AMA/Specialty RVS Update Committee
February 4-6, 2000

The Point Hilton Resort at Squaw Peak
Phoenix Arizona

I. Call to Order:

Doctor James G. Hoehn called the meeting to order on Friday, February 4, 2000 at 1:30 p.m. The following RUC members were in attendance:

James G. Hoehn, MD, Chair
Joel Bradley, MD*
Thomas Cooper, MD*
Lee Eisenberg, MD
Robert Florin, MD
John Gage, MD
William Gee, MD
Alexander Hannenberg, MD
W. Benson Harer, MD
James Hayes, MD
Richard J. Haynes, MD
David Hitzeman, MD
Charles Koopmann Jr., MD
Barbara Levy, MD*
J. Leonard Lichtenfeld, MD
James Maloney, MD
David L. Massanari, MD*
John Mayer, MD
David L.McCaffree, MD
James Moorefield, MD
Eugene Ogrod, MD
Alan L. Plummer, MD
David Regan, MD
William Rich, MD
Peter Sawchuk, MD*
Chester Schmidt, MD
Paul Schnur, MD
Bruce Sigsbee, MD
Sheldon Taubman, MD
Trexer Topping, MD*
Laura Tosi, MD*
Richard Whitten, MD*
Don E. Williamson, OD
Robert Zwolak, MD

*Alternate RUC Member

II. Chair's Report:

Doctor Hoehn regretfully announced that Charles Vanchiere, MD passed away and requested that the RUC have a moment of silence in his memory. Doctor Hoehn stated that a donation would be made to the Baylor International Pediatric Aids Initiative on behalf of the RUC.

Doctor Hoehn announced the resignation of William L. Winters, Jr., MD, the RUC representative for the American College of Cardiology (ACC). Doctor James C. Blankenship will be replacing Doctor Winter's as the representative for the ACC.

Doctor Hoehn informed the RUC that Doctor Ogrod had resigned as PEAC chair for personal reasons and to focus on his other professional activities. Doctor Hoehn thanked Doctor Ogrod for all of his significant contributions to the process and presented a gift to him as a small token of the RUC's appreciation.

To select the new PEAC chair, Doctor Hoehn stated that a letter would be forwarded from Doctor E. Ratcliffe Anderson, Jr., MD to all specialty societies. A list of nomination criteria will be included. The nominees will then be forwarded to the Administrative Subcommittee who will provide a list of candidates for selection to Doctor Hoehn.

Doctor Hoehn expressed concern regarding the September RUC meeting date. The RUC had been alerted that the meeting date falls at the beginning of the Jewish High Holy Days. Due to this conflict, the RUC's meeting date will be changed to October 4-8, 2000. Doctor Hoehn noted RUC that the meeting would finish by noon on October 8, 2000 to allow adequate travel time as Yom Kippur begins Sunday evening.

Other Issues

Doctor Hoehn announced the Facilitation Committees:

Facilitation Committee 1
John E. Mayer, MD, Chair
William F. Gee, MD
Richard Whitten, MD
W. Benson Harer, MD
Alexander Hannenberg, MD
David Massanari, MD (Advisor)
Jerilynn S. Kaibel, DC (HCPAC)

Facilitation Committee 2
Sheldon Taubman, MD, Chair
Richard J. Haynes, MD
David F. Hitzeman, DO
David L. McCaffree, MD
Paul Schnur, MD
Bruce Sigsbee, MD
Sidney Levitsky, MD (Advisor)
Don E. Williamson, OD (HCPAC)

Facilitation Committee 3
James E. Hayes, MD, Chair
Robert Florin, MD
Charles F. Koopmann, Jr., MD
James Moorefield, MD
James Blankenship, MD
Robert M. Zwolak, MD
Neil A. Busis, MD (Advisor)
Mary Foto, OTR (HCPAC)

Facilitation Committee 4
John O. Gage, MD
Chester W. Schmidt, Jr., MD
J. Leonard Lichtenfeld, MD
Alan L. Plummer, MD
David Regan, MD
William Rich, MD
Laura Lowe Tosi, MD (Advisor)
Eileen Sullivan-Marx, PhD (HCPAC)

III. Director's Report:

Patrick Gallagher presented the Director's Report and announced that new 2000 edition of *Medicare RBRVS: The Physician's Guide* were placed on the chairs and RUC members should feel free to take them home. Patrick Gallagher introduced Jennifer Kopacz as the new Policy Associate for the Department of Relative Value Systems. Lastly, Patrick Gallagher indicated there would be an update and dissemination of the RUC database prior to the April meeting.

IV. Approval of the April/May, 1999 Minutes:

The minutes of the September 1999 RUC meeting were approved after the following Revisions were noted:

- Page 1, Call to Order: Replace: Sheldon B. Taubman, MD with George Kwass, MD.
- Page 3, Item IV second bullet: Delete the phrase "would represent an unbundling of E/M services and the code" from the fourth sentence in the paragraph.
- Page 21, Item XVI, Add a sentence regarding individual members expressed significant concerns about the intellectual and scientific validity of the current Practice Expense methodology.

The minutes were approved as amended.

V. CPT Update:

Doctor Lee Eisenberg, CPT representative to the RUC, indicated there would be a high volume of codes the Panel will address at the upcoming CPT Editorial Panel meeting February 11-13, 2000. Doctor Eisenberg indicated there would be over 70 issues on the CPT Editorial Panel Agenda.

CPT-5

Mark Segal, PhD, Vice President of Coding and Medical Information Systems, presented to the RUC a Power Point presentation on the CPT-5 project:

Dr. Segal informed RUC members that the first phase of the CPT-5 project is concluding. He indicated that the overall responsibility of CPT 5 is to preserve CPT as the language to communicate clinical information for administrative and financial purposes. Dr. Segal noted that the Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires the Secretary of Health and Human Services (HHS) to adopt national standards for electronic transmission of financial and administrative data. This includes code sets for procedures and diagnoses. Additionally, Dr. Segal informed RUC members about the changes to CPT which include the elimination of "starred" and "separate procedure" designations, improving the definition of a surgical package as defined in CPT and, as feasible, replacing ambiguous terms such as "with or without," "any method," "any technique," and "any approach" with greater specificity.

The tasks for 2000 include beginning implementation of new sections of CPT for performance measurement and investigational services, enhancing the clarity and consistency within CPT, implementing internet communications for the CPT Editorial Process and beginning CPT education initiatives for users.

Another major initiative beginning in 2000 is the development of a CPT terminology model based on the inherent hierarchy in CPT and the representation of the model in a database. This will facilitate the development of electronic versions of CPT that are browser based or use XML to include more detailed information on the service. Dr. Segal concluded the presentation by announcing to RUC members that the RUC played an invaluable part in the CPT-5 process.

VI. HCFA Update:

Doctor Thomas Marciniak provided the RUC with an update from the Health Care Financing Administration (HCFA), which included the following pertinent issues:

- Doctor Marciniak reminded RUC members that the total time for physician values are linked to top-down methodology. Doctor Marciniak also acknowledged the imperfection of Dan Dunn's data, but indicated now is the time for the RUC to address this issue and refine the data.
- The Balanced Budget Refinement Act (BBRA) included the following provisions:
  - Changes to the Medicare SGR formula. A regulation is in final approval and should be released soon.
  - A requirement that HCFA establish guidelines for the use of external practice expense data. Doctor Marciniak stated the data should be usable for the 2001 fee schedule. Doctor Marciniak also indicated that this regulation is also going through final clearance.
  - The $1500 payment capitations for PT and OT services were suspended for two years.
  - Payment rates for PAP smears were increased.
  - The prospective payment system for Ambulatory Surgery Centers will be phased in.
- Doctor Marciniak summarized the Lewin report delivered to HCFA in December 1999 regarding patient care hours. There were four different ways patient care hours could be validated:
  1.Compare the detailed patient care hours to the summary patient care hours.
  2. Compare the total number of Medicare claims data physician time to the Medicare percentage in SMS data.
  3. Review historical trends per specialty.
  4. Compare to other physician surveys (e.g., MGMA).

Doctor Paul Rudolf, who indicated this was his first full RUC meeting, provided the RUC with an update regarding the following issues:

- For the Five-year Review, HCFA does not feel they will be able to identify misvalued codes, as HCFA is currently reviewing physician time with an independent contractor. Doctor Rudolf suggested it would be helpful if the Five-year review could be accomplished in two phases. Specifically, phase one would include reviewing codes from the public comment process and phase two would include addressing HCFA identified codes.

- Regarding Evaluation and Management guidelines, HCFA will be performing an internal review assessment that should be concluded in the next two weeks. Doctor Rudolf stated that there is currently no specific time-line regarding pilot testing of the E/M guidelines. HCFA will not rush the process, as its priority is to collect good data.
- HCFA developed units edits which will be implemented for the prospective payment system (PPS) for Ambulatory Surgical Centers then for the physician fee schedule. However, Doctor Rudolf indicated that the date for implementation may be October 1, 2000 or January 1, 2001. Specialty societies will have an opportunity to comment on these edits.
- As a result of the BBRA, HCFA made changes regarding how the Ambulatory Patient Groups (APG's) are structured. Doctor Rudolf indicated there is a significant difference from last year's proposed rule.

VII. **Washington Update**

Sharon Mcllrath from the AMA's Washington office reviewed a number of legislative and regulatory initiatives of interest to medicine.

On the Legislative side:

- Likely to see a bill on the Patient Bill of Rights again this year.
- A Medicare prescription drug benefit is included in the President's budget and favored by many in Congress. The AMA will work to ensure any benefit is appropriately designed and funded.
- Regarding fraud and abuse, it is likely there will be additional bills. One positive development is Rep. Fletcher's Doctor Bill of Rights, which would improve the due process rights.
- The President's budget includes a program that would cost $110 billion over 10 years by extending coverage to parents of kids in the Children's Health Insurance Program, which would provide a tax credit to help low income families purchase insurance and people who are 55 to 64 years of age to purchase Medicare. The budget also includes a $3000 tax credit for caregivers providing long-term care. There is also increased budgeting for funding for biomedical research.

On the Regulatory side:

- IOM report was issued in November and called "To Err is Human: Building a Safer Health System." There are calls for a new Center for Patient Safety within the Agency for Healthcare Research and Quality. The President has directed federal agencies to provide him with recommendations for improving patient safety. Regarding this issue, AMA stated that rather than imposing mandatory reporting, the president should try to evaluate the impact of existing reporting provisions.
- In July, HCFA issued an interim final rule about seclusion and restraints that requires a physician or licensed independent practitioner to conduct a face-to-face evaluation of the patient within one hour of the initiation of restraints or seclusion.

At that time, the AMA protested and joined a coalition of six other groups including the ANA, APA and AHA to try to reverse the final rule.

