an alternate to serve in the absence of the PEAC representative and will also serve one year and his/her term will be renewed by the HCPAC Review Board for the balance of the three-year term.

Election of the PEAC and PEAC Alternate

The HCPAC Review Board elected Mary Foto, OTR to represent the HCPAC on the PEAC and Marc Lenet, DPM, to serve as the PEAC-Alternate.

The approved HCPAC Report is attached to these minutes.

IX. Relative Value Recommendations for Codes Currently Without Work RVUs:

Allergy Testing and Immunotherapy Injections (Tab 6) Tracking Number I1-I4

The Joint Council of Allergy, Asthma and Immunology (JCAAI) and the American Academy of Otolaryngic Allergy (AAOA), withdrew this issue due to time constraints of reaching a consensus on relative value recommendations. This issue will be presented at the April 29-May 2, 1999 RUC meeting.

X. Relative Value Recommendations for New or Revised Codes for CPT 1999:

Intravascular Distal Blood Flow Velocity Measurements (Tab 7) Tracking Numbers U1-U2.

These codes were assigned interim values by the RUC that HCFA did not accept and instead assigned lower values to these procedures. The American College of Cardiology is not contesting HCFA's valuation of these procedures and withdraws these procedures from consideration by the RUC. Doctor Rich addressed this issue and his concern that the RUC should not submit interim relative value recommendations, particularly if they are not going to be readdressed by the RUC. The RUC agreed that the relative values assigned for these codes will not be submitted to HCFA as RUC recommendations. Doctor Hoehn referred the issue of interim recommendations to the Administrative Subcommittee for discussion.

XI. Relative Value Recommendations for New and Revised Codes for CPT 2000:

Cardioverter-Defibrillator Pacemaker Systems (Tab 8) Tracking Numbers B5-B8 Presentation: Doctor James Maloney, American College of Cardiology

A facilitation committee (Doctors Hanley, Chair, Britton, Fanale, Gage, Gee, Hayes, Moran, Schnur, and Eileen Sullivan-Marx, PhD) met to consider this issue.

A series of new CPT codes, 9374X1-9374X4 have been established to describe electronic analysis of combination ICD/single and dual chamber pacemaker systems with and without reprogramming. The FDA recently approved a new implantable cardioverter defibrillator that combines the features of a typical defibrillator with a dual-chamber pacemaker into one device.

The current codes do not reflect the more extensive follow-up and additional time and expertise required in the electronic analysis of this combined device.

Codes 9374X1 & 9374X2

The work described by 9374X1 is most similar to the work of 93737 *Electronic analysis of cardioverter/defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming* (work RVU=0.45) plus 50% of 93734 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming* (work RVU= 0.38) for the additional work. Based on the additional work of 9374X1 compared to 93737, the RUC recommends a work RVU at twice the value of 93737 for a recommendation of .90.

CPT Code 9374X2 *Electronic analysis of single chamber pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with programming* is very similar in work to several existing CPT codes 93738 *Electronic analysis of cardioverter/defibrillator only (interrogation,*

evaluation of pulse generator status); with reprogramming (work RVW=0.92) plus 50% of 93735 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response)*; with reprogramming (work RVW=0.74) for the additional work. According to survey data, there is a 14% increase in total time between 9374X1 and 9374X2. Therefore, the RUC agreed that 14% should be added to the work value of 9374X1 to arrive at a recommended work RVU of 1.03 for CPT code 9374X2.

CPT codes 9374X3 & 9374X4

The work involved in CPT Code 9374X3 *Electronic analysis of dual chamber pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response)*; without reprogramming is very similar to a combination of existing codes 93738 (work RVW = 0.92) plus 50% of 93735 (work RVW=0.74) for the additional work. The RUC agreed that the 30% increase in time from CPT 9374X1 to 9374X3 supported a 30% increase in work RVU for a dual chamber and that the increase in time between 9374X3 and 9374X4 was considered equivalent to 9374X1 and 9374X2. Therefore, the RUC supports a work RVU of 1.17 for 9374X3 and 1.33 for 9374X4.

