AMA/Specialty RVS Update Committee
February 1-3, 2001

The Pointe Hilton Tapatio Cliffs Resort
Phoenix, Arizona

I. Call to Order

Doctor James G. Hoehn called the meeting to order on Thursday, February 1, 2001 at 3:00 p.m. The following RUC members were in attendance:

James G. Hoehn, MD, Chair
James Blankenship, MD
Joel Bradley, MD
Lee Eisenberg, MD
Robert Florin, MD
John Gage, MD
William Gee, MD
Alexander Hannenberg, MD
James Hayes, MD
Richard J. Haynes, MD
David Hitzeman, DO
Charles Koopmann Jr., MD
M. Douglas Leahy, MD*
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Charles Mabry, MD
David L. Massanari, MD
John Mayer, MD
David L. McCaffree, MD
James Moorefield, MD
Bill Moran, MD
Alan L. Plummer, MD
Greg Przyblski, MD*
Sandra Reed, MD*
David Regan, MD
William Rich, MD
Peter Sawchuck, MD*
Chester Schmidt, MD
Paul Schnur, MD
Bruce Sigsbee, MD
Sheldon Taubman, MD
Trexler Topping, MD*
Arthur Traugott, MD*
Richard Whitten, MD
Don E. Williamson, OD
Robert Zwolak, MD

* Alternate

II. Chair's Report

Doctor Hoehn welcomed RUC members and made the following announcements:

- Doctor Ken Simon, a new medical officer at the Health Care Financing Administration, is attending the RUC meeting. Doctor Simon is a general and vascular surgeon and will be involved in the CPT and RBRVS Processes on behalf of HCFA.

- Melinda Buntin, a health economist from RAND, is attending the meeting as an observer. The Agency for Health Care Research and Quality has contracted with RAND to conduct a Congressionally mandated study of the determinants of increases in Medicare expenditures for physicians' services. She is here to understand how the relative value update process accounts for changes in medical technology.

- Doctor John Wade from the Ontario RBRVS Commission is attending the RUC meeting as an observer.

Doctor Hoehn announced the following Facilitation Committees:

Facilitation Committee 1

David Hitzeman, DO (Chair)
James Blankenship, MD
Robert Florin, MD
J. Leonard Lichtenfeld, MD
James Moorefield, MD
Sheldon Taubman, MD
Robert Zwolak, MD
Stephen Kamenetzky, MD

Facilitation Committee 2

Barbara Levy, MD (Chair)
John Gage, MD
Charles Koopmann, MD
John Mayer, MD
David McCaffree, MD
Alan Plummer, MD
William Rich, MD
Bruce Sigsbee, MD

Facilitation Committee 3

Richard Haynes, MD (Chair)
Joel Bradley, MD
William Gee, MD
Alexander Hannenberg, MD
David Massanari, MD
David Regan, MD
Chester Schmidt, MD
Gary Seabrook, MD

III. Director's Report

Patrick Gallagher summarized the remaining RUC meeting dates in 2001:

- The April 26-29, 2001 RUC meeting will be convened at the InterContinental Chicago Hotel.

- The September 13-16, 2001 RUC meeting will be convened at the Swissotel Chicago Hotel.

Mr. Gallagher also reminded that the tenth anniversary of the RUC will be celebrated on Saturday, September 15 at the Chicago meeting.

IV. Approval of Minutes for the October 5-8, 2000 RUC Meeting

The minutes of the October 2000 RUC meeting were approved without revision.

V. CPT Update

Doctor Lee Eisenberg informed the RUC that the committee should see numerous coding changes from the February 2001 CPT meeting. The CPT Editorial Panel has also begun to receive requests from specialty societies regarding Five-Year Review generated coding changes.

Michael Beebe, Director of CPT Strategic Development at the American Medical Association, presented an update on the CPT-5 Project. Mr. Beebe announced that changes resulting form the project have already been implemented, and all the recommendations should be phased-in by *CPT 2003*. These changes include the following enhancements to CPT:

- New sections for performance measures (CPT Category II Codes) and emergency technology (CPT Category III codes)
- Improvements in the counseling/preventive medicine codes
- Framework for non-MD professional evaluation services
- Improved description, enhance specificity, and elimination of ambiguity
- Code combinations that are consistent with CPT guidelines (ie, coding edits)
- Refinement of instructions/guidelines
- Enhancements to CPT Editorial Process
- Development of digital document management systems and enhancements to CPT versions

A RUC member expressed concern regarding coding changes generated by manufacturers of medical equipment where there is no change in physician work in the underlying physician service. Grace Kotowicz, Director of CPT Editorial Research and Development at the American Medical Association and Doctor Eisenberg clarified the CPT Process and explained that the Panel relies on the specialty societies to review these proposals and offer their opinion on the merit of the changes.

VI. HCFA Update

Doctor Paul Rudolf presented an update on the following HCFA activities:

- Ken Simon, MD is a new medical officer at HCFA working on Medicare physician payment schedule activities.

- A Proposed Rule on the Five-Year Review is expected to be published in April 2001. The Proposed Rule on the 2002 payment policy changes is expected to be published in June 2001.

- The E/M guidelines clinical examples, currently under construction by Aspen, should be completed by early April and specialties will have the opportunity to review them at this point. The pilot studies should then begin this summer.

- Barbara Paul, MD continues to coordinate the Physicians Regulatory Issues Team (PRIT). She is currently working to identify the top ten regulatory burden issues to address these issues over the next year.

- The Stark II regulations have been published, including a list of CPT codes to which these regulations apply. HCFA attempted to limit this list as much as possible, including the elimination of many interventional radiology and nuclear medicine services.