- Concerning SGR, 15 specialties have signed on with the AMA as plaintiffs in our suit against HCFA. The AMA is working with the Agency for Healthcare Research and Quality on the study mandated in the Balanced Budget Refinement Act to factor changes in technology and medical practice into the formula. AMA is also working with MedPAC, which will review this study and projected updates that HCFA is required to supply each year by March 1. The Commission's March report will retract last year's recommendation to expand the SGR to include outpatient departments and ambulatory surgery centers. The AMA expressed concerns regarding how a target could account for technological changes and shifts in site of service.
- Regarding privacy regulations, comments are due by February 17. Concerns include that it could prove extremely costly and burdensome to individual physicians or small groups. The rule would make physicians and health plans responsible for what a "business partner" did, as the secretary's authority is limited to physicians, providers, health plans and data clearinghouses.
- Regarding Medicare+ Choice, over the last two years, nearly 200 plans have withdrawn or reduced their services areas. The MedPAC report concludes that the program has not met any of its goals.

VIII. Practice Expense Advisory Committee Report:

Doctor Ogrod presented the PEAC report and summarized the highlights of the February PEAC meeting. Doctor Ogrod explained that the direct inputs that were approved by the PEAC will be presented for RUC approval in April. Doctor Ogrod discussed the PEAC's progress in developing standard supply packages. While the PEAC presented two supply packages for RUC approval, it is the intention of the PEAC to have specialties develop additional packages that will standardize the supplies applied to codes. Doctor Ogrod explained that the PEAC intends to establish benchmarks for both supplies and clinical staff and the standardized packs would be applied to groups of codes selected by the specialties.

The following supply packages were approved by the RUC.

<u>Multi-specialty Minimum Supply Package for Visits</u>

One patient gown
7 feet of exam table paper
1 pillow case
2 pairs of gloves (non-sterile)
1 temperature probe cover

<u>Basic Post-Operative Incision Care Kit</u> – intended for use in a post surgical encounter when staples are removed. This kit can be used anytime after the first post-operative visit.

1 pair of sterile gloves
2 alcohol swabs
2 packages of steri-strips
12 inches of tape (2 increments of tape @ 6 inches each)
1 staple remover kit
10 ml betadine (20 units)
2 Gauze packages
1 Tincture Binzoin Swab

The following standardized clinical staff times were also approved by the RUC:

1. **The greeting of the patient, escorting patient to room, gowning of patient, and notifying physician that the patient was ready, was standardized as 3 minutes of time.**
2. **The obtaining of vital signs was standardized into 3 levels of service with the following times:**
   Level 0 (no vital signs taken) = 0 minutes
   Level 1 (1-3 vitals) = 2 minutes
   Level 2 (4-6 vitals) = 4 minutes
3. **Cleaning of the room and equipment was standardized to 1 minute.**

While the PEAC allows specialties to withdraw codes from the agenda, Doctor Ogrod stated that the PEAC will need to address this issue in the future. At a minimum, the PEAC will require specialties to provide a reason for withdrawing codes so that the PEAC can examine the reasons and attempt to identify any systemic reasons why specialties are withdrawing codes. Also, the PEAC will need to discuss at the April meeting the process it will use to select codes for the September meeting and all remaining meetings. Several PEAC members as well as the HCFA representatives stressed the need for the PEAC to select objective code selection criteria. **To prepare for this issue, the RUC passed the following recommendation:**

All representatives of the PEAC will come to the April PEAC meeting with their favored code selection criteria, either from the list provided in the PEAC staff note, or some other criteria. The April 2000 meeting is the final date at which a code selection criteria will be approved.

Doctor Ogrod explained that the PEAC discussed the process for reviewing the direct inputs for the E/M codes. While an informal workgroup of various specialties have been working on this issue since the September RUC meeting, the PEAC decided to form a small workgroup to develop recommendations for PEAC consideration in April.

The RUC approved the following recommendation:

A workgroup be appointed to present recommended direct practice inputs for E/M services at the April 2000 PEAC meeting

Doctor Ogrod also discussed the PEAC's use of facilitation committees and clarification of attendance at the meetings. The intent of the PEAC was to limit participation in the facilitation committee to those committee members, presenters and interested PEAC members. The RUC approved the following recommendation:

When facilitation committees meet, only the facilitation committee members, presenters, presenter's staff, and interested PEAC members should attend. In addition, it was agreed that HCFA officials might attend. If a facilitation committee chair wishes to limit attendance this should be discussed with the PEAC chair prior to the meeting.

The approved Practice Expense Advisory Committee report is attached to these minutes.

IX. Relative Value Recommendations for New & Revised Codes for CPT 2000

Escharotomy (Tab 6) Tracking Numbers A1 and A2 (16035 and 16036X). Presentation: John W. Derr, Jr., MD (American Society of Plastic Surgeons), Robert W. Gillespie, MD (American Burn Association)

The specialty presented data based on a survey performed with a global period of 90 days; however, the specialty now requests the global be adjusted to 000 days. The RUC did not approve the work RVU recommendations after extensive discussions, with particular concern that the survey respondents may have misunderstood the two vignettes and the global period issue. The RUC did recommend that the code be re-surveyed with a global period of 000. The specialties will re-present this issue at the April 2000 RUC meeting.

Harvesting of Upper Extremity Artery (Tab 8) Tracking Numbers B1 (3353X). Presentation: Sidney Levitsky, MD (Society of Thoracic Surgeons)

The initial specialty society recommendation was not accepted by the RUC. Facilitation Committee A reviewed the issue and presented the following recommendation to the RUC.

Work Relative Value Recommendations
A new CPT code 3353X was added to describe the harvesting of one segment of an upper extremity artery for coronary artery bypass procedures.

Currently, procurement of an artery is included in the Coronary Artery Bypass procedure codes and is not separately reported. However, the procurement of an upper extremity artery (e.g., radial artery) requires a separate operative field and there is an increased risk associated with the use of an upper extremity artery. There is also increased work in procuring an upper extremity artery, medical management of the graft and care of the extremity.

The specialty society recommended work value for code 3353X of 9.50 was decreased by the RUC. The RUC considers the work in the procedure (3353X) to be comparable to vein harvesting, CPT code *35500 Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)*. CPT code 35500 has a work value of 6.45. However, the CABG codes inherently include harvesting and anastomosis of the vessel, with an increment of 3.00 for each additional coronary arterial graft. Therefore, the RUC reduced the value by deducting ½ of this increment 3.00 (1.50) to account for the harvesting that is already an inherent part of the CABG codes. **Therefore, the RUC recommends a work value of 4.95 for CPT code 3353X.**

In the CPT proposal form, the society noted that 10% of the population who receive CABG may be eligible for this type of grafting. However, the specialty society clarified that at their recent annual meeting, updated data was presented that .25% - 2.5% of the CABG patient population are eligible. The use of the radial artery is used more often in younger patients.

Practice Expense Recommendations:
There are no direct practice expense inputs for this service.

Hemodialysis Flow Study (Tab 9) Tracking Number H1 (909X1).
Presentation: Emil P. Paganini, MD (Renal Physicians Association)

Work Relative Value Recommendations
A new CPT code was added to describe a hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, measurement and disconnection. This new code describes the technical component of a hemodialysis access flow study. There is no additional code for the professional component of this procedure as the delivery of this service is via dialysis personnel and the physician work component is captured in the Monthly Capitated Payment (MPC) activities provided by physicians to patients receiving dialysis support.

Practice Expense Recommendations

The direct expense inputs are attached beginning on page 5 of the summary of RUC recommendation form. The RUC recommends that a mix of the personnel be utilized for clinical staff practice expense. In addition, it was noted that 42% of the time the clinical staff are paid by the facility and 58% of the time separate personnel employed by the physician are utilized. Therefore, the typical clinical staff inputs are as follows:

RN/LPN/MA/PA/Dialysis Tech: 5.1 minutes pre-service; 17.9 minutes service period

The RUC also recommends a change to the specialty recommendation for medical supplies and equipment. Seventy to eighty percent of the time the Transonics equipment is utilized. Therefore, the RUC recommends deletion of the Critline supplies, procedure specific medical equipment and overhead equipment. It was also noted that the Transonics monitoring system is used for other purposes.

Complex Cataract (Tab 10) Tracking Numbers U1 (66984) and U2 (669XX). Presentation: Stephen S. Lane, MD (American Society of Cataract and Refractive Surgery)

Work Relative Value Recommendation

CPT code *669XX Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, endocapsular rings, or primary posterior capsulorrhexis) or patients in the amblyogenic developmental stage*, was created to describe complex extracapsular cataract removal. Complicated cataract extraction cases are infrequently performed and most often referred to surgeons experienced in specialized techniques for removal of these complex lenses. The specialty society surveyed its members and determined that 1.5% of all cataract cases will be reported utilizing this new code. These cases represent the management of complicated cases due to previous trauma, concurrent disease states, or congenital abnormalities. Most often, specialized equipment or techniques are used during the procedure making the cases more time consuming and complicated with more risk and requiring more frequent postoperative follow-up. There is an extraordinary amount of work involved in performing the preoperative evaluation, increased time of performing the procedure and the use of specialized intraoperative devices and techniques and an increase in follow-up visits. These factors differentiate these cases from cataract surgery (CPT code 66984) in which no specific specialized devices or techniques are necessary.

Based on the utilization rate of code 66984, 1.6 million cases are performed per year, with a projected utilization rate of 24,000 cases per year for new code 669XX. Therefore, the RUC recommends a work value of 13.50 for new code 669XX.

To maintain work neutrality, the work value for CPT code 66984 should be decreased from a work value of 10.28 to a new revised work value. Therefore, the RUC recommends a revised work value of 10.23 for code 66984.

Practice Expense Recommendation

The RUC recommends that the direct practice expense inputs for this new code be equivalent to code 66984 with the additional clinical staff time and supplies to reflect one additional office visit. In addition, four Greishaber hooks at a cost of $95 will also be utilized for this procedure. The specific inputs are attached on the summary form.

Laparoscopic Radical Nephrectomy (Tab 11) Tracking Numbers P1-P3 (5054X-50548).
Presentation: Thomas Cooper, MD (American Urological Association)

Work Relative Value Recommendations

A new code *5054X Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)* was added to describe a laparoscopic radical nephrectomy. Currently, there is not an existing CPT code that accurately describes this service and is therefore reported using the unlisted code *53899 Unlisted procedure, urinary system*. There are CPT codes that describe open radical nephrectomies; however, the laparoscopic procedure requires different instrumentation and procedural steps to safely remove the kidney.

The RUC considered the results from the work survey, which provided a median work relative value of 24.00. When evaluating the physician work, RUC members agreed that the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50). The time and intensity of these services are comparable. When compared to the existing CPT code *50546 Laparoscopy, surgical; nephrectomy* (work RVU = 20.48), new code 5054X has a greater intra-service time period.
It was the consensus of the RUC that this is an appropriate value. **Therefore, the RUC recommends a work relative value unit of 24.00 for CPT code 5054X.**

CPT codes 50546 and 50548 were revised; however, the RUC does not recommend a change in the work relative value recommendation, as the RUC views these changes as editorial.

Practice Expense Recommendations

The direct practice expense inputs for code 5054X were crosswalked from existing inputs for code *50546 Laparoscopy, surgical; nephrectomy*. The RUC recommendations are attached and reflect the clinical staff pre-time and two post operative office visits. This service is always performed in a facility.