Recommendation: The RUC supports the following work RVUs for the four new CPT codes: 9374X1(.90); 9374X2(1.03); 9374X3 (1.17) and 9374X4 (1.33).

The specialty society did not offer any recommendations regarding direct practice expense inputs for these codes.

Additional codes were presented to the RUC and the facilitation committee (codes 3324X – 3325X3). However, the RUC did not come to consensus on these codes and they were subsequently deleted by the CPT Editorial Panel at its February 12-14, 1999 meeting.

Intracardiac Conversion (Tab 9) Tracking Number G1

Presentation: Doctor James Maloney, American College of Cardiology

A new CPT code 9296X *Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)* was established to describe an effective therapy for patients unresponsive to external cardioversion. Although cardioversion does not reflect new technology, advancements in catheter technology and techniques have greatly increased the efficacy and applicability of this procedure. Currently, this procedure is being reported using codes 92960 *Cardioversion, elective, electrical conversion of arrhythmia, external* (work RVW=2.25) plus 93602 *Intra-atrial recording* (work RVW=2.12) plus 93603 *Right ventricular recording* (work RVW=2.12) with appropriate modifiers. These codes are inadequate as intracardiac cardioversion is quite different from external cardioversion in that intracardiac cardioversion requires vascular access, placement of catheters into the heart under

fluoroscopy, and a much greater knowledge of electrophysiology procedures. Therefore, the physician work, risk and practice expense of intracardiac conversion are significantly greater than for external cardioversion.. Therefore, the RUC accepted the specialty society's recommendation of 4.6, which is the final median RVW for CPT code 9296X.

Recommendation: The RUC supports a work relative value unit of 4.60 for 9296X.

The specialty society did not offer any recommendations regarding direct practice expense inputs for these codes.

Removal of Intra-Aortic Balloon Assist Device (Tab 10) Tracking Number D1 Presentation: Doctor Sidney Levitsky, Society of Vascular Surgeons

A new CPT code 9353X was created to describe *Removal of intra-aortic balloon assist device; percutaneous*. The procedure for the removal of Intra-Aortic Balloon Assist Device (IABAD) has been utilized for more than thirteen (13) years. IABAD procedures are frequently used in cardiogenic shock patients and hemodynamically unstable cardiac surgery patients.

CPT presently instructs physicians to report the percutaneous removal of an intra-aortic balloon device (IABAD) with "an appropriate E/M code." The removal of such a device does not necessitate the performance of an Evaluation and Management (E/M) service, which includes a history, exam and medical decision-making. In addition, the code for percutaneous insertion of the device does not include removal, which is frequently performed by a physician other than the physician who originally inserted the device. Other codes related to IABAD removal, such as CPT 33971 *Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft* (work RVU = 9.69) and CPT 33974 *Removal of an intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft* (work RVU = 14.41) are not appropriate because they apply to situations when the IABAD is removed surgically and a vascular surgical repair of the arteriotomy is performed.

In its development of a proposed work relative value unit, the RUC noted that the procedures described in the new code are most usually provided by physicians when treating unstable patients. It was the consensus that these particular services require some of the cognitive aspects associated with physician work for the provision of Critical Care services to patients. It was agreed that the work of removal of the assist device and the provision of associated cognitive services approximated 30 minutes of Critical Care services.

Recommendation: Based on this rationale, the RUC recommends a work relative value unit of 2.00 for CPT code 9353X.

The specialty society did not offer any recommendations regarding direct practice expense inputs for these codes.

Integumentary System Repair (Tab 11)

Presentation: Doctor John Derr, Jr., MD, American Society of Plastic and Reconstructive Surgeons

A facilitation committee met following the RUC's activities Saturday, February 6, 1999. The facilitation committee's report will be presented at the April 29-May 2, 1999 RUC meeting.