- The Correct Coding Initiative (CCI) edits related to services with XXX global periods and Evaluation and Management codes have been suspended. Approximately 800 of these edits were implemented in version 6.3 in October 2000. Physicians may re-file claims to receive retroactive payment on these services. HCFA will continue to review where it is appropriate to require the –25 modifier with an E/M code reported on the same date as another service. It is likely that some of these coding edits will be re-implemented in the future. Doctor Rudolf clarified that specialty societies have had an opportunity to review these code edits and HCFA has reviewed these comments. HCFA is currently developing its work-plan to re-implement these edits, including any future specialty society review.

A RUC member asked Doctor Rudolf to explain the current status of the physician time contracts. Doctor Rudolf explained that the contracts related to a review of physician time are moving along slowly. HCFA has decided to expand a contract currently reviewing the intra-service time, the number and level of post-operative visits, and the length of hospital stay for eleven high volume surgical procedures. The contract HER continues as they look at other data sources to validate the DJ Sullivan time data, as certain problems have been identified with the DJ Sullivan data. HCFA is hopeful that that they will have a report later this year that they may share with the RUC.

Doctor Whitten noted the high cost to individual physicians for the CCI edits ($300 per year for four updates) and suggested that a mechanism be developed to provide this data at a lower cost.

A RUC member asked Doctor Rudolf about the new requirement that all physicians in Medicare+ Choice plans submit claims for individual services. This encounter data will go to the HCFA Central Office.

VII. **Washington Update**

Sharon McIlrath from the AMA's Washington office reviewed a number of legislative and regulatory initiatives.

- Ms. McIlrath discussed the transition to the new Administration and changes in Congressional Committees. Tommy Thompson, former Governor of Wisconsin has been confirmed as Secretary of Health and Human Services. At this time, a HCFA Administrator has not been named.

- Priorities in 2001 are likely to be the Patient's Bill of Rights, a prescription drug benefit, regulatory relief, medical errors, and structural Medicare reforms. The AMA will also work on anti-trust relief, expanded health insurance coverage through tax credits, and reform of insurance market to move toward individual coverage.

- Ms. McIlrath explained that Medicare regulatory relief will be one of the top two or three issues that the AMA will work on this year. The AMA will advocate adoption of the Medicare Regulation Fairness Act. This bill would:

  1) preclude the application of new regulations before the Secretary has issued a Final Rule;
  2) enhance the ability of physicians to legally challenge a regulation;
  3) reform the post-payment audit and recovery process;
  4) enhance education activities;
  5) require HCFA to include the costs of regulations in the calculation of the SGR; and
  6) preclude implementation of new E/M documentation guidelines prior to the completion of at least four pilot programs, one of which would have to be a peer reviewed approach.

  Ms. McIlrath noted that the AMA is also working with HCFA, and specifically Barbara Paul, MD, on immediate solutions for certain regulatory burdens. The GAO and MedPAC are also currently reviewing this issue.

- The AMA is also reviewing several regulations released by the Clinton Administration prior to leaving office, including: privacy regulations, self-referral; conditions of participation (supervision of CRNA issue); and Medicare/Medicare managed care appeals.

VIII. **Relative Value Recommendations for *CPT 2001:***

Bioengineered Tissue Grafts (Tab 4)

The RUC had previously provided an interim recommendation that the work values for the new CPT codes 15342 and 15343 should be cross-walked from the existing HCPCs Level II G codes. The specialty societies did not conduct a survey of these codes as they indicated agreement with the relativity of the work values established by HCFA in 2001. The RUC is notifying HCFA that it should consider the previous RUC recommendations unvalidated. The RUC is providing no further recommendations on these codes as this time. Any data included in the RUC database for this code will be deleted.

GI Endoscopy Services (Tab 5)
Presenter: Maurits Wiersema, MD, American Society for Gastrointestinal Endoscopy
Reviewed by Facilitation Committee #2 (Pre-Facilitation)

The RUC recommended interim values for the gastrointestinal endoscopy services in April 2000. The specialty provided additional data at the February 2001 RUC meeting to review these codes. The RUC did not agree that the new survey data were valid and requested that it not be considered in determining work values. This data will not be submitted to HCFA, nor included in the RUC database.

The RUC recommends that the interim RUC recommendations, as adopted and published by HCFA, are too high, with the exception of 43242 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopys(s)*. The RUC recommends that code 43242 be increased from 5.51 to 7.31 work relative values. Absent valid survey data, the RUC relied on a building block approach to evaluate these services.

The RUC recommends new work relative value recommendations for these GI endoscopy services, based on the following rationale:

CPT Code 43231 ***Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination:***

Base Code: 1.59

43200 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (work RVU = 1.59)

+ Ultrasound Probe Placement: 0.76

93313 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only (work RVU = 0.95) * 80% to represent the intra-service component only

+ Interpretation and Report: 0.84

93314 Echocardiography, transesophageal, real time with image documentation (2D)(with or without M-mode recording); image acquisition, interpretation and report only (work RVU = 1.25) * 67% to represent the intra-service component only

The RUC Work Relative Value Recommendation for 43231 is 3.19.

43232 ***Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s):***

Base Code: 3.19

43200 Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination (RUC recommended work RVU = 3.19)

+Ultrasound Guidance for Needle Placement: 0.67

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device); imaging (work RVU = 0.67) The specialty presented that this procedure requires passage of a third scope to obtain the biopsy. Coding and payment policy allows for ultrasound guidance and interpretation to be reported on the same date. The gastroenterologists presented that a full report of the ultrasound must be completed by the physician performing the service.

+Biopsy Increment: 0.62

Blend between 19291 Preoperative placement of needle localization wire, breast; each additional lesion (0.63) and the increment between 31629 Bronchoscopy, (rigid or flexible); with transbronchial needle aspiration biopsy (work RVU = 3.37) and 31622 Bronchoscopy (rigid or flexible); diagnostic with or without cell washing (separate procedure) (work RVU = 2.78) of 0.59.