Laparoscopic Ureterneocystostomy (Tab 12) Tracking Numbers Q1 (5094X2) and Q2 (5094X3).
Presentation: Thomas Cooper, MD (American Urological Association)

Work Relative Value Recommendation
CPT Code 5094X2
CPT Code *5094X2 Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placements* was created to describe ureteroneocystostomy with cystoscopy and ureteral stent placements performed laparoscopically.

Currently, there is not an existing CPT code that describes a laparoscopic technique for ureteroneocystostomy with cystoscopy and ureteral stent placements and the unlisted code *53899 Unlisted procedure, urinary system* is reported. With the advent of better laparoscopic techniques, ureteroneocystostomy can be performed in a less invasive manner with equally satisfying results. This procedure is performed generally in children and the procedure is more difficult than when performed through an open approach.

When evaluating the physician work, RUC members agreed the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50) and used this as a reference service. The median intra-service time for new code 5094X2 is higher than the comparison code (50547). Additionally, the intensity and complexity measures are generally higher for new code 5094X2 than the comparison code. **Therefore, the RUC recommends the survey median work RVU of 24.50 for code 5094X2**.

CPT Code 5094X3
CPT code *5094X3 Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement* was created to describe ureteroneocystostomy performed laparoscopically without cystoscopy and ureteral stent placement. Currently, there is not an existing CPT code that describes a laparoscopic technique for ureteroneocystostomy performed without cystoscopy and ureteral stent placements. Therefore, the unlisted code *53899 Unlisted procedure, urinary system* is reported.

When evaluating the physician work, RUC members agreed the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50) and used this as a reference service. The median intra-service time is higher for new code 5094X3 than the comparison code (50547). The intensity and complexity factors for the new code are generally higher than the comparison code 50574. **Therefore, the RUC recommends the survey median work RVU of 22.50 for code 5094X3**.

The RUC agreed that an increment of 2.00 for the cystoscopy was appropriate and compares to code *52000 Cystourethroscopy (separate procedure)*.

Practice Expense Recommendations

The direct expense inputs were crosswalked from existing inputs for *50546 Laparoscopy, surgical; nephrectomy* with the addition of one additional office visit. The RUC recommendations are attached and reflect the clinical staff pre-time and three post operative office visits for code 5094X2. These services are always performed in a facility.

Endoscopic Urinary System Procedures (Tab 13) Tracking Numbers R1-R12)
Presentation: Thomas Cooper, MD (American Urological Association)

Work Relative Value Recommendations

CPT Code 5234X1

New CPT code *5234X1 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created. Cystoscopy with treatment of ureteral stricture has been performed for years. However, over the past 10 years, this procedure has become more commonplace due to improved ureteroscopic techniques and new technology.

The RUC considered work survey results, which provided a median work value of 6.00. It was the consensus of the RUC that this value was appropriate. Additionally, when evaluating the physician work, RUC members agreed that the physician work was similar to CPT code *52330 Cystourethroscopy (including ureteral catheterization); with manipulation, without removal or ureteral calculus* (work RVU = 5.04) and used this as a reference. The physician time is comparable to code 52330. The mental effort and judgement for new code 5234X1 is generally higher than the comparison code (52330). **Therefore, the RUC recommends a work relative value of 6.00 for CPT code 5234X1**.

CPT Code 5234X2

New CPT code *5234X2 Cystourethroscopy; with treatment of ureteropelvic juncture stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 6.50. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 5234X2 was similar to code *52325 Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)* (work RVU = 6.16). The median intra-service time and intensity/complexity measures are greater for new code 5234X2 than the comparison code 52325. **Therefore, the RUC recommends a work relative value of 6.50 for CPT code 5234X2**.

CPT Code 5234X3

New CPT code *5234X3 Cystourethroscopy; with treatment of intra-renal obstruction (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 7.20. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 5234X3 was similar to code *52330 Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus* (work RVU = 5.04) and used this as a reference. The median pre and intra-service time for new code 5234X3 are significantly higher than the comparison code 52330. Additionally, the intensity and complexity measures are higher for new code 5234X3. **Therefore, the RUC recommends a work relative value of 7.20 for CPT code 5234X3**.

CPT Code 5234X4

New CPT code *5234X4 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 7.70. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 5234X4 was similar to code *52335 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method)* (work RVU = 5.86) and used this as a reference. The median intra-service time is comparable between the new code 5234X4 and the comparison code 52335. Additionally, the intensity and complexity measures are generally higher for the new code 5234X4. **Therefore, the RUC recommends a work relative value of 7.70 for CPT code 5234X4**.

CPT Code 5234X5

New CPT code *5234X5 Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 8.20. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 5234X5 was similar to code 52339 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor* (work RVU = 8.82). The median intra-service time and intensity/complexity measures for this new code are comparable to the reference code 52339. **Therefore, the RUC recommends a work relative value of 8.20 for CPT code 5234X5**.

CPT Code 5234X6

New CPT code *5234X6 Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing CPT code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 9.23. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 5234X6 was similar to code 52339 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor* (work RVU = 8.82).
The median intra-service time for new code 5234X6 is 30 minutes longer than the comparison code 52339. Additionally, the intensity and complexity measures are generally higher for new code 5234X5 than the comparison code. **Therefore, the RUC recommends a work relative value of 9.23 for CPT code 5234X6**.

CPT Code 5235X1-5235X5

CPT codes 5235X1 – 5235X5 have been renumbered from codes 52335-52339. CPT code 5240X was renumbered from code 52340. The work RVUs should be crosswalked from the deleted codes to the new codes. The RUC did discuss the nomenclature changes for code 5235X1 (R7). The society clarified that the procedure still includes "dilation of the ureter and/or pyeloureteral junction by any method." However, this language was deleted so that users would not confuse this code with codes 5234X1-5234X6. The change is considered editorial. Urologists understand that it is necessary to dilate to perform the diagnostic service; however, any dilation used in treatment is not included in these codes.

Practice Expense Recommendations

These services are performed in the facility setting only, with a global period of 000. Therefore, there is no practice expense related to post-procedure office visits. However, the specialty recommended that there was pre-time associated with clinical staff activities.

The PEAC is currently developing standard packages of pre-time. Therefore, the RUC has tabled action on the pre-time for these codes until after these standardized packages are developed.

Partial Orchiectomy (Tab 14) Tracking Numbers S1 (5451X) and S2 (5452X)
Presentation: Thomas Cooper, MD (American Urological Association)

Work Relative Value Recommendation

CPT Code 5451X

New code *5451X Excision of extraparenchymal lesion of testis* was created as CPT does not contain an existing code that accurately described an excision of an extraparenchymal lesion of the testis. Therefore, the unlisted code *55899 Unlisted procedure, male genital system* was used to report this procedure.

When evaluating the physician work, RUC members agreed the physician work is similar to code *54530 Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.58) and used this as a reference service. The physician time and intensity/complexity measures of new code 5451X are comparable to the reference code (54530). New code 5451X was compared to existing code *19180 Mastectomy, simple,complete* (Work RVU = 8.8) as the work relative value is comparable. **Therefore, the RUC recommends the survey median work RVU of 8.58 for code 5451X**.

CPT Code 5452X

New code *5452X Orchiectomy, partial* was created, as CPT did not contain an existing code that accurately described this service. Therefore, the unlisted code *55899 Unlisted procedure, male genital system* was used to report this procedure.

When evaluating the physician work, RUC members agreed the physician work is similar to code *54530 Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.58) and used this as a reference service. The median intra-service time for new code 5452X is higher than the comparison code 54530. Additionally, the intensity and complexity measures for new code 5452X are generally higher than the comparison code. **Therefore, the RUC recommends the survey median work RVU of 9.50 for code 5452X.**

Practice Expense Recommendations

The direct practice expense inputs are included in the attached summary forms. Code 5451X was crosswalked to code *54530 Orchiectomy, radical, for tumor; inguinal approach*. The RUC agreed that 69 minutes of a RN for pre-time was appropriate as the procedure is performed the same day the physician initially sees the patient and finds the mass.

The schedule is disrupted for the entire day as this patient must be scheduled for emergent surgery and the rest of the schedule is interrupted. The RN must obtain approval for surgery.

The RUC also recommended that the inputs for the post-operative office visits be modified as code 54530 includes four visits and these new codes only include two office visits. These services are only performed in the facility setting.

X. Professional Liability Insurance Relative Values

Robert J. Milligan, Esq. provided an overview about HCFA's methodology for calculating Practice Liability Insurance relative values to the RUC members. Robert Milligan indicated he was charged with looking at the Federal Register to review how HCFA developed the professional liability RVU's and then explained and critiqued the methodology to the RUC. A copy of Mr. Milligan's slides are attached to these minutes.

A request was made that in future correspondence with HCFA, the RUC should request a timetable for the update on PLI premium data. In addition, HCFA should provide the premium data used for all specialties (not only those selected to serve as crosswalks).

XI. Administrative Subcommittee Report

Doctor Alexander Hannenberg presented the report of the Administrative Subcommittee. The Administrative Subcommittee met on February 3, 2000 and discussed the five-year review of the work relative values; PEAC membership on RUC subcommittees; and the process to stagger the two internal medicine rotating seat terms.

Doctor Hannenberg provided an overview of the document attached to these minutes, entitled "Five-Year Review of the Work Component of the RBRVS: Proposed Process, Work Plan, and Timetable." He also summarized the HCFA update to the Subcommittee, which included the announcement that HCFA was not prepared at this time to submit codes into the five-year review. Accordingly, HCFA current plans to conduct the five-year review in two phases: 1) the first phase in 2000 to review all codes submitted during the public comment process; and 2) a review of codes identified by HCFA in the future.

Several members of the RUC expressed concern that HCFA is considering a submission of several codes to the RUC based on a comparison of physician time from the Harvard and RUC databases to other secondary time databases. The work relative values were determined through magnitude estimation, not solely dependent on physician time. In addition, RUC members were concerned that reviewing only large volume codes out of context with all other codes on the Medicare Physician Payment Schedule would be misleading, as all services may changed proportionally.

The RUC approved the following recommendation of the Administrative Subcommittee:

The proposed process, work plan, and timetable should be approved with the following modifications (included as an attachment to these minutes):

- **The workgroup meeting should be held on August 24-27, 2000.**

- **The document should be clarified on page seven to indicate that any service not meeting the initial screens may be pulled from the consent calendar at the April RUC meeting. This clarification is necessary to demonstrate that services performed primarily in the non-Medicare population are not inappropriately screened out under the first criteria.**
- **Page 10 should be corrected to state that "Codes cannot be withdrawn from the five-year review by a specialty or workgroup. The withdrawal of a code is a action to accept the lower of the current work RVU or the recommended decrease."**

The RUC comment letter to HCFA (attached to these minutes) should be submitted to HCFA by March 1, 2000.

Doctor Hannenberg also explained that the Administrative Subcommittee agreed that it was appropriate to formalize the PEAC members involved on the RUC Subcommittees. The RUC approved the following recommendation:

The following revision to the RUC's Structure and Function document:

Section III, F,

(2) <u>Composition</u> – Each Subcommittee will have a permanent number of seats, will be chaired by an RUC member, and be comprised of members selected from the RUC, the AC, the HCPAC<u>, and the PEAC.</u> Chairman and members of each Subcommittee are to be selected by the RUC Chair.