**Laparoscopic Donor Nephrectomy (Tab 12) Tracking Number E11
Presentation: Thomas P.Cooper,MD,American Urological Association**

In 1998, CPT accepted the addition of a new code for inclusion in CPT 2000. CPT code 503XX *Donor nephrectomy, with preparation and maintenance of allograft; from living donor (laparoscopic)* was created to specifically address the use of new technology associated with this procedure.

The use of laparoscopic techniques for living donor nephrectomies has been in place since 1995. The typical patient is a male or female without major medical problems who consents to donate a kidney to a relative or close acquaintance with renal failure. Following an extensive medical and psychosocial evaluation confirming the health of the prospective donor, the donor is accepted for the procedure. The laparoscopic procedure is associated with decreased pain, length of stay and morbidity in comparison to those of the traditional open procedure.

As with other new codes, there is presently no nomenclature which captures the utilization of laparoscopic technology used in the performance of this code. Physicians are currently reporting this procedure using CPT code 50320 *Donor nephrectomy, with preparation and maintenance of allograft; from a cadaver donor, unilateral or bilateral* (work RVU= 22.21) and CPT 56399 *Unlisted procedure, laparoscopy, hysteroscopy* (work RVU= 0.00). Again, neither of these CPT codes appropriately includes identification of the laparoscopic technology component used in conjunction with donor nephrectomy procedures.

The RUC considered results from work survey data, which provided for a survey median of 25.50. It was the consensus of the RUC that this value was appropriate. The RUC recommends a work relative value unit of 25.50 for CPT code 503XX.

Recommendation: The RUC supports a work relative value of 25.50 for 503XX. The RUC also recommends that the practice expense value for CPT code 503XX be based on a *Laparscopic fundoplasty*, CPT code 56349 with a practice expense of 11.88 as the hospital stay and follow-up for both procedures are similar in time and expense.

**Weekly Radiation Treatment Management (Tab 13) Tracking Number C1
Presentation: Paul E.Wallner, DO,American Society For Therapeutic Radiology and Oncology, Michael L.Steinberg, MD, American College of Radiation Oncology, Theodore J. Brickner, MD, American College of Radiology**

A new code was developed CPT 7742X to report *Radiation treatment management, five treatments*. Radiation oncology has been practiced for over seventy years and is primarily used in the treatment of benign and malignant lesions.

The new treatment management code was created to describe in a single definition scenario, a significant variety of cancer and patient problems. Four treatment management codes, CPT 77419, *Weekly radiation therapy management; conformal* (work RVU = 3.60); CPT 77420, *Weekly radiation therapy management; simple* (work RVU = 1.61); CPT 77425, *Weekly radiation therapy management; intermediate* (work RVU = 2.44); CPT 77430 *Weekly radiation therapy management; complex* (work RVU = 3.60) were collapsed into a single code.

The modifications to the treatment codes were implemented for several reasons. The current CPT descriptions for treatment management no longer reflect the practice of radiation oncology. The origin of the current descriptors originated in the 1970s. At that time, the term “treatment management” was used to describe both the supervision of technical factors of treatment and the clinical/medical care of the patient. It generally was believed that the complexity of the technical factors of treatment (e.g. number and type of treatment devices, type of beams(s) used) were directly related to the seriousness of the medical condition of the patient and the clinical work of the radiation oncologist. Since the time the descriptors were originally created, there have been significant changes in the practice of radiation oncology.

Again, when the codes were created over 20 years ago, technical factors were used as the proxy for physician work. However, this analogy is less appropriate today. Furthermore, during the Five-Year Review of the RBRVS, the AMA’s RVS Update Committee (RUC) noted that the codes’ descriptors did not represent the physician work involved in the treatment management. The intent of the recent code changes was to make treatment management codes dependent on clinical factors and physician work, rather than technical factors. Weekly management currently consists of four factors: 1) Review of port films; 2) Review of dosimetry and chart prescription; 3) Review of patient treatment set-up; and, 4) Examination of patient for medical evaluation and management.