The RUC Work Relative Value Recommendation for 43232 is 4.48

43240 ***Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst:***

In order to maintain the current rank order within this family of codes, the RUC reviewed their recommended work RVUs for 43232 and 43242, along with the intra-service time from the April 2000 survey data and the intra-service intensity of these services. The intra-service time for 43240 of 90 minutes is comparable to the intra-service time of 43242 of 90 minutes, however, the RUC recommends that the intra-service intensity for 43242 is slightly higher than 43240. **The RUC recommends a work RVU of 6.86 for code 43240.**

43242 ***Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s):***

The RUC had previously recommended an interim work RVU of 5.51 for this service. However, the RUC has further reviewed this service and is convinced that this is not an appropriate work RVU as this code represents the most lengthy and technically difficult service in this family. The RUC developed the following building block approach to correct this rank order anomaly:

Base Code: 4.89

43259 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination (work RVU = 4.89)

+Ultrasound Guidance for Needle Placement: 0.67

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device); imaging (work RVU = 0.67) The specialty presented that this procedure requires passage of a third scope to obtain the biopsy. Coding and payment policy allows for ultrasound guidance and interpretation to be reported on the same date. The gastroenterologists presented that a full report of the ultrasound must be completed by the physician performing the service.

+Biopsy Increment: 1.27

88171 Fine needle aspiration; deep tissue under radiologic guidance (work RVU = 1.27)

+Interpretation and Report: 0.48

93312 Echocardiography, transeophageal, real time with image documentation (2D) (with without M-mode recording); including probe placement, image acquisition, interpretation and report (work RVU = 0.95) * 50% to represent the S&I only

The RUC Work Relative Value Recommendation for 43242 is 7.31 .

45341 ***Sigmoidoscopy, flexible; with endoscopic ultrasound examination:***

In order to maintain the current rank order within this family of codes, the RUC reviewed their recommended work RVUs for 45432 and 43242, along with the intra-service time from the April 2000 survey data and the intra-service intensity of these services. The intra-service time for 45341 of 30 minutes is comparable to the intra-service time of 45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* (2001 work RVU = 2.66; new RUC recommendation = 2.84) of 30 minutes. The RUC recommends that the intra-service intensity for 45341 is similar to 43242 and 45342 and computed a work RVU of 2.60. **The RUC recommends a work RVU of 2.60 for code 45341.**

45342 ***Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s):***

Base Code: 2.60

45341 Sigmoidoscopy, flexible; with endoscopic ultrasound examination: (RUC recommended work RVU = 2.60)

+Ultrasound Guidance for Needle Placement: 0.67

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device); imaging (work RVU = 0.67) The specialty presented that this procedure requires passage of a third scope to obtain the biopsy. Coding and payment policy allows for ultrasound guidance and interpretation to be reported on the same date. The gastroenterologists presented that a full report of the ultrasound must be completed by the physician performing the service.

+Biopsy Increment: 0.79

55700 Biopsy, prostate; needle or punch, single or multiple, any approach (work RVU = 1.57) * 50% to represent the intra-service component only

The RUC Work Relative Value Recommendation for 45342 is 4.06.

<u>Naso- or Oro-gastric tube placement (Tab 6)</u>
Presenters: Joel Brill, MD, American Gastroenterological Association
James Borgstede, MD, American College of Radiology

The RUC recommends that 43752 *Naso-or-oro-gastric tube placement, necessitating physician's skill* does require distinct physician work. The physician is requested to perform this service after a nurse has not been able to place the tube. The RUC reviewed survey data from gastroenterology and radiology which indicated that a physician typically spends 5 minutes pre-, 15 minutes intra-, and 5 minutes post-procedure. **The RUC recommends 0.45 for code 43752.**

There is no direct practice expense inputs as this service is peformed in a facility setting only.

Endoscopic Enteral Stenting (Tab 7)
Presenters: Maurits Wiersema, American Society of Gastrointestinal Endoscopy
Reviewed by Facilitation Committee 2 (Pre-Facilitation)

The RUC provided interim recommendations on endoscopic enteral stenting to HCFA in May 2000. The gastroenterologists had requested the opportunity to re-survey these codes and present additional data at the February 2001 RUC meeting. The RUC did not feel that the survey data collected was valid, and, therefore, no update in the physician time data will be provided. However, the RUC was able to determine recommendations via the following building block approach:

CPT Code	43256	44370	44379	44383	44397	45327	45345	45387
	Esophagoscopy (EGD)	Enteroscopy	Enteroscopy +ileum	Illeoscopy	Stoma/ Colon	Rigid Procto	Flex Sigm.	Colon
Base Code	**43235**	**44360**	**44376**	**44380**	**44388**	**45303**	**45330**	**45378**
Base Work RVU	2.39	2.59	5.26	1.05	2.50 3.70*	0.44	.88 0.96*	3.68 3.70*
Dilation**	1.00	1.00	1.00	1.00	1.00	0.00	0.75	1.00
Stent***	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21
Total	**4.60**	**4.80**	**7.47**	**3.26**	**4.71** **5.91***	**1.65**	**2.84** **2.92***	**5.89** **5.91***

*Three of the base codes listed above (44388, 45330, and 45378) were included in the five-year review. If HCFA accepts the RUC's recommendation for these codes, the recommendations for the stent codes should be adjusted accordingly.

** The physician work involved in the dilation for EGD, small bowel, and colonoscopy procedures (43256, 44370, 44379, 44383, 44397, and 45387) is based on the incremental work relative value of 1.00 between codes 43245 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction, any method* (work RVU = 3.39) and 43235*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*. The dilation for code 45345 was determined to be 0.75, based on the increment between 43226 *Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire* (work RVU = 2.34) and 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*

(work RVU = 1.59). The RUC determined that an add-on for dilation for 45345 would not be appropriate as the base procedure 45303 includes dilation.