Finally, Doctor Hannenberg informed the RUC that the Administrative Subcommittee agreed that at the April 2001 election of the rotating seats, a lottery process would be utilized to assign a two-year term and a three-year term for the internal medicine rotating seats.

The RUC approved the following recommendation:

The terms of the rotating seats to be elected in April 2001 will be as follows:

Surgical Rotating Seat	**September 2001-May 2003**
Internal Medicine Rotating Seat #1	**September 2001-May 2003**
Internal Medicine Rotating Seat #2	**September 2001-May 2004**

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

XII. Research Subcommittee Report

Doctor Sigsbee presented the Research Subcommittee report to the RUC. The RUC discussed a recommendation for the Subcommittee regarding the collection of practice expense data for individual codes based on either the typical or average patient. The RUC discussed the various limitations of collecting practice expense data according to the typical patient. Some RUC members stated that the typical patient will not accurately account for a range of expenses associated with the service. In some instances, it was suggested that a typical patient does not even exist if three separate scenarios apply for a service. There was a concern also that by focusing on the typical patient the expenses associated with the more complex cases are not captured. At this time, to maintain consistency with the RUC work survey the RUC agreed to base practice expense data collection on the typical patient and passed the following recommendation:

Practice expense data collection for individual codes should be based on the CPT vignettes that describe the typical patient.

The College of American Pathologists presented for RUC approval a modified RUC practice expense survey that was tailored for the specialty of Pathology.

The RUC passed the following recommendation:

The RUC approves the use of the Pathology version of the RUC Practice Expense survey for Pathology codes and the Subcommittee welcomes specialty societies to modify the RUC practice expense survey for consideration by the Subcommittee.

The RUC then discussed the role of the Research Subcommittee in reviewing alternative methodologies that will be utilized in the five-year review. It was explained that any specialties that will use a methodology, other than the standard RUC survey instrument, must obtain approval of the methodology by the Research Subcommittee during the April RUC meeting. The Subcommittee members discussed that they were generally comfortable with using the Rasch methodology for codes within families but still had concerns with the methodology for comparing codes across specialties.

Doctor Sigsbee explained that several Subcommittee members suggested that the use of an alternative methodology such as the Rasch methodology could be used in support of data collected through the regular RUC process and that any additional data would only serve to strengthen specialty recommendations.

The RUC passed the following recommendation:

The RUC accepts the use of Rasch paired comparison methodology as an analytical tool to examine rank order anomalies for families of codes within a single specialty, for use in the five-year review.

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

XIII. Practice Expense Subcommittee Report

Doctor John Gage presented the Practice Expense Subcommittee report. The Subcommittee met on February 4, 2000 and reviewed assumptions regarding physician time in the RUC database, and the definition of Evaluation and Management time in the global period.

An extensive discussion ensued throughout the RUC meeting regarding the new importance placed on physician time as collected during the RUC survey process. At the September 1999 RUC meeting, the RUC approved a motion to begin "voting" or "validating" physician time. At this meeting, it was debated and clarified that the RUC should not conduct a separate vote of the physician time after the committee has approved the specialty societies work relative value recommendation. Instead, the RUC approved the following motion:

The RUC's acceptance of a specialty society's work relative value recommendation explicitly means acceptance of the physician time data collected in the specialty society survey. If, however, the RUC does not approve a work RVU recommendation, the facilitation committee may wish to either recommend the original time or alternative time data.

For example, if a facilitation committee were to recommend an adjusted work relative value based on reducing the number of post-operative visits, it may also be appropriate to adjust the time captured for those visits.

Doctor Gage explained that the Subcommittee discussed the issue of which E/M tine data is appropriate to include in the RUC database. The Subcommittee agreed that the CPT time would not be appropriate as it only reflected face-to-face time. The RUC database time is not appropriate as this time was deemed to be invalid during the five-year review and is only available or certain E/M codes. The post-five year review time was selected as it reflects the increased pre and post service work approved in the five-year review.

The RUC approved the following Subcommittee recommendation:

- **The Subcommittee recommends the following time be utilized for E/M time in computing total time in the global period:**

CPT Code	Time in Minutes
99211	**7**
99212	**15**
99213	**23**
99214	**38**
99215	**59**
99231	**19**
99232	**30**
99233	**41**
99238	**36**

The RUC requested that the RUC Survey Instrument be modified for the next round of surveys to include this total post five-year review time.

The Subcommittee then discussed the importance of ensuring that the E/M time data are correct. Representatives of HCFA explained that HCFA is very interested in validating all physician time and encouraged the RUC to participate in this validation. HCFA staff explained that they are currently engaged in a number of activities to validate not only E/M physician time, but also all physician time. The RUC extensively discussed this issue and approved the following motion:

- If HCFA is to conduct a study of E/M physician time that it share the methodology and results with the RUC.

Finally, the Subcommittee agreed that the RUC should not forward any additional data on physician time to HCFA until the committee computes and reviews RUC total time and compares this data to the time data currently utilized by HCFA.

The RUC approved the following motion:

- **AMA staff should compute RUC total time and conduct a side by side comparison of each code's RUC total time to the total time currently utilized by HCFA. AMA staff should also continue to pursue methodology used by HCFA's contractor for the Practice Expense Subcommittee to review and discuss the discrepancies at the April 2000 meeting.**

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

XIV. Other Issues

During the course of the meeting, it was suggested that the RUC develop a conflict of interest policy to address concerns regarding financial relationships with companies or manufacturers. Doctor Hoehn referred this issue to the Administrative Subcommittee.

Doctor Robert Florin disseminated an alternative practice expense methodology for the RUC's discussion. He briefly summarized this methodology. A member of the RUC requested that HCFA model the impacts to individual specialties based on this methodology. Doctor Hoehn referred the issue to the Research Subcommittee for discussion at the April RUC meeting.

Doctor Richard Whitten announced that Doctor Kay Hanley's term as the AMA representative to the RUC will conclude after the April 2000 RUC meeting. He suggested that any individual that may be interested in either this seat or the alternate seat for the AMA should contact AMA RUC staff.

Several RUC members asked that AMA staff continue to explore an increased use of electronic dissemination of materials for RUC meetings and other mailings.

Doctor William Gee disseminated a newspaper article discussing telemedicine and noted that the CPT Editorial Panel and the RUC need to discuss alternatives in coding and payment for this new technology.

It was noted that the multi-specialty points of comparison (MPC) had been developed approximately five years ago and that it may be worthwhile to review this list again. Doctor Hoehn agreed that a workgroup should be formed to review the MPC to determine if some codes should be added or removed from the list.

Doctor Charles Koopmann informed the committee that he had seen Doctor Grant Rodkey, former Chair of the RUC, recently. Doctor Rodkey wished the committee "Godspeed" on the RUC's future endeavors.

The meeting adjourned at 5:50 p.m.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 3, 2000

On February 3, 2000, the Administrative Subcommittee met to discuss the five-year review of the work relative values; PEAC membership on RUC subcommittees; and the process to stagger the two internal medicine rotating seat terms. The subcommittee members in attendance included: Doctors Alexander Hannenberg (Chair), Boyd Buser, Lee Eisenberg, James Georgulakis, James Hayes, Charles Koopmann, James Maloney, David Regan, William Rich, Paul Schnur, and Richard Whitten.

Five-Year Review of the RBRVS

Doctor Paul Rudolf presented HCFA's plans for the five-year review of the physician work component of the RBRVS. Doctor Rudolf informed the subcommittee that HCFA planned to conduct the review in two phases: 1) public comments to be reviewed in 2000 and 2) HCFA submitted codes to be reviewed in 2001 and perhaps beyond.

HCFA has currently contracted with Health Economics Research (HER) to review secondary databases of physician time to validate the time collected by both Harvard and the RUC. The three data sets to be reviewed by HER include: 1) DJ Sullivan intra-operative time data; 2) MGMA group practice data on total clinical time and services; and 3) outpatient and ambulatory care survey data obtained by the National Center for Health Statistics. Doctor Rudolf indicated that none of this information will be ready in time for this cycle and it is unlikely the DJ Sullivan and MGMA data will be utilized to validate time. In addition, HCFA has contracted with one of its Carriers to review inpatient and outpatient records, as well as the operative report, for a sample of surgical procedures (all with a 090 global period). It is anticipated that this data collection effort would produce data on not only intra-service time, but the quantity of visits, as well. HCFA has also recently decided to conduct a Part A/Part B data merge to collect data on anesthesia claims and time and length of stay information.

Doctor Rudolf explained that HCFA's goal in reviewing these external secondary sources of data is to validate the physician time data, which is also utilized in the practice expense formula. He acknowledged that physician time does not equate to physician work, but suggested that perhaps work per unit time would be calculated using this validated time. This work per unit time could then be used to identify codes for further review.

Finally, Doctor Rudolf suggested that cross-specialty issues that arise from the public comment period might be similar to issues that would be identified by HCFA in 2001 after their time validation is complete. He noted that duplicative work may consequently result and commented that perhaps the public comments should be divided into issues that are related to anomalies within a family or specialty and issues that are cross-specialty. Doctor Rudolf did, however, note that all public comments would be submitted to the RUC for review.

Doctor William Rich summarized the report of the five-year review workgroup and the proposed process, work plan, and timetable. In general, the workgroup felt that the process utilized in the previous five-year review worked well and only a few minor modifications would be necessary, including:

1) The screening criteria to eliminate codes with low frequency should be modified to provide the opportunity for those infrequently performed services with significant changes in work relative values (greater than +/- 10%) to be reviewed now. Other minor modifications were made to the screening criteria and may be found on page seven of the proposed process.
2) The workgroup meetings and decision-making processes should be open to the presenters and all others wishing to attend.

The Administrative Subcommittee reviewed the proposed process, work plan, and timetable and recommends its adoption with the following modifications:

- **The workgroup meeting should be held on August 24-27, 2000.**
- **The document should be clarified on page seven to indicate that any service not meeting the initial screens may be pulled from the consent calendar at the April RUC meeting. This clarification is necessary to demonstrate that services performed primarily in the non-Medicare population are not inappropriately screened out under the first criteria.**
- **Page 10 should be corrected to state that "Codes cannot be withdrawn from the five-year review by a specialty or workgroup. The withdrawal of a code is a action to accept the lower of the current work RVU or the recommended decrease."**

The Administrative Subcommittee also recommends that the RUC comment letter to HCFA, included in the agenda book, be approved and submitted to HCFA.

Review of PEAC membership on RUC Subcommittees

The Administrative Subcommittee agreed that it was appropriate to formalize the PEAC members involved on the RUC Subcommittees.

The following revision to the RUC's Structure and Function document:

Section III, F,

(2) Composition – Each Subcommittee will have a permanent number of seats, will be chaired by an RUC member, and be comprised of members selected from the RUC, the AC, the HCPAC, and the PEAC. Chairman and members of each Subcommittee are to be selected by the RUC Chair.

Proposal to Stagger the Terms of the Internal Medicine Rotating Seats

The Administrative Subcommittee agreed that at the April 2001 election of the rotating seats, a lottery process would be utilized to assign a two-year term and a three-year term for the internal medicine rotating seats.

The Administrative Subcommittee recommends that the terms of the rotating seats to be elected in April 2001 will be as follows:

Surgical Rotating Seat	**September 2001-May 2003**
Internal Medicine Rotating Seat #1	**September 2001-May 2003**
Internal Medicine Rotating Seat #2	**September 2001-May 2004**

February 15, 2000

Nancy Ann Min-DeParle, JD
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room C5-16-03
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: HCFA-1065-FC (5-Year Refinement)

Dear Ms. DeParle:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) is pleased to provide comments to the Health Care Financing Administration (HCFA) on the five-year review of the work relative units of the Resource-Based Relative Value Scale (RBRVS). The RUC looks forward to developing recommendations to HCFA for consideration and potential implementation on January 1, 2002. The extraordinary efforts of the RUC and HCFA in the past five-year review led to work relative values perceived to be more fair and equitable, and we hope that the upcoming review will further improve the RBRVS.

Attached is a document outlining the RUC's proposed process, work plan, and timetable for our involvement in the five-year review. This document was developed by a subcommittee of the RUC and approved by the entire committee at our meeting in early February. We welcome the opportunity to discuss it with your staff and hope that it will provide the foundation for this review.

The RUC would like to highlight a few issues that are of utmost concern to the medical profession as we begin this process. First, it is our understanding that HCFA has contracted to review various secondary databases to identify potentially misvalued codes for the five-year review. This project is still underway, and it is likely that HCFA will receive this report by the close of the comment period on March 1, 2000. We have planned our timetable dependent on receiving the codes to be reviewed by late March 2000. It is important to realize that any codes received after March 2000 will not be reviewed by the RUC in time for submission to HCFA in October 2000. Immediately following the five-year review, the RUC will be committed to reviewing many codes initiated by the CPT-5 project and we ask you to consider these resource needs in determining when you submit codes to the RUC to review after the initiation of the five-year review process.

Secondly, we caution HCFA to carefully consider any sources of extant data that it reviews in determining if current work relative values are appropriate. We are specifically concerned that HCFA is considering a submission of several codes to the RUC based on a comparison of physician time from the Harvard and RUC databases to other secondary time databases. The work relative values were determined through magnitude estimation, not solely dependent on physician time.

Finally, the RUC understands that HCFA may receive special studies or proposals regarding large number of codes during this comment period. The RUC reviewed such proposals during the last five-year review and we would request that you submit these suggested methodologies for our review again.

The task of reviewing large number of codes in the short timeframe of seven months is an arduous one, however, we believe that it is critical for the medical profession to provide input during this five-year review. The RUC was able to conduct this review and submit timely recommendations of high quality to HCFA in 1995 and we look forward to the challenge in 2000.

Sincerely,

James G. Hoehn, MD

AMA/Specialty Society RVS Update Committee

Five-Year Review of the Work Component of the RBRVS
Proposed Process, Work Plan, and Timetable
February 9, 2000

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

The RUC accomplished this task by developed a detailed process, work plan, and timetable prior to the submission of the codes from HCFA. The RUC's efforts were successful, as more than 93% of the RUC recommendations were accepted by HCFA, with a greater number accepted after a refinement panel review. Many anomalies in the RBRVS were corrected, including gynecological and neurosurgical services. In addition, the work RVUs for the Evaluation and Management services were increased, both for the individual codes and all of the codes with global surgical periods. The five-year did not result in increases for all codes; the RUC recommended decreases for more than 100 codes.

This proposal will use the framework and ground rules from the previous five-year review to outline a process, work plan, and timeframe for the upcoming five-year review to begin in March 2000 and conclude with the implementation of the values on January 1, 2002. It should be noted that the time for this five-year review would be similar to the previous one, as the RUC will have approximately seven months to complete its review. Also, the scope of the review is unknown at this time, as HCFA's comment period does not conclude until March 1, 2000. In memos of February 25 and July 27, 1998, AMA RUC staff asked specialty societies to share their intentions regarding the next five-year review. With only a small number of specialties responding (fifteen), nearly 350 codes were identified. Therefore, it will be prudent, and realistic, to assume that HCFA will receive comments (and identify from other sources) on a large number of codes and a special process will need to be developed to review these codes.

November 2, 1999 Final Rule

On November 2, 1999, HCFA announced that it has opened a 120-day comment period for the public to identify any misvalued code for review. HCFA clarified that the scope of the review will be limited to the work RVUs. The practice expense RVUs will not be fully transitioned until 2002 and are currently undergoing refinement. The professional liability insurance (PLI) RVUs was just implemented on January 1, 2000. Comments on the work RVUs will be considered if they are received by March 1, 2000.

HCFA announced in this *Final Rule* its intention to share comments received with the RUC. HCFA notes that the RUC process used during the first five-year review was "beneficial" and further states:

> *The RUC's perspective will be helpful because of its experience in recommending RVUs for codes that have been added to, or revised by, the CPT panel since we implemented the physician fee schedule in 1992. Furthermore, the RUC, by virtue of its multi-specialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process. We emphasize, however, as we reiterated for the first 5-year review, that we retain the responsibility for analyzing the comments in the 2000 physician fee schedule, developing the proposed rule for 2001, evaluating the comments on the proposed rule, and deciding whether to revise RVUs. We are not delegating this responsibility to the RUC or any other organization.*

HCFA's preferred format for submitting a code for review is to include the following:

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

HCFA also states its concern regarding the identification of potentially overvalued services via the public comment process. HCFA, has therefore, awarded a contract to Health Economics Research to examine secondary databases to validate RUC and Harvard physician time data. The three specific databases that are currently under review are:

1. DJ Sullivan intra operative time data
2. National Center for Health Statistics - outpatient and ambulatory care survey data.
3. MGMA group practice data on total clinical time and services.

The results of this review are expected in February 2000. The RUC will ask HCFA for an update at its February 4-6, 2000 meeting.

The RUC may wish to discuss its desire to analyze data points to identify potentially misvalued codes. During the last five-year review, the RUC contracted with Dan Dunn to analyze various trends; however, the number of codes actually identified was limited. The RUC shall charge the Research Subcommittee to review this issue.

Timetable

February 4-6, 2000	RUC approves process, work plan, and timetable for five-year review.
February 2000	HER report on secondary sources of physician time expected.
	RUC comment letter submitted to HCFA outlining RUC's work plan and any specific comments regarding the HER report **(HER Report not yet available)**.
March 1, 2000	Comment period closes on public solicitation of codes to be reviewed.
March 21, 2000	HCFA staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
March 27, 2000	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by HCFA on March 21.
April 10, 2000	Responses to the LOI due to the AMA.

April 27-30, 2000	Initial screen of all codes at the April RUC meeting. See discussion of screening criteria under the Process and Work plan section of this proposal.
	Research Subcommittee to review any changes to the existing RUC survey instrument.
	Research Subcommittee to review any alternative methodologies introduced.
May 8, 2000	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.
August 1, 2000	Recommendations due to the AMA.
August 24-27, 2000	Five-year review workgroups meet and review recommendations.
September 18, 2000	Workgroup recommendations and consent calendars sent to the RUC.
October 5-8, 2000	RUC meeting to review workgroup recommendations and consent calendars
October 2000	RUC recommendations submitted to HCFA.
November 2000-February 2001	HCFA Review
March 2001	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2001	Final Rule on Five-Year Review
January 1, 2002	Implementation of new work relative value units.

Process, Work Plan, and Policies

Drawing on the ground rules and policies from the past five-year review, the following proposed process should provide the framework for the current five-year review.

HCFA Submission and Level of Interest Process

HCFA's 120-day comment period will make it impossible to allow the RUC any extra time for its review, however, it is still feasible to carry out the RUC's activities under the same timeframe as the previous five-year review (ie, seven months). However, it will be imperative that the RUC receive the request by HCFA on or before March 21, 2000 (three weeks after the close of the comment period). This should be realistic as the comment period on the first five-year review closed on February 6, 1995 and the list of codes were received from HCFA on February 23, 1995. It would also be preferable to receive the comments and list of codes in a similar format as the previous five-year review. This format is illustrated in attachment A and included the following fields:

1. CPT Code
2. Ref Set? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
3. Short or Medium CPT Descriptor
4. Control Number - linked the code back to a comment letter where the specific comment was identified.
5. Commenter - the specialty society or individual commented on the code (a key was provided to define acronyms).
6. Current RVU - the 2000 work RVU would be included here.
7. Rec RVU - the recommended RVU - or a note that the presenter requested an increase or decrease.
8. 1 Ref Code - Code number for a reference code identified
9. Ref Set? - an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
10. 2 Ref Code - Code number for second reference code identified
11. Ref Set ? – an indication as to whether the code was included on the RUC's multi-specialty points of comparison (MPC) or not.
12. Source - the source of the current RVU, for example, Harvard, RUC surveyed, etc (a key was included for this field).
13. Year - the year the current value was determined
14. Freq - frequency of claims for the code
15. Dif. - the difference between work RVU requested and the current work RVU.
16. % Dif. - the percentage difference between the work RVU requested and the current work RVU
17. Impact - difference in work RVU x conversion factor x frequency

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

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

Initial Screen of Codes

In the past five-year review, a special meeting of the Subcommittee on the Five-Year Review was convened to review all of the codes after the LOI process to determine if codes should be surveyed and discussed in detail or placed immediately upon a consent calendar for the RUC to review. Rather than go through each code, on a code-by-code basis, the Subcommittee developed a set of criteria to "screen" the codes. The criteria were as follows:

- Frequency is less than 1,000 annual Medicare claims per 1994 BMAD data
- Overall change in work is +/- 10% or less
- No request to survey (ie, no interest expressed by any specialty during the LOI process)
- Service has recently been reviewed by the RUC (interpreted as any review by the RUC since the inception of the RBRVS)

The Workgroup on the Five-Year Review met via conference calls in November and December 1999 and suggest that these criteria be reviewed for applicability to the current five-year review. The workgroup had the greatest difficulty in screening out codes with low frequency of claims in the Medicare population. In the first five-year review, one goal was to screen out codes to reduce the number of codes to a manageable workload. It was interpreted that the codes rarely performed were of lower priority. It would be unfair to exclude these codes from review for another five years. In addition, the Medicare RBRVS has become more widespread by non-Medicare payers and reviewing Medicare frequency alone would not reflect those services primarily performed in the non-Medicare population.

The workgroup also discussed the screening criteria regarding the difference between the requested value and the current value and determined that it may be relevant in some cases. It was noted that for services with high frequency, a 10% increase or decrease might be significant in the overall impact or importance to a specialty or the overall RBRVS. The workgroup agreed that the screen might be appropriate for low volume services as a survey process has limited value in identifying small percentage changes. The workgroup agreed that an appropriate replacement for this screen would be to exclude codes where the request is for a change +/- 10% and has a frequency of less than 10,000 per year.