In its evaluation of a proposed work relative value unit, the RUC observed the values for CPT codes currently used in reporting as well as survey data provided by physicians who performed these services. It was the consensus of the RUC that a work value of 3.31 appropriately valued the physician work involved in performing these procedures.

Recommendation: The RUC recommends a work relative value unit of 3.31 for CPT code 7742X. The RUC also supports the specialty society’s recommendation that the CPEP 6 direct inputs for CPT code 77430 should be assigned to the new CPT code 7742X.

XII. Practice Expense Advisory Committee Report

On February 4, 1999 the Practice Expense Advisory Committee (PEAC) met to select a set of codes so the PEAC can begin to review the CPEP data for those codes during its meeting in

April. The PEAC also met to elect the two rotating seat members. The following members were in attendance: Doctors Eugene S. Ogrod (Chair), Michael L. Berman, Joel F. Bradley, Jr, Neil Busis, Neal H. Cohen, Thomas Cooper, Anthony N. DeMaria, Peter K. Dempsey, Dudley D. Jones, Gregory Kwasny, Alex G. Little, A. Clinton MacKinney, James Maloney, Clay Molstad, Willard Moran, Frank Opelka, Tye Ouzounian, Dighton C. Packard, Jeffrey I. Resnick, Ronald Shellow, Daniel Mark Siegel, Ray Stowers, Bill Thorwarth, Richard Whitten, and Candia Baker Laughlin, MS, RN, CS, Mary Foto, OT, Ron Nelson, PA-C, and John W. Potter Jr. FACMPE.

Doctor. Ogrod reported that Ronald L. Kaufman, MD was elected to the Internal Medicine rotating seat and Susan Spires, MD was elected to the other rotating seat. In addition to these new PEAC members, the PEAC agreed to allow specialties to designate alternate representatives to the PEAC if they desire.

The majority of the PEAC meeting was devoted to developing the criteria for selecting those codes that the PEAC will review during its first full meeting in April. The PEAC agreed to select a total of 150 to 250 codes based on the following criteria:

First those codes which appear on all of the existing prioritization lists in the agenda book will be selected. There are approximately 25 of these codes. Those codes that appear on the MPC list and also have the highest Medicare frequency will also be selected as will those codes, which are on both the MPC list and have the largest variation in PE RVUs. The MPC list was selected as a starting point since it contains codes representative of each specialty, while recognizing that it was developed for work RVUs and not practice expenses. The list will be reviewed to ensure a broad number of codes are performed by more than one specialty and also to limit to impact in terms of workload for any one specialty to approximately five codes. The specialty societies will review this list to suggest codes that should be pulled from the list.

In addition to the codes identified above, approximately 30 codes will be selected based on suggestions from specialty societies reflecting codes of focused concern the specialty society wants reviewed this first round. These codes will be selected by the PEAC chair based on unique factors and compelling criteria. (e.g., frequency and or change in practice expense relative values) Approximately 10 codes with zero work RVUs will be selected based on specialty society input and finally 10 codes suggested by HCFA will be included.

The PEAC will limit its initial review to the approximately 200 codes but if a specialty determines that their practice expense for one of the initial codes is exactly the same for a family of codes they may present this data as well, however the direct inputs must be identical across the particular family of codes being reviewed. If the direct expenses vary among codes in the family, then a specialty can only present the data for those codes on its initial PEAC list.

The results of the PEAC meeting will be provided to the RUC in time for the RUC's April meeting. The PEAC will provide the RUC with the direct input data for those codes it has reviewed and come to a consensus on the direct inputs.

The PEAC report was approved and is attached to these minutes.

XIII. Practice Expense Subcommittee Report

On February 4, 1999, the Practice Expense Subcommittee met to discuss several issues, including: recent activities of MedPAC; the PEAC meeting; physician time data and the indirect cost methodology. The following subcommittee members were in attendance: Doctors J. Leonard Lichtenfeld (Chair), William Gee, James Hayes, David Hitzeman, Charles Koopmann, David Massanari, William Thorwarth, Charles Vanchiere, David West, William Winters, and Don Williamson, OD. Doctor Laura Tosi attended for Doctor Richard Haynes. Doctor Lichtenfeld discussed the meeting with the full RUC and first informed the RUC that the Subcommittee had discussed the issue of expense disposable medical supplies specific to certain services. The Subcommittee agreed that it is very difficult, if not impossible, to fairly value codes that have a bimodal distribution of expense supplies. The Subcommittee offered the following recommendation that was approved by the RUC:

Above a certain dollar threshold and where it is impractical to incorporate the data into the CPEP direct expense, HCFA should allow for separate payment for certain medical supplies utilizing a J-code like mechanism.

The Subcommittee also discussed the physician time data and made several recommendations for action that were approved by the RUC:

- **AMA staff will distribute the RUC data to all specialty societies to audit or compare the data to recommendations previously submitted. Once verified, the RUC will resubmit this data to HCFA.**
- **AMA staff will collate the time data from the reference service codes surveyed over the past few years. This data will then be compared to existing Harvard time data to determine if the scaling factors used are appropriate.**
- **The increases in physician time for the codes with global periods of 010 and 090 were appropriate as long as the changes were consistent with the increase in E/M time.**
- **The RUC will need to review the time data provided for new and revised codes and determine if the data appear valid.**
- **For those small number of codes identified for refinement of time data, the specialty society may bring the issue to the RUC for discussion.**

Finally, Doctor Lichtenfeld explained that HCFA will be looking to an outside contractor for advice on the indirect cost methodology. The Subcommittee will defer any formal recommendation until it reviews the report of the HCFA contractor. However, it was the sense of the committee that physician work is not an appropriate allocator for indirect expense.

The Practice Expense Subcommittee report was approved and is attached to these minutes.

XIV. Research Subcommittee Report

On February 4, 1999, the Research Subcommittee met to discuss several issues relating to the refinement of the RUC survey, the status of SMS practice expense activities, and results of a paired comparison study. The following subcommittee members were in attendance: Doctors Florin (Chair), David I. Berland, John O. Gage, W. Benson Harer, John E. Mayer, Alan L. Plummer, Chester W. Schmidt, Paul Schnur, Sheldon Taubman, and Emily Hill PA-C, and Eileen Sullivan-Marx, PhD.

Doctor Florin summarized some of the difficulties experienced by the specialty societies' recent use of the revised RUC survey. Specialties informed the research subcommittee that the survey was complex and too lengthy and summarizing the practice expense data was very challenging. Dr. Florin acknowledged that the responses to the practice expense portion of the survey will vary greatly do to the differences in practice settings, however, it is the responsibility of each specialty's RVS advisory committee to examine the data and make a recommendation which represents the practice expenses for a typical practice for that specialty. While some specialties may not feel that a typical practice does not exist, the RUC is currently bound by HCFA's methodology that is based on the assumption that practice expense relative values represent a typical practice.

- The research subcommittee has formed two taskforces responsible for revising portions of the RUC survey. The first taskforce will examine the survey questions pertaining to clinical staff inputs and the second taskforce will evaluate the section of the survey dealing with supplies and equipment. The research subcommittee has agreed to make editorial changes to the survey, such as separating the work and practice expense portions and make the survey available for codes which will be presented at the April RUC meeting. At the April RUC meeting, the RUC will have an opportunity to review a revised RUC survey incorporating the recommendations from the two taskforces. Specialties were instructed to use this current version of the survey and not the old version of the RUC work survey, however, due to the additional work that needs to be completed for revising the RUC survey, the Subcommittee agreed that specialty societies should be given the option of not using the current RUC survey for providing practice expense direct inputs and rely on the specialty society RVS committee to determine inputs. The following recommendations offered by the Subcommittee were approved by the RUC:

- **Due to the additional work that needs to be completed for revising the RUC survey, the Subcommittee agreed that specialty societies should be given the option of not using the current RUC survey for providing practice expense direct inputs and rely on the specialty society RVS committee to determine inputs. The Research Subcommittee will develop a revised survey for collecting direct inputs for RUC approval at the April RUC meeting.**
- **Specialty society relative value committees are encouraged to play an important role in reviewing survey data and to develop a set of direct input recommendations which reflect the predominant mix of direct inputs.**
- **A question which lists various types of physician practices and geographic settings will be added to the RUC survey. This will allow specialties to examine practice cost variations across practice settings.**
- **The subcommittee agreed to form two taskforces to further clarify the ground rules for collecting direct inputs. The first taskforce will be responsible for survey questions and the summary of recommendation form sections relating to clinical staff direct inputs and a second taskforce to clarify the questions pertaining to supplies and equipment.**

Some RUC members were concerned that the RUC survey is based on Medicare payment rules and these rules do not always apply to private payors. Therefore, the practice expenses collected according to Medicare rules may not be the same as the practice expenses allowed by private payors. For example, Medicare allows certain clinical staff to bill separately, and their costs are excluded from the current practice expense methodology, however, private payors may not allow them to bill separately, and this leads to an understatement of practice expenses according to private payor rules.

Doctor Florin reported that the Subcommittee strongly opposed HCFA's suggested changes to the RUC survey that would make a distinction between clinical staff activities that substitute for physician work and those activities that are not a substitute. HCFA's rationale for this suggested change is that inclusion of some clinical staff clinical activities in the practice expense portion of the survey would result in double counting. For example, HCFA noted that the work relative value for 99211 was actually work performed by nurses. The Subcommittee argued that this work is actually the physician supervision of the nursing activities. The subcommittee strongly objected to this assumption that clinical staff activities such as obtaining medical history are always a substitute for physician work. The subcommittee disagreed with these HCFA suggested changes and will not exclude certain clinical staff activities from the practice expense portion of the survey and offered the following recommendations:

- **The subcommittee agreed that it would be inappropriate to operate under the HCFA assumption that certain clinical staff activities such as obtaining a medical history and obtaining consent are a replacement for physician services.**

The AMA has begun the development of a new SMS survey, which will be administered to physician practices rather than individual physicians. As the AMA continues developing this survey AMA staff will solicit input from the RUC via the Research Subcommittee. The Research Subcommittee offered the following recommendation which was approved by the RUC:

- **The subcommittee agreed to work with SMS staff in providing recommendations on the new practice level and in serving as focus groups that may be needed to develop the survey.**

Some RUC members were concerned that the RUC survey does not collect data on bad debt expenses that they consider a valid category of practice expense. Doctor Florin explained that this category of expense would not be covered in the RUC survey since it is not a direct expense, and if these expense were to be captured it would be through the SMS survey. The SMS survey has added a question pertaining to charity care but the RUC members would like more specific data relating to bad debt expense. Regardless of they type of bad debt data collected it would first be necessary for HCFA to incorporate this category into their practice expense methodology.

Doctor Florin provided a briefing on the results of a study of the relativity of work values for a series of injection code procedures. The surveys consisted of all these pairs of codes, and respondents were asked for their judgement about which of the pairs represented the greater amount of physician work. The results were analyzed using the Rasch methodology, which is described in Tab 16 of the RUC agenda book. The study presented an alternative methodology for examining the family for rank order and then for developing RVWs. Due to the success of this initial study, the Subcommittee made the following recommendation that was approved by the RUC:

- **The Subcommittee agreed to pursue use of Rasch analysis and paired comparison in the five year review of physician work.**

The RUC discussed the growing workload due to the introduction of practice expense relative values and passed a motion designed to improve coordination between the RUC and PEAC and help to ensure that the RUC continues to develop well justified work relative values. It is apparent that confusion still exists regarding the division of responsibilities amongst the PEAC, the Practice Expense Subcommittee, and the Research Subcommittee. The November 21, 1998 RUC minutes clarify this issue – essentially, the PEAC is responsible for the refinement of direct practice expense inputs (i.e., CPEP data); the Research Subcommittee is responsible for the work and direct practice expense survey methodology, as well as any coordination with AMA SMS staff on the SMS survey input; and the Practice Expense Subcommittee is responsible for reviewing physician time and the indirect cost methodology. The RUC will review direct practice expense inputs for new and revised codes at the same time it reviews work relative value recommendations.

The following motion was approved:

- 1) **The RUC needs to decide if the RUC Research Subcommittee or the PEAC is responsible for gathering PE information, be it survey or expert comment Note: The PEAC is responsible for direct practice expense inputs for existing codes. The RUC is responsible for this data for new and revised codes.**
- 2) **The Responsible Party (RUC Research Subcommittee or the PEAC) must insure that any PE survey process does not interfere with the RUC RVW survey responsibility. The Research Subcommittee is responsible for recommendations to the RUC on both the work and practice expense survey.**
- 3) **The Responsible Party (RUC Research Subcommittee or the PEAC) must demonstrate their validation process for any proposed survey process & that the survey is easily done & works before societies are required to use surveys. The Research Subcommittee is responsible for recommendations to the RUC on both the work and practice expense survey.**

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

XV. Administrative Subcommittee Report

On February 5, 1999, the Administrative Subcommittee met to discuss RUC representation for ACP/ASIM and proposed changes to the “Structure and Functions” and “Rules and Procedures” documents necessitated by the implementation of the Practice Expense Advisory Committee (PEAC).

The following Subcommittee members participated in the discussion: Doctors William Rich (Chair), Melvin Britton, Tracy Gordy, Alexander Hannenberg, David McCaffree, Clay Molstad, James Moorefield, Richard Whitten, Eugene Wiener, and Mary Foto, OTR.

Doctor Rich informed RUC participants that the Administrative Subcommittee had again reviewed recommendations that were previously tabled by the RUC at the September 1998 RUC meeting in Tucson, Arizona. The Administrative Subcommittee proposed recommendations related to RUC representation for the American College of Physicians/American Society of Internal Medicine. The RUC considered, and subsequently accepted, the following recommendations for this issue set forth by Doctor Rich on behalf of the Administrative Subcommittee:

Recommendations:

The ACP and ASIM seats should both be retained by current incumbents until the First Term expires in May 1999.

At that time, ACP-ASIM will be asked to designate a single RUC member and alternate to initiate a new three-year term, representing ACP-ASIM.

A new internal medicine RUC seat will be established (thereby keeping the total seats the same) designated as an internal medicine rotating seat. The eligible societies are listed on Appendix F, Page 2 of the RUC's "Structure and Functions" document.

In addition, the RUC also examined both editorial and substantive changes suggested by the Administrative Subcommittee related to the RUC's governing documents:

1) "Structure and Functions," and 2) "Rules and Procedures."

Following a review and discussion of the changes, the RUC approved the following Administrative Subcommittee's recommendation:

Recommendation:

The "Structure and Functions" and "Rules and Procedures" documents should be amended to include the changes detailed on Attachment A given the implementation of the Practice Expense Advisory Committee (PEAC).

The Administrative Subcommittee report was approved by the RUC and is attached to these minutes.

XVI. Other Issues

Several RUC members mentioned that there appears to be inconsistency amongst global periods for certain surgical procedures. Doctor Gage introduced a motion that the RUC should recommend: 1) elimination of global periods, and 2) if that is not possible, to at least apply consistency in the assignment of global periods amongst CPT codes. The RUC did not act on this motion, but instead referred the issue to a workgroup to include: Doctors John Gage (Chair), Chair, William Gee, Clay Molstad, Bruce Sigsbee, and William Winters. Doctor Hoehn announced that effective with the September 1999 RUC meeting, he will again rotate RUC members amongst the three RUC Subcommittees. He also noted that he plans to appoint new a new Chair to each Subcommittee to provide other RUC members with this leadership opportunity.

Doctor Hoehn also announced that Patrick Gallagher will be the acting Department Director during Sherry Smith's maternity leave.

The meeting adjourned at 5:02 p.m.