***The RUC determined that an appropriate increment to describe the work involved in the stent placement is the incremental difference between codes 43219 *Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent* (work RVU = 2.80) and 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 1.59).

The RUC noted that there is a code for dilation and placement of stent during a bronchoscopy (31631) with a work value of 1.59 above the bronchoscopy code. However, this code is not performed with flouroscopy and is not considered as work intensive as the GI stent placement procedures.

Cutaneous Electrogastrography Provocative Testing (Tab 8)
Presenters: Joel Brill, MD and Kenneth Koch, MD, American Gastroenterological Association
Reviewed by Facilitation Committee #2

The RUC did not provide recommendations on cutaneous electrogastrogaphy provocative testing in May 2000, and HCFA subsequently carrier priced these services for 2001. The specialty has submitted survey data for these services and the RUC is recommended work relative values and direct practice expense inputs at this time.

The RUC compared 91132 *Electrogastrography, diagnostic, transcutaneous;* to the Electrocardiographic monitoring codes 93014, 93224, 93227, 93230, 93233, 93268, and 93272 (work RVUs = 0.52). The RUC reviewed the survey time data for 91132 of 11 minutes pre-, 25 minutes intra-, and 12.5 minutes post-time and agreed that this was comparable to the physician time for 93014 *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), per 30 day period of time; physician review with interpretation and report only* (work RVU = 0.52), which includes 10 minutes pre, 20 minutes intra-, and 12 minutes post-time. **The RUC recommends 0.52 for code 91132.**

The RUC reviewed the survey data for 91133 *Electrogastrography, diagnostic, transcutaneous; with provocative testing* and agreed that the relativity indicated in the survey was appropriate. The survey respondents had indicated that the provision of provocative testing added approximately 26% more work to the base procedure 91132 (1.70/1.35 = 1.26). The RUC agreed that the same incremental

increase should be applied to the RUC recommendation for 91132 (.52 x 1.26 = .66). **The RUC, therefore, recommends 0.66 for code 91133.**

Practice Expense

The RUC recommends 15 minutes of pre-service clinical staff time (RN/LPN/MA) when these services are performed in a facility setting. There is no direct practice expense associated with medical supplies or medical equipment for this service when performed in a facility setting.

Endovascular Graft for Abdominal Aortic Aneurysm (Tab 9)
Presenters: Robert L. Vogelzang, MD, Society of Cardiovascular and Interventional Radiology, and James Borgstede, MD, American College of Radiology
Reviewed by Facilitation Committee #3

In May 2000, the RUC recommended a work value of 4.00 for code *75952 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation*. The specialties had requested that the RUC consider this an interim recommendation to provide them with the opportunity to collect additional data. The RUC has reviewed this data and now recommends a change in the work relative value for this service.

The RUC reviewed the physician time data for this service, which indicates that there is 20 minutes pre, 60 minutes intra, and 15 minutes post-procedure. The RUC also received clarification by the specialty that this procedure is not a typical supervision and interpretation service. This procedure involves active participation and considerable angiographic and fluoroscopic imaging skills by an interventional radiologist, often assisting the vascular surgeon or cardiologist. The committee also noted the large number of survey respondents (72), representing multiple specialties, and agreed that the survey median of 4.50 was reasonable. **The RUC recommends 4.50 for code 75952.**

Incision and Drainage of Vaginal Hematoma (Tab 10)
Presenters: Sandra Reed, MD and George Hill, MD, American College of Obstetricians and Gynecologists

In May 2000, the RUC submitted a recommendation for 57022 *Incision and drainage of vaginal hematoma; post-obstetrical* of 2.56. At the time that the RUC reviewed this service, it noted that a code should be created to describe when this service is performed in trauma cases, particularly as it relates to children. The CPT Editorial Panel did create code 57023 *Incision and*

drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding) for CPT 2001, however the Panel action was after the last RUC meeting for the cycle. The RUC did not have the opportunity to review this service until our February 2001 meeting.

The specialty presented survey data from 30 obstetricians and gynecologists based on a vignette describing a nine-year old female who had a straddle injury. According to the presenter, 90% of the patients who present for this service will be children. The survey indicated that the service typically requires 45 minutes of pre-time, 45 minutes of intra-time, and 30 minutes of immediate post-service time. Often this service will include a hospital stay, which includes 1 hospital visit and a discharge day management service. The patient will be seen once in the office within the ten day global period. The RUC compared this time to the time collected for 57022 (30 minutes pre-time, 30 minutes intra-time, and 20 minutes immediate post-service time, one hospital visit, and one office visit). The RUC noted that the additional pre, intra, and post-time warranted the incremental increase suggested for this code. The RUC agreed that the survey data and median work relative value was valid for this service. **The RUC recommends a work value of 4.75 for 57023.**

Practice Expense

This service is performed in the facility setting only, therefore, the RUC will not provide any direct practice expense inputs for the office setting.

The RUC agreed that the clinical staff, medical supplies, and medical equipment for the post-operative office visit appeared reasonable. It was noted that the supplies should be categorized in the approved packages: OB/GYN Minimum Supply Package for Office Visits; Minimum Supply Package for Pelvic Exam; and Basic Post-Operative Incision Care Kit for OB/GYN Services, rather than separately listed. The RUC also recommends that an exam table be included as medical equipment utilized in this office visit.

Cyrosurgical Ablation of the Prostate
Presenters: James Regan, MD, American Urological Association
Reviewed by Facilitation Committee #1

In May 2000, the RUC recommend a work relative value of 17.80 for code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)*. The American Urological

Association requested the RUC to reconsider its previous action and the RUC agreed to do so at the February 2001 RUC meeting.

The RUC reviewed 55873 in comparison to the following CPT codes:

50546 *Laparoscopy, surgical; nephrectomy, including partial ureterectomy* (work rvu =20.48)

50660 *Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach* (work rvu=19.55)

50750 *Ureterocalycostomy, anastomosis of ureter to renal calyx* (rvu = 19.51)

50770 *Transureteroureterostomy, anastomosis of ureter to contralateral ureter* (work rvu = 19.51)

55801/55810 Mid-point between 55801 *Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)* (work RVU = 17.80) and 55810 *Prostatectomy, perineal radical* (work RVU = 22.58)

The RUC also reviewed a building block methodology to compare this service to the intra-service intensity for code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 28.55). The time data listed below originated from the survey the urologists conducted for the April RUC meeting:

Pre-Service Period	60 minutes x .022 intensity	1.32
Intra-Service Period	200 minutes x .071 intensity	14.20
Same Day Post	30 x .022 intensity	.66
Discharge Day Mgt.	99238	1.28
Office Visits	3 x 99213	2.01
Total Computed Work Relative Value		19.47

The RUC recommends a work relative value of 19.47 for code 55873.

Computed Tomographic Angiography (Tab 12)
Presenters: James P. Borgstede, MD, American College of Radiology
Reviewed by Facilitation Committee #3 (Pre-Facilitation)

In May 2000, the RUC submitted relative value recommendations for codes 70496 *Computed tomographic angiography, head, without contrast material, followed by contrast material(s), including image post-processing* and 70498 *Computed tomographic angiography, neck, without contrast material,*

followed by contrast material(s), including image post-processing. The RUC is maintaining its earlier recommendations for these codes. Unfortunately, the specialty society was not prepared to present data to the RUC on the remaining Computed Tomographic Angiography (CTA) codes 71275, 72191, 73206, 73706, 74175, and 75635. The specialty has now collected this data and the RUC submits recommendations for these services.

71275, 72191, 73206, 73706, 74175 (SS3-SS7)

The RUC received compelling evidence from the specialty society that these CTA services represent new physician work, rather than a redistribution of existing physician work. The specialty presented data from survey responses from more than 60 radiologists. The RUC reviewed this data and the recommended work relative values and determined that the values were inconsistent with codes 70496 and 70498 adopted in April 2000. The RUC recommends that the 25% of the survey median be utilized to develop work relative values for these codes. The RUC also reviewed the previous RUC and HCFA work value ratio between CTA and CT of the head and neck. The radiologists stated that the higher work relative values for the chest and upper and lower extremities is justified in comparison to the head and neck due to the additional work required in these areas.

The RUC recommends the following work relative values for these CTA services: 71275 (1.92); 72191 (1.81); 73206 (1.81); 73706 (1.90); and 74175 (1.90).

75635 (SS8)

The RUC reviewed survey data from 30 radiologists for code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material, followed by contrast material(s), including image post-processing* and concluded that the 25% of the survey work relative value of 2.40 was appropriate. The RUC noted that the intra-service time of 45 minutes for this service is higher than the 30 minutes required for codes SS3-SS7, as there are numerous images involved in this service. **The RUC recommends a work relative value of 2.40 for code 75635.**

The RUC performed the following analysis and reviewed the following data in developing their recommendations for these services:

	CPT Code	CT Reference Work RVU	CTA Work RVU	Ratio CTA/CT	RUC **Recommended Work RVU**	Ratio of Rec. RVU to CTA/CT	Intra-Service Time**	Reference Intra-Service Time**
Head	70496*	1.27	1.75	1.38	**1.75**		20	
Neck	70498*	1.45	1.75	1.21	**1.75**		20	
Chest	71275	1.38	2.1	1.52	**1.92**	1.39	30	15
Pelvis	72191	1.22	2.00	1.64	**1.81**	1.48	30	15
Arm	73206	1.22	2.00	1.64	**1.81**	1.48	30	15
Leg	73706	1.22	2.00	1.64	**1.90**	1.56	30	10
Abdomen	74175	1.22	2.20	1.57	**1.90**	1.56	30	15
Runoff	75635		3.00		**2.40**		45	

*RUC recommendation accepted by HCFA.
**Radiology Survey Time

Practice Expense

The RUC made minimal changes to the practice expense direct inputs presented by radiology for these services. The revised summary forms will be attached to this recommendation.

Magnetic Resonance Imaging (Tab 13)

At the request of the specialty society, this issue is deferred to the April 2001 RUC meeting.

IX. Five-Year Review Remaining Issues:

Anesthesia Facilitation Committee Report (Tab 14)

Doctor Massanari presented the report of the Anesthesia Facilitation Committee. Doctors Massanari (Chair), Blankenship, Florin, Hayes, Gage, Plummer, and Topping met with the specialty society representatives on February 2, 2001.

The American Society of Anesthesiologists submitted a comment to HCFA requesting revaluation of the approximately 250 anesthesia services to correct undervaluation that has persisted since the implementation of the RBRVS. The ASA proposed a building block methodology to place the anesthesia codes and values on the same scale as the RBRVS. The model relies primarily on a group of E/M codes to be equated to various components of anesthesia services. The total work value of these comparable services are then compared with an imputed value of anesthesia values converted to RBRVS values.

The ASA initially submitted 13 codes for review by the RUC. These codes account for 54% of all Medicare allowed charges, 44% of cases of anesthesia services and each one accounted for at least $10,000,000 in charges. These codes were also selected to represent a variety of surgical procedure types, and a range of basic unit values ranging from 3 to 20.

For each of the 13 codes, the ASA divided the anesthesia code into five service elements and equated each service element to an E/M or induction procedure code, or an intensity value was assigned. The five service elements are preoperative evaluation, equipment and supply preparation, intra-operative anesthesia care, induction period procedure, and post-operative care. After the RUC reviewed the 13 codes, the RUC concluded that the building block values are between 13% and 49 % higher than the current imputed work values. On average the estimate work values are 28% higher than the current work values.

The original five-year review workgroup had a number of concerns with making a specific recommendation to increase the anesthesiology conversion factor. These concerns included the lack of survey data to determine the high and low intensity values and associated intensity distribution, the use of 1993 HCFA BMAD time data rather than more current data, use of a building block methodology to place ASA values on the same scale as the RBRVS, and blending of values used in the building block. Some RUC members questioned the validity of the entire methodology of placing the ASA values on the same scale of the RBRVS and using 13 codes and then extrapolating the results to all ASA codes. Also, RUC members were concerned that the ASA had not presented any compelling evidence for changes in anesthesia services since the last five-year review that would warrant an increase in the conversion factor.

Facilitation Committee

To reconcile the issues identified in the five-year report before the RUC, a short term facilitation committee was established to work with the ASA to identify new data that ASA might be able to present to the RUC in February, 2001. In response to the October 2000 meeting, the ASA collected new data outlined below.

- The ASA selected six additional anesthesia codes to survey, for a total of 19 codes. The survey form was identical to the one used for the original thirteen codes, except that the survey requested specific information on post-induction anesthesia intra-operative time. According to the ASA, the 19 codes represent more than 55% of Medicare allowable payments in anesthesiology. The selection of the additional codes was due to a concern by Workgroup 4 that

the original 13 codes were not sufficiently representative of anesthesia codes to allow extrapolation to all anesthesia codes.

- The ASA presented updated time data. The presentation to Workgroup 4 used 1993 BMAD average time data for the specific "0xxxx" anesthesia codes. The ASA now is using 1998 time data related to the anesthesia reported time for the specific surgical procedures used in the ASA surveys. This time data was obtained from HCFA's 5% sample claim database.

- The ASA developed more specific data relating to the levels of intensities during the post-induction anesthesia time period. The Facilitation Committee had asked the ASA to divide this service period into 4-5 intensity levels and to obtain survey data to allocate time values based on new HCFA data among these levels. Survey respondents were provided the new time data and asked to distribute the time among the five quintiles listed below.

Intensity Level 1	Monitoring and recording standard physiologic monitors (EKG, ETCO2, SpO2, BP, respiratory parameters) in a stable patient Positioning a patient for surgery (supine)	0.026
Intensity Level 2	Evaluating and managing transient aberrations in hemodynamic or respiratory status such as moderate tachycardia or hypotension. Responding to abrupt changes in surgical activity – e.g. visceral traction, orthopedic cement application, abdominal insufflation Positioning an unconscious patient (prone, sitting, lateral) for surgery	0.036
Intensity Level 3	Inducing intentional hypotension for intracranial aneurysm clipping Evaluation and management of sustained hypertension using vasoactive agents Preparing and evaluating a patient for anesthetic emergence and tracheal extubation	0.051
Intensity Level 4	Evaluating and managing intraoperative myocardial ischemia, sustained hypotension, serious cardiac arrhythmias Initiating single lung ventilation	0.070
Intensity Level 5	Managing separation from cardiopulmonary bypass Managing clamping or unclamping of abdominal aorta Managing massive transfusion for resuscitation of hemorrhagic shock	0.085

Using the survey data showing the quintile distribution of post-induction anesthesia time, a work value for this period was calculated for each respondent by multiplying the time allocated to each quintile by the corresponding work intensity. These quintile work relative values were summed to obtain post-induction anesthesia work values for each respondent. Finally, a median value of the total RVWs for all respondents was calculated.

The new facilitation committee presented its recommendation to the RUC in February, 2001. Although the ASA responded to a number of the concerns raised by the original workgroup, the RUC concluded that there remain a number of concerns that could not be resolved by the five-year review deadline of February 2001. There are five primary issues with the ASA data.

1. Primarily, the Committee questioned if the surgical codes selected for each anesthesia code are truly representative of all surgical codes associated with each of the 19 anesthesia codes. Given the methodology, it is necessary that the surgical code be representative of the family of surgical codes. For example, code 00210 has 87 surgical codes in the family. The committee felt that the data presented to data was inconclusive given the large number of codes contained in some of the families.

2, The committee questioned the RVUs associated with the Induction Period Procedure (IPP) because in some instances such as with code 00914, the calculated IWPUT approached a value of 1. In addition there was a concern that the cross walked IPP codes contained pre and post service work that needed to be removed prior to including the value in the ASA calculations. The inclusion of this work may lead to a double counting of work.

3. Some of the committee members had remaining concerns regarding the selection of the five levels of IWPUTs and the allocation of time among the five quintiles.

4. The Committee also pointed out that there appeared to be a disconnect between the values associated with the pre-service time period. Although the time varied for some codes the relative values assigned to the time period varied and the Committee needed to discuss this issue further.

5. The primary goal of the five year review is to demonstrate how physician work has changed since the last five year review. During the last five-year

review the RUC recommended an increase in the anesthesia values that was accepted and implemented by HCFA. HCFA is concerned that sufficient data has not been presented to demonstrate that the work has changed since the last five year review especially since the anesthesia codes received an increase during the last five year review. However, the presenters stated that the purpose of the five year review is to identify codes that are not correctly valued.

Given the number of concerns identified by the original five-year review workgroup as well as the concerns identified by the facilitation committee, the RUC concluded that it was not possible to reach a recommendation on the ASA five year review submission at this time. However, the RUC supported allowing the ASA to continue its work in refining their five-year review recommendation. The RUC therefore agreed to form a new committee to first determine if these concerns can be addressed by a time certain, or whether the methodological differences between the anesthesia payment system and the RBRVS prohibit resolution of the concerns. This committee will also examine whether it is possible to place anesthesia services on the RBRVS scale.

Conscious Sedation Workgroup Report (Tab 15)

Doctor Paul Schnur presented the report of the conscious sedation workgroup. The following individuals participated in the workgroup meeting on February 3: Doctors Schnur (Chair), Bradley, Brill, Eisenberg, Wiersema, and Eileen Sullivan-Marx, PhD, RN. The RUC extensively discussed the report. After the RUC rejected the workgroup's recommendation to increase 72 gastroenterology services by 0.50, a facilitation committee (Doctors Moran, Koopmann, Moorefield, and Rich) was convened to review the RUC's written ballots on this issue and recommended a zero work value increase. The RUC recommendation on this issue is presented below:

HCFA did not initially submit the comment from the gastroenterology societies that specific gastrointestinal endoscopy services should be increased to account for increased physician work in providing conscious sedation. The specialty society collected data in July 2000 and petitioned HCFA to ask the RUC to review this information. Due to this delayed request to review the comment, and a RUC workgroup concern that the issue of conscious sedation should be addressed as a global issue, the RUC recommendation on this issue was not completed in time for our earlier October 2000 submission.

The RUC discussed this issue briefly in October 2000 and also at our most recent February 2001 meeting. The RUC heard arguments presented by gastroenterology representatives that the physician work in the provision of conscious sedation has changed over the past five years due to changes in specialty guidelines and JCAHO requirements. The specialty argued that physicians typically spend 20-25 minutes of additional time (10 minutes pre-, 7.5 minutes intra-, and 5 minutes post-time) performing this service than was required five years ago.

The specialty presented the following list of physician tasks that are either new or have changed in the past-five years:

Pre-Service:

- Informed consent dealing with spectrum of sedation (conscious or moderate to deep sedation) and documentation thereof.

- Obtaining a history pertinent to the risks and co-morbid conditions that may influence administration of sedation (eg, underlying pulmonary, vascular, cardiac, kidney, and/or liver disease). The specialty argued that a separate E/M service is not reported on the same date as the patient has been seen by the performing physician a week or two prior to the endoscopy, or the service is performed via open access endoscopy, where an E/M service would not be reported by the performing physician.

- Physical examination of the heart and lung systems with an anesthesia risk score and airway assessment with documentation thereof.

Intra-Service:

- Diminished rate and quantity of administration of midazolam and meperidine. For example, conscious sedation policy at Myo Clinic dictates 0.5-1.0 mg of midazolam to be given over 2 minutes with 2 minutes of observation in healthy patients under 60 years old. For debilitated or patients more than 60 years old, the dose and increment should be reduced by 25%. In the same policy, meparidine is titrated in 10 mg. aliquots each over 1-2 minutes. Importantly, the administration and monitoring of sedating effect is done independently. That is, midazolam and merperidine should not be administrated simultaneously but rather sequentially.

- Ascertainment of minimum discharge criteria prior to release to the recovery room.

Post-Service:

- Documentation (including written and dictated) of adverse events and response to these during the procedure. This would include desaturation, hypotension, and administration of reversal agents.

- Provision of detailed patient instructions as it relates to sedation and explanation thereof to the family members.

- Attainment of measured discharge criteria prior to release of the patient from the endoscopy suite. Requirements for discharge criteria now result in physician interventions to deal with patients not meeting these criteria or experiencing prolonged recovery periods.

The specialty testified that JCAHO requires a RN level nursing staff for the recovery period only. The typical staff type to assist the physician in the pre- and intra- period is a LPN, which adds to the evidence that the physician performs most of these activities.

The RUC reviewed the above list and agreed that the elements of physician work related to conscious sedation has changed over the past five-years. However, the RUC was not able to quantify this increase in physician work.

The RUC had reviewed CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation* (work RVU = 0.80) and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal* (work RVU = 0.60) and provided recommendations to HCFA on these codes. The typical patient described for these codes was a child receiving services where conscious sedation would not typically be utilized (eg, laceration repair). **The RUC recommended then, and urges HCFA now to allow separate reporting and payment of conscious sedation codes 99141 and 99142 when conscious sedation is not inherently included as a component of the physician work of the procedure code.**

The representatives of gastroenterology argued that the RUC should recommend specific increases to their services to account for the increased work in providing conscious sedation. **The RUC is unable to recommend any specific conscious sedation increase to these existing gastrointestinal endoscopy codes** for the following reasons:

- The amount of time or physician work related to conscious sedation currently captured in the gastroenterology codes is unknown. There appears to be no

written documentation of this issue in the Harvard/Hsaio studies, although the gastroenterologists provided verbal testimony that it was considered in the Harvard panels. The RUC reviewed the time data and current work relative values for stand-alone codes 99141 and 99142 and suggested that today's physician work for conscious sedation may already be captured appropriately in the gastrointestinal codes.

- The issue of conscious sedation extends beyond gastroenterology. Many specialties, including colon and rectal surgery, dentistry, interventional radiology, cardiology, pulmonary medicine, and others are also affected by any changes in requirements and regulations related to conscious sedation. Any increases in work related to conscious sedation should be applied fairly to all procedure codes where it is considered an inherent component. It is difficult to determine which codes inherently include conscious sedation (ie, the services where conscious sedation is typically performed and the physician work relative values were determined based on the assumption that conscious sedation would be performed).

- RUC members expressed concern that much of the work described relating to conscious sedation relates to activities performed by nursing staff. There appears to be overlapping issues related to the direct practice expense inputs and these issues need to be resolved.

Thoracic Surgery Facilitation Committee Report (Tab 16)

Doctor William Rich presented the report of the Thoracic Surgery Facilitation Committee. Doctors Rich (Chair), Gee, Hitzeman, Moorefield, and Schnur met via conference call with the specialty on Tuesday, January 3.

The Society of Thoracic Surgeons submitted revised Summary of Work Recommendation Forms for nine codes: three esophageal resection codes (43107, 43112, and 43122), two pulmonary resection codes (32482 and 32500), and four additional general thoracic surgical codes (32100, 32110, 32220, and 32320). The RUC determined during the October, 2000 RUC meeting that these nine codes could be resubmitted to the RUC to prevent rank order anomalies due to the revaluation of codes 32440, 32480, and 43117.

The presenters stated that a concerted effort was made to ensure that the survey respondents included general surgeons and thoracic surgeons outside of academic practice. The STS used a combination of random sample and nominations from respondents to identify additional respondents. The STS also enlisted the help of the American Society of General Surgeons & the American College of Surgeons.

These specialties faxed the list of codes to be surveyed to a geographically distributed sample of their membership, asking the surgeons to indicate which procedures they were familiar with and whether they were able to participate in the survey effort. The STS identified 10 general thoracic surgeons that were geographically distributed and asked them to nominate five or more additional general thoracic surgeons in their region from both academic and nonacademic settings.

The RUC examined all nine codes as a group and in relation to the three codes that the RUC approved in October. This allowed the RUC to first obtain a sense of the relativity among the codes before examining each code individually. While 7 of the 9 codes reviewed included critical care visits, the three codes approved in October (32440, 32480, and 43107) did not include these visits. The STS presenters stated that they used a level three hospital visit instead of a critical care visit in their October presentation because they were not aware that critical care could be included. However, for the 7 codes with revised data, as well as the three previously submitted codes, thoracic surgeons stated that they are typically providing the critical care services such as ventilator management for their patients. The RUC agreed with this recommendation and to ensure consistency, the RUC changed the one level three hospital vist to a critical care service for codes 32440,32480, and 43107.

32100 Thoracotomy, major; with exploration and biopsy

The STS recommended the 25th percentile of 18 RVUs because it was felt that the median survey value of 20 would have created a rank order anomaly with this family of codes, since this code requires less *total* work than a wedge resection 32500 (STS recommended RVW, 22) or control of traumatic lung hemorrhage 32110 (STS recommended RVW, 23). Also, these patients may not require critical care management (depending on comorbidities) and the length of hospital stay may be less than for the other lung codes. Because of new technology, the patients going to the operating room for *open* exploration and biopsy are probably more fragile and complex than previously (i.e., easier cases are now biopsied percutaneously). This was verified by the decrease in frequency of this procedure; from 5,306 in 1993 to 3,192 in 1998. Additionally, failed cases diagnosed and treated by non-operative methods have resulted in delayed presentation of sicker and more complex patients. However, the RUC felt that even the 25the percentile was not supported based on the resulting IWPUT of .088 and in comparison with other codes in the family. The RUC then compared this code to the work involved in 58150, *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU 15.24)* Since the intraperative times, and the number of office and hospital visits were very similar, the RUC felt that this code served as

an accurate anchor code. Upon extensive discussion of the work involved in 32100 and in comparison to other codes such as 49000 *Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (Work RVU, 11.68)* The RUC determined that to create the proper rank order within this family of codes, and to ensure the IWPUT is in line with the remainder of codes within the family, the value of 15.24, which is the value assigned to code 58150 is recommended.

The RUC recommends a work relative value of 15.24 for code 32100.

32110 Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear

The STS explained that this procedure is typically performed on an emergent basis with a high potential for complex intraoperative multidisciplinary work. Compared with lobectomy and pneumonectomy, the preoperative work is shorter, but more intense. Similar to lobectomy and pneumonectomy, an ICU stay and critical care will generally be anticipated for several days because of the potential for blood transfusions, pneumonia, or other lung-related postoperative or traumatic sequelae. Postoperative care for 32110 is different, but still as complex as for 32480 *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)*. The patient requiring 32480 (RUC work RVU recommendation, 23.75), is generally of advanced age, is more fragile going into the procedure, and has many comorbidities that need to be addressed during postoperative care. The patient requiring 32110 is generally younger, but typically presents with multiple injuries, often requiring multidisciplinary work. In the final analysis, there is probably more variability in the patients that present for a either operation than there is between total work for each code. Given the information provided, the RUC felt that the survey results supported the recommendation and created proper rank order within the family by reflecting the difference in work for code 32110 compared code 32480.

The RUC recommends a work relative value of 23.00 for code 32110.

32220 Decortication, pulmonary (separate procedure); total
32320 Decortication and parietal pleurectomy

The intraoperative work for codes 32220 and 32320, which involves significant long and tedious dissections, is greater than a single lobectomy (32480), but less than either a bilobectomy (32482) or total pneumonectomy (32440). In current practice, resistant organisms and delayed presentation of the patient have resulted in much more debris and infection in the chest, requiring more complex and

aggressive decortication and drainage. Relative to each other, 32320 is slightly more work than 32220 in that it includes the additional work of a pleurectomy, although the decortication may not be "total." Code 32320 is generally performed for traumatic hemothorax or for incompletely drained empyema. Significant adhesions exist within the chest and blood loss may be significant. Removal of the parietal pleura may also produce significant blood loss, particularly in individuals with previous trauma or with cancer. For both procedures, a prolonged hospitalization may be required to insure expansion of the underlying injured lung and minimization of the residual intrathoracic space. Based on the survey results and the recommendation for using the median RVU, the RUC felt that the information presented supported the recommendation. Additionally, