

**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 McIlrath 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.

Multi-specialty Minimum Supply Package for Visits

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

Basic Post-Operative Incision Care Kit – 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 Ureteroneocystostomy (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 intrarenal 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 5234X6 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) **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.**

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 time 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 on 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.