The workgroup agreed that a code would be placed on the initial consent calendar if no specialty expresses an interest in conducting a survey or compelling evidence for the service. The workgroup also recommends that services recently reviewed by the RUC should not be reviewed again. It is recommended that codes reviewed after the previous five-year review fall into this category (*CPT 1996* and forward).

The workgroup recommends the following screening criteria for use in this five-year review:

1. Overall recommended change in work RVU is within +/- 10% or less AND frequency is less than 10,000 annual Medicare claims per 1998 data.
2. No request for involvement (ie, no interest expressed by any specialty during the LOI process).
3. Service has been reviewed by the RUC, and accepted by HCFA, since the previous five-year review (*CPT 1996* and forward).

After this screening process is applied to all of the codes identified, each code will be assigned one of the following action keys:

1. Survey/Rationale developed by specialty societies
2. Refer to RUC for Approval in April (Accept lower value)
3. Refer to RUC for Approval in April (No change from published current value)
4. Refer to CPT Editorial Panel
5. Not a work issue (eg, practice expense or payment policy issue)

Even though a code is assigned a "1," this does not necessarily mean that a survey is necessary; however, it is necessary for the specialty to at least develop a more complete rationale either supporting the change or defending the current value, and to compile whatever objective data might be available to them to support this rationale. These recommendations will be due to the AMA on August 1, 2000 and will be considered by workgroups in late August and then the RUC on September 28-30, 2000.

Actions keyed as "2" or "3" involve services for no further in-depth review or survey is required. Any service not meeting the initial screens may be pulled from the consent calendar at the April RUC meeting. These codes will be reviewed via a consent calendar at the April 27-30, 2000 RUC meeting:

- Services that are assigned a 2 are those identified as overvalued. By assigning a 2 to these codes, the consent calendar will specify that the recommended reduction in value be accepted.

- Services that are assigned a 3 are services that have been identified as currently undervalued, but for which no survey should be conducted. For example, a specialty society had initially commented that a code was undervalued, but has since decided that they do not wish to survey this code. By assigning a 3 to these codes, the consent calendar will specify that the current published value (2000) be maintained, and that the recommended increase from the original comment not be accepted.

Codes assigned a "4" are those which have been identified (via the LOI process and the workgroup on the five-year review) as issues that need to be reviewed by the CPT Editorial Panel before they are considered by the RUC. The RUC will vote on the appropriateness of this list at the April 2000 meeting.

Surveys and Alternative Methodologies

The Research Subcommittee will review the current RUC survey used to develop work RVU recommendations at the April 2000 RUC meeting to determine if any changes need to be incorporated for the five-year review. During the previous five-year review, the survey instrument was substantially improved and was used for the new and revised code review process after the five-year review was completed. However, there may be relevant questions that should be added to the current survey. For example, questions that solicits information on how the service has changed in past five years.

The Research Subcommittee will also be charged with reviewing any alternative methodologies introduced for this five-year review. At this time, it is not known whether any specialty society will be submitting any such study or request the RUC to review a specialty methodology for their services. However, if this does occur, the Research Subcommittee will be prepared to discuss these issues in April and the RUC will determine the appropriateness of any such study/methodology at their April 2000 meeting.

The surveys for the five-year review will be mailed to the specialty societies immediately following the April RUC meeting. As in the past, specialty societies may, if they choose, share their vignettes with the workgroup who will be reviewing their codes to receive feedback prior to the release of their surveys. Copies of all final survey instruments, including vignettes and cover letters, must be provided to the AMA for filing. The completed summary of recommendation forms will be submitted to the AMA RUC staff by August 1, 2000.

Workgroups

The previous five-year refinement process incorporated workgroups to review the recommendations. Eight workgroups were utilized with four RUC members or RUC alternate members on each workgroup. For planning purposes, a similar structure will be implemented this year. The assignment of the workgroup Chairs, composition, and topics to be addressed will be done prior to the April 2000 RUC meeting. The RUC Chair will assign individuals to these workgroups. The workgroups will meet for organizational purposes at the April RUC meeting and for 1 and 1/2 days in August to review their assigned codes.

It should be noted that for services performed only by non-MDs/DOs, the Health Care Professionals Review Board would meet in April and September 2000 to discuss these issues.

Workgroup Rules and Policies

The attached document, *Procedures for July Workgroup and August RUC Meetings* was developed in July 1995 to guide the workgroups and to ensure consistency in the rules used by each workgroup. The workgroup on the five-year review agrees that principles in this document were appropriate and recommends that an update version of this document be forwarded as instructions for the August 2000 workgroup meetings. A few key points from this document are as follows:

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

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

    1. Adopt the recommended increase in RVUs
    2. Maintain the current RVUs
    3. Adopt the recommended decrease in RVUs
    4. Suggest a new RVU
    5. Refer the code to CPT
    6. No consensus

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

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

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

RUC Review/Consent Calendar Process

At the October 5-8, 2000 RUC meeting, the recommendations from each workgroup will be presented to the RUC in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, following each of the first five action keys. Codes for which the workgroup does not reach consensus will be listed individually. During the previous five-year review, there were not significant issues concerning the ability to reach consensus within the workgroups.

Codes on the consent calendar may be extracted by any RUC member or specialty advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. The item initially on the table for each code will be the workgroup's recommendation. As required by the RUC's Structure and Functions document, a vote by two-thirds of the representatives present at the RUC meeting shall constitute passage of each RVS recommendation.

If a facilitation committee is needed for an issue, the issue will be referred to a workgroup other than the one to which it was originally assigned. This facilitation committee may be augmented with other specialty or HCPAC members as appropriate.

Submission to HCFA

AMA staff will develop detailed recommendations to be submitted to HCFA immediately following the September 2000 RUC meeting. These recommendations will be circulated to the RUC for comment prior to their submission to HCFA in October 2000.

HCFA Review of RUC recommendations

The RUC will request to be invited to any Carrier Medical Director or other committee meetings convened by HCFA to review the RUC recommendations. The RUC believes that this participation is necessary to clarify any questions that may arise regarding the RUC recommendations.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
February 4, 2000

The following members of the Practice Expense Subcommittee met on February 4, 2000 and reviewed assumptions regarding physician time in the RUC database, and the definition of Evaluation and Management time in the global period. Doctors John O. Gage (Chair), J. Leonard Lichtenfeld, W. Benson Harer, John Mayer, Jr., David McCaffree, Alan Plummer, Sheldon Taubman, Robert Zwolak, Melvin Britton, Daniel Mark Seigel, and Walter Smoski, PhD.

Doctor Gage began the discussion by reminding the group of two decisions that were made at the September 1999 RUC meeting. These decisions were:

1. The RUC should explicitly evaluate the physician time when it recommends a work RVU. If the RUC does not approve the specific time, the RUC may make revisions to this time or refer back the issue to the specialty society.

2. Where multiple specialty societies present different physician time data for the same codes, the specialty societies should also develop a joint time recommendation that will be then submitted to HCFA in accordance with RUC policy and procedures. The time data from each society should still be provided to the RUC to assist the RUC in its analysis and deliberations.

For some insight into these decisions the Chair asked Doctor Lichtenfeld to explain the history of the physician time issue. Doctor Lichtenfeld brought the group up to date on the issues and stressed the need to understand the implications. The physician time issue has taken on a much greater sense of importance recently, since physician time is now relied on by HCFA for its calculation of specialty society pools in developing resource-based practice expense relative values. Physician time has been one data element used by the RUC in its determination of work RVUs. The critical review and validation of physician time has now also become part of the RUC process.

The RUC reviewed this issue and approved the following motion:

The RUC's acceptance of a specialty society's work relative value recommendation explicitly means acceptance of the physician time data collected in the specialty society survey. If, however, the RUC does not approve a work RVU recommendation, the facilitation committee may wish to either recommend the original time or alternative time data.

For example, if a facilitation committee were to recommend an adjusted work relative value based on reducing the number of post-operative visits, it may also be appropriate to adjust the time captured for those visits.

Evaluation and Management Code Time in the Global Period

In February 1999, the RUC asked that a physician time audit be conducted by all specialty society societies and that the resulting audited RUC time data be re-sent to HCFA. AMA staff then distributed the RUC physician time data to all specialties to compare the data to recommendations previously submitted, to ensure that there were no data entry errors. The AMA staff submitted the audited physician time data to HCFA in late September, 1999. Upon submission to HCFA, AMA staff received a request back to provide a "total physician time" amount for each code in the RUC database. When AMA staff reviewed this request, it became apparent that a key assumption would need to be made about the E/M time for each E/M service included in a global surgical period.

For surgical codes surveyed after 1996 computed total physician time that is merely a mathematical computation, explained in the accompanying staff note in Tab 19 of the RUC agenda book. However, for many codes surveyed prior to 1996 this requires an assumption to be made regarding E/M time, since the RUC only collected the number and level of post operative visits, not the time for each visit. The RUC could utilize the assumptions currently used by HCFA (e.g., 23 min. for 99213) for these pre-1996 codes. However, this would be inconsistent with other surgical codes in the database, where the specialty society used the CPT time and those codes would then need to be adjusted.

The Subcommittee was presented a table listing the various sources of E/M time that exist today, and asked to choose a column of data to be used in the total time calculation used by HCFA. After discussion, the Subcommittee agreed that the RUC should use the HCFA post-five year review time currently utilized by HCFA. The Subcommittee agreed that the CPT time would not be appropriate as it only reflected face-to-face time. The RUC database time is not appropriate as this time was deemed to be invalid during the five-year review and also this time is only available or certain E/M codes. The post-five year review time was selected as it reflects the increased pre and post service work approved in the five-year review.

- **The Subcommittee recommends the following time be utilized for E/M time in computing total time in the global period:**

CPT Code	Time in Minutes
99211	7
99212	15
99213	23
99214	38
99215	59
99231	19
99232	30
99233	41
99238	36

The Subcommittee then discussed the importance of ensuring that the E/M time data are correct. Representatives of HCFA explained that HCFA is very interested in validating all physician time and encouraged the RUC to participate in this validation. HCFA staff explained that they are currently engaged in a number of activities to validate not only E/M physician time, but all physician time. The RUC extensively discussed this issue and approved the following motion:

- **If HCFA is to conduct a study of E/M physician time that it share the methodology and results with the RUC.**

RUC Definitions of Time Periods in the RUC Database

It was explained by AMA staff that a clarification of the RUC defined time periods was placed on the agenda to bring to the Subcommittee's attention the differences between HCFA's base physician time and the RUC database physician time. HCFA currently uses total physician time from its own analyses. If the RUC is to calculate total time for HCFA (as discussed above) the time for these codes will differ from what is currently in place at HCFA and could potentially have an impact on the calculation of the practice expense pools. There were many assumptions that went into HCFA's base time calculations that are shown on HCFA's physician time data that are still unclear. What is known from the AMA's reconciliation attempt is that HCFA's base time may duplicate some time between the day of surgery until discharge, for approximately 400 RUC reviewed codes.

The Subcommittee expressed its concern that if the methodology that was used to come up with HCFA's physician time data is unknown, then it should not make any assumptions. A side by side comparison of the differences between HCFA's base and final time, and the RUC database total time based on the number and level of office visits was proposed. It was also proposed that the HCFA contractor used to calculate physician time be contacted again for any other information they may provide.

The Subcommittee moved and approved the following motion:

- **AMA staff should compute RUC total time and conduct a side by side comparison of each code's RUC total time to the total time currently utilized by HCFA. AMA staff should also continue to pursue methodology used by HCFA's contractor for the Subcommittee to review and discuss the discrepancies at the April 2000 meeting.**

AMA/Specialty RVS Update Committee
Practice Expense Advisory Committee

February 1-3, 2000

Phoenix, Arizona

Eugene Ogrod, MD (Chair)
James Anthony, MD
Stephen N. Bauer, MD
Michael Berman, MD
Joel F. Bradley, MD
Ann C. Cea, MD
Neal Cohen, MD
Peter K. Dempsey, MD
Thomas A. Felger, MD
Mary Foto, OTR
Robert H. Haralson, MD
David Hoak,MD
Ronald L. Kaufman, MD, MBA
Gregory Kwasny, MD
Candia Baker Laughlin, MS, RN
Alex G. Little, MD
Bill Moran, Jr., MD
Marc Nuwer, MD
Frank Opelka, MD
Tye Ouzounian, MD
Dighton Packard, MD
Emil P. Pagianini MD
Alan Pearlman, MD
James Regan, MD
Jeffery I. Resnick, MD
Ronald Shellow, MD
Daniel Mark Siegal, MD, MS
Robert Stomel, DO
William Thorwarth, MD
Charles H. Weissman, MD

HCFA Issues

Elimination of Low Cost Supplies

HFCA presented some initial thoughts on a proposal to reduce the burden of verifying the supply inputs associated with visit services. The suggested approach would consist of grouping supply inputs into standardized packages of inputs. These standardized packages could then be applied across families of codes. For example, a basic office visit package and a post surgical visit package could be developed. Several PEAC members suggested that different post surgical packages could be developed based on the complexity of the codes.

After the packages are developed, the entire package would be priced and replace the individual supply items. Before implementing such a change, HCFA would examine the impact on specialties and codes associated with establishing these packages.

It was suggested that the individual specialties would be in the best position to develop the packages as well as recommend what codes or families of codes should be assigned to specific packages. HCFA proposed to refine this issue further in time to present a more concrete proposal at the April PEAC meeting. In addition, if specialties have already

examined this issue or would like to do so, they were encouraged to present these packages to the PEAC for approval. It was also suggested that after packages are developed, it would be appropriate to the PEAC to approve them.

In addition to grouping supplies, HCFA proposed eliminating low cost supplies from the CPEP database. This would have to be examined very carefully since there are some specialties such as Pathology that use a large number of small cost supplies, and removing them could have an impact.

The Supply Package Committee

The PEAC formed an ad hoc committee to develop the possibility of creating standardized supply packages. The committee presented the PEAC with a proposal consisting of three steps:

1. The committee proposed two supply packages. The first is a basic visit package, and the second is a basic post-operative incision kit. These packages would be considered the minimal supplies necessary and could be augmented with additional supply packages or individual supplies.
2. Specialties could develop additional packages. For example, a debridement package could be developed.
3. The involved specialties would then discuss the various packages together, and present a consensus to the PEAC.

The PEAC suggested and agreed to this proposal. The committee then developed and proposed the following two supply packages based on the draft proposed by HCFA:

<u>Multi-specialty Minimum Supply Package for Visits</u>

One patient gown
7 feet of exam table paper
1 pillow case
2 pairs of gloves (non-sterile)
1 temperature probe cover

<u>Basic Post-Operative Incision Care Kit</u> – intended for use in a post surgical encounter when staples are removed. This kit can be used anytime after the first post-operative visit.

1 pair of sterile gloves
2 alcohol swabs
2 packages of steri-strips
12 inches of tape (2 increments of tape @ 6 inches each)
1 staple remover kit
10 ml betadine (20 units)
2 Gauze packages
1 Tincture Binzoin Swab

The PEAC agreed with the packages proposed by the committee.

Clarification of Equipment Lists

HCFA officials summarized their calculations involving the different utilization assumption regarding procedure specific and overhead equipment. While a clear definition has not been developed regarding the criteria to be used to classify equipment as overhead, HCFA suggested that procedure specific equipment should have the following characteristics:

1. It is typical for the procedure/visit in the office.

2. It is reported as medical equipment in SMS.

3. It is exclusively dedicated to the patient for a determinable time.

The PEAC and the RUC have questioned previously the validity of including overhead equipment as a direct input and the RUC research Subcommittee will be discussing this issue further at its next meeting. The Subcommittee has discussed the possibility of moving overhead equipment costs into the indirect cost pool. HCFA stressed that its objective was to maintain some consistency between the SMS and CPEP pools for equipment. HCFA has already examined the impact associated with moving overhead equipment from the direct input category to the indirect category from the top 25 codes per specialty and determined that the impacts were negligible. HCFA will continue to examine the impacts on a greater number of codes and will report in April on this additional impact analysis. At this meeting, the PEAC decided to not review this cost category, as the definitional issues should first be addressed by HCFA.

Updating Pricing Lists

HCFA is considering establishing a contract with a firm to update all pricing lists. Specialties were also encouraged to provide HCFA with any updated pricing information. Updating the pricing lists is necessary not only because of changes in price levels but also as a verification of the original estimates. In many instances, the source of the prices was from CPEP members, and may never have been validated.

Standardizing Clinical Staff

HCFA suggested that the PEAC might want to develop reasonable parameters for many of the pre-service clinical staff activities. Establishing these parameters would expedite the review of time data. Additionally, these parameters could be applied to families of codes. It was suggested that the individual specialties could develop the families that the standardized times would apply and then present these recommendations to the PEAC for approval. A starting point would be to develop standardized times for each of the activities listed on the RUC practice expense survey.

Clinical Staff Time Committee

The PEAC formed an ad hoc committee to develop standardized benchmarks for some of the clinical staff activities. The committee presented times for four clinical staff activities:

1. The greeting of the patient, escorting patient to room, owning of patient, and notifying physician that the patient was ready, was standardized as 3 minutes of time.
2. The obtaining of vital signs was standardized into 3 levels of service with the following times:
   Level 0 (no vital signs taken) = 0 minutes
   Level 1 (1-3 vitals) = 2 minutes
   Level 2 (4-6 vitals) = 4 minutes
3. Cleaning of the room and equipment was standardized to 1 minute.
4. Post service instructions; medication, lab, diet, referrals, follow up, etc. was standardized into 3 levels of time.
   Level 0 (no instructions)
   Level 1 (1-3 items of instruction) = 2 minutes
   Level 2 (4-6 items of instruction) = 4 minutes

The PEAC approved items 1-3, but did not approve a standardized time for #4 post service instructions because they could not reach an agreement at this time.

Clinical Package Committee

The PEAC formed an ad hoc committee to develop a methodology for designing packages of clinical staff activities and associated times. The committee presented two options for PEAC consideration.

The first option would consist of specialties developing various pre-service, intra-service, and post-service blocks of time for various settings, global periods, and also elective versus urgent procedures. The specialties would use the existing RUC clinical staff templates and standardize the times for various times and global periods. Due to the need to further discuss E/M codes, the post service time would not be standardized until E/M codes are refined. It was suggested that a grid could be developed where specialties could present their various times for their different practice settings, global periods, clinical staff activity time periods. The specialties would then present their recommended blocks of time to the PEAC for approval. These blocks could be used for individual codes or families of codes.

The second option consisted of compressing the various packages described above into one basic package that specialty societies would develop. This basic package would be presented to the PEAC for approval. Whenever individual codes or families of codes

were presented to the PEAC, specialties would have to justify any upgrades to this basic package.

The PEAC passed the first option that encourages the specialties to develop different time packages to account for different practice settings. For example, the following spreadsheet could be set up.

Elective Procedure

	Office	ASC	Inpatient Hospital
Pre – Service			
000 Day Global			
010 Day Global			
090 Day Global			
Service Period			
000 Day Global			
010 Day Global			
090 Day Global			
Post Service Period			
000 Day Global			
010 Day Global			
090 Day Global			

Coordination of Care

The PEAC discussed the specific activities that constitute coordination of care. This is referred to as the time spent by physician clinical staff on clinical activities performed in the office, in support of clinical services to hospital patients. The PEAC agreed that there are two types of services that fit into this category:

1) Providing clinical information to family members while the patient is in the hospital
2) Providing clinical information to hospital staff.

The PEAC reached a consensus that these services are routinely provided and should be recognized as valid clinical staff activities since staff are frequently requested to provide test results and other information to family members of hospital staff. It was suggested that specialties should develop the appropriate coordination of care times for their codes and when appropriate they could develop several standardized times that would vary according to the complexity of the code.

The PEAC passed the following motion:

- **Continue to review the time attributed to coordination of care on a code by code basis but encourage specialties to divide codes into standardized packages of coordination of care times.**

Evaluation and Management Codes Work Plan for April 2000
PEAC members suggested several methods on how to begin their review of the Evaluation and Management (E/M) codes. Several suggestions were made concerning the formation of a PEAC workgroup. Specifically, PEAC members suggested that a group of 6-8 members volunteer or be selected by the chair to work on a work plan proposal and present it to the PEAC in April 2000. Members suggested that the group concentrate on refinement of a particular reasonable CPEP as a start for a small group of E/M codes, and when refined and approved, it would be used as an anchor for other E/M code refinement. It was suggested that more than one workgroup be formed and a consensus made by the PEAC, when all workgroups present proposals in April. It was mentioned that having more than one workgroup could skew each group's results, and possibly favoring one specialty per group. It was then suggested that as a backup approach, that a panel of specialties that have no interest in E/M codes be appointed to determine the E/M inputs after presentation by the affected specialties. The PEAC did not agree that a backup plan was necessary.

The PEAC approved the following process for the refinement of E/M codes:

- **A workgroup be appointed to present recommended direct practice inputs for E/M services at the April 2000 PEAC meeting**

The workgroup would initially be sent the existing CPEP data for E/M codes. This group will plan to come to a consensus in time to supply a recommendation to the PEAC by April 7, 2000. This group would be expected to represent the PEAC, and not any specific specialty. Specialty societies not on the workgroup should send written comments to AMA staff for workgroup consideration. Sub specialty societies should express their suggestions directly to umbrella specialty society, if represented in the workgroup. The workgroup will consist of the following members:

Neal Templeton - American College of Radiology, Chair
Tom Felger - American Academy of Family Practice
Greg Kwasny - American Academy of Ophthalmology
Frank Opelka - American College of Surgeons
Emil Paganini - American College of Physicians – American Society of Internal Medicine
Jeff Resnick - American Society of Plastic Surgeons
Ronald Shellow - American Psychiatric Association
Daniel Mark Siegel - American Academy of Dermatology
Charles Weissman - American Society of Clinical Oncology

Code Selection Criteria

The current guideline for withdrawing codes for consideration is that specialties may drop a code at any time. This guideline was enacted and will be maintained, because specialty societies are still learning the process. Some PEAC members expressed

concern about this guideline, since so many codes have been withdrawn. If specialty societies do withdraw a code, the PEAC agreed that they must provide a reason to assist the PEAC in determining if there is a systematic problem. Specialty societies will be given the following options to choose from when withdrawing codes:

1. Technical flaw in the data
2. Insufficient data
3. Methodological change
4. Grouping abnormality
5. Other reason (please specify)

The PEAC and HCFA stressed the importance of establishing code selection criteria as soon as possible.

The PEAC developed the following motion:

- **All representatives of the PEAC will come to the April PEAC meeting with their favored code selection criteria, either from the list provided in the PEAC staff note, or some other criteria. Any new criteria should be submitted to AMA staff by April 7, 2000, to be incorporated into the PEAC agenda. The April 2000 meeting is the final date at which a code selection criteria will be approved.**

These proposals should be submitted to AMA staff by April 7, 2000. The following is a list of some of the criteria that have been discussed in the past and appear in the staff note:

- Codes that will have the greatest change in practice expense relative values from 1998 to final transition in 2001 – Previously, 238 codes have been identified as having the greatest change in PE RVUs
- Codes with the highest Medicare frequency – Previously, 218 codes were identified according to this criteria
- Codes that were reviewed by more than one CPEP ("redundant codes")- There are 654 codes reviewed by more than one CPEP
- The RUC's Multi-Specialty Points of Comparison (MPC)- This list contains 340 codes
- HCFA's validation panel list – This list contains 211 codes

Facilitation Committees

The PEAC passed the following motion:

- **When facilitation committees meet, only the facilitation committee members, presenters, and presenters staff should attend. In addition, it was agreed that HCFA officials might attend. If a facilitation committee chair wishes to limit attendance this should be discussed with the PEAC chair prior to the meeting.**

Future Issues

- Discuss whether entire families of codes should be presented rather than individual codes. At a minimum it was suggested that specialty societies should list the family of codes that relate to the individual code under review
- Suggested that HCFA needs to provide the updated prices associated with supplies and equipment, and to ensure a consistent source and date
- How to treat indirect equipment that is less than $500 but taken as a group is greater than $500. HCFA's current instructions state that any equipment less than $500 is not included as a direct expense. HCFA did reiterate that all costs of equipment greater than $500 are captured in the SMS data and are allocated as indirect expense to individual codes, so these costs are not lost
- Assign each code, or group of codes to selected PEAC members to take the lead in reviewing each proposal and posing questions to presenters
- Limit discussions for each code to a certain amount of time
- PEAC members expressed the need for the development of additional checks using data such as SMS data to determine if the clinical staff times reported are consistent with the number of procedures performed in a typical day or week, given the number of hours worked in that period. This data to compare to individual code times could be used by specialties to confirm their individual clinical staff times.

Suggestions to PEAC presenters

- When a code is presented to the PEAC, and the code is part of a family, the presenters should be prepared to answer questions about the family and how the code relates to the family.
- When filling in the clinical labor template for each presented code, societies should be careful as to how they allocate clinical labor time into the pre, intra, and post service time, from the total time. Societies should not just fill in the time so that it adds up to the total, and therefore presenters should know what each time increment represents.

Resignation of Doctor Eugene Ogrod

At the conclusion of the PEAC meeting Doctor Ogrod informed the group that he would no longer chair the PEAC. For professional and personal reasons Doctor Ogrod will step down. Doctor Ogrod told the committee that they have accomplished a great amount of work over the past year, and that he is proud of the member's efforts. Doctor Hoehn thanked Doctor Ogrod on behalf of the PEAC and the RUC for all his leadership.

Doctor Hoehn explained that letters will be sent forth to specialty societies requesting nominations for the new PEAC chair and specific selection criteria will be included. The selection process will last 1 month, and the Administrative Subcommittee will produce a short list of names from which Doctor Hoehn will select the PEAC Chair in the next month.

Meeting adjourned 12:05 pm Thursday, February 3, 2000

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
February 4, 2000

On February 4, 2000, the Research Subcommittee met to discuss several issues relating to the practice expense methodological issues, errors in the HCFA claims database, approval of an additional RUC practice expense survey, and update on a paired comparison study. The following subcommittee members were in attendance: Doctors Bruce Sigsbee, Robert Florin, William Gee, Richard Haynes, David Hitzeman, David Massinari, James Moorefield, Eugene Weiner, and Don Williamson, OD.

Typical vs. Average Calculations for Practice Expense

The Subcommittee discussed the pros and cons of basing the collection of practice expense data on the average vs. the typical patient. Some Subcommittee members suggested that basing data collection on an average patient might possibly result in more accurate practice expense data collection for codes that have a wide range of expense utilization scenarios. These might be codes where the work values may not vary with the various types of patients and acuity but the practice expenses may vary significantly. Most likely this difference in practice expense would be tied to the use of supplies and equipment where in a certain percentage of cases, particular equipment may be used.

While basing practice expenses on the average patient in an attempt to capture more accurate practice expense data may improve data accuracy; it was suggested that neither typical nor average might be sufficient in some instances. Depending on supply and equipment utilization, another mechanism such as a J code may be required to accurately capture practice expenses.

The Research Subcommittee approved the following motion:

Practice expense data collection for individual codes should be based on the CPT vignettes that describe the typical patient.

Inclusion of Overhead as a Direct Expense

HCFA officials stated that they have examined the impact associated with moving overhead equipment from the direct input category to the indirect category for the top 25 codes per specialty. While the impact on individual specialties were negligible, the impacts on several codes were significant. HCFA proposed to expand its impact analysis to a greater number of codes per specialty and report the results of this study at the April RUC meeting. HCFA was not opposed to moving overhead equipment to the indirect cost category but first wanted to ensure there weren't any adverse effects on specialties. HCFA officials also requested that specialty societies examine the list of procedure specific equipment and overhead equipment and provide HCFA with input as to which category specific pieces of equipment should belong in. HCFA would also incorporate this specialty input into its impact analysis.

HCFA officials also reviewed how equipment is allocated to individual codes and suggested that the current utilization rate needs to be reexamined as part of the refinement of practice expense methodology. The issue of overhead equipment was tabled until the April meeting pending the results of the HCFA analysis.

Clinical Labor Wage Rates

The Subcommittee again pointed out inconsistencies in the wage rates assigned to the various categories of clinical staff types. For example, it was stated that the wage rates for a MRI technician and a x-ray technician should not be the same as is currently the case in the HCFA wage rate list. HCFA officials explained that the wage rates were calculated based primarily on Bureau of Labor Statistics but HCFA is considering establishing a contract with a firm to update all pricing lists used in the practice expense methodology. HCFA officials stated that there is a need to achieve greater consistency in data sources since for some pieces of equipment, the pricing source was a CPEP member.

Use of SMS Survey in the Calculation of Practice Expenses

Jim Rodgers and Sara Thran presented an update on future SMS practice expense data collection activities. Within the past two years, surveying physicians to collect practice expense data no longer works as well as in the past and as a result the SMS survey response rate is falling while the cost of implementing the survey is rising. Several problems have been identified, including; many physicians do not have the information available to complete the detailed financial sections of the survey. Also, an increasing number of physicians can not be located by phone, and those that are contacted by phone are no longer willing to participate in a 25-minute phone interview.

This year the AMA will redesign the SMS survey, shorten it, use more resources on locating physicians, and most likely remove questions on expenses, assuming the practice level survey is successful. The new practice level survey has been designed to overcome some of the difficulties listed above. However, no one else has performed a successful survey of practice costs but the SMS staff are attempting to make this survey work by focusing on physician-owned practices, offering incentive payments, and considering the possibility of jointly working with the Medical Group Management Association. This practice level survey is currently being field tested and results of the test are expected by May. If the pilot is successful, the plan is to conduct the first full practice survey will be fielded later this year. Then the practice level survey and the SMS physician survey would be conducted in alternating years. The goal of the practice level survey is to capture data from physician owned practices, but the details for allocating expenses from a multispecialty practice to individual specialties has not yet been determined.

Since the SMS survey may not include practice expense questions in the future, specialties interested in conducting an oversample would have to contract directly with a survey firm, most likely one of the firms used to implement the SMS. This will be the only option this year since the only survey being fielded is a practice level survey. Also, such a change will impact HCFA's practice expense methodology and the HCFA officials stated that they would have to develop plans for addressing this issue.

The subcommittee agreed to discuss the SMS survey again in April when the committee will receive a briefing on the results of the practice level survey field test.

Uncompensated Care

The Subcommittee discussed a method for better defining uncompensated care since an accepted definition regarding which type of expenses can be considered uncompensated care does not exist. However, before expending effort on such a project the Subcommittee agreed to first determine how such a definition could be used. It was suggested that one possible use would be for inclusion in future SMS practice level surveys. The 1999 SMS survey included questions on charity care and bad debt and it might be possible to add questions on EMTALA- induced care to the practice survey in the future. Since Lewin will address how to capture uncompensated care costs the subcommittee agreed to discuss this issue further after receiving the final Lewin report.

Accuracy of the HCFA Claims Database

The Research Subcommittee has previously identified instances where the specialty designation in HCFA's database has been inappropriately applied. HCFA is currently using the 1997 claims data in the calculation of practice expense relative values. For privacy reasons, claims with a frequency of 10 or less have been removed. HCFA has performed an internal analysis to examine the effects of removing outliers or moving certain claims to the appropriate specialty and found no impact from such changes. HCFA officials encouraged specialties to send them specific examples of inconsistencies in frequency amounts between Medicare claims databases so these differences can be researched.

Review of Additional RUC Practice Expense Survey

During the September RUC meeting, representatives from the College of American Pathologists provided a listing of clinical staff activities relevant to their specialty since the newly revised RUC practice expense surveys did not pertain to the pathology clinical staff activities. These activities were incorporated into the RUC practice expense survey and the survey is included in the agenda material for Subcommittee approval.

The Subcommittee approved the following motion:

Approve the use of the Pathology version of the RUC Practice Expense survey for Pathology codes and the Subcommittee welcomes specialty societies to modify the RUC practice expense survey for consideration by the Subcommittee.

Use of Paired Comparison Methodology

Doctor Florin provided an update on the results of a recent paired comparison study involving Neurosurgery and General Surgery. While the results were promising, Doctor Florin stated that additional studies were being analyzed such as one involving Orthopedic Surgery and Neurosurgery and offered to brief the Subcommittee again in April. Since several specialties may be utilizing paired comparison methodology in their review of codes for the five-year review, the Subcommittee discussed the suitability of this methodology for the five-year review. Since the Research Subcommittee is tasked with reviewing any alternative methodology for developing physician work relative values for the five year review, the Subcommittee discussed whether a paired comparison methodology would be sufficient data to develop a physician work relative value recommendation. Some Subcommittee members suggested that paired comparison data should be introduced to the RUC as supplemental data and not a replacement for the data collected by the current RUC survey. Alternatively, it was suggested that recommendations based on paired comparison methodology should be sufficient for making RUC recommendations during the five year review.

The Subcommittee passed the following motion:

The Subcommittee accepts the use of Rash paired comparison methodology as an analytical tool to examine rank order anomalies for families of codes within a single specialty, for use in the five-year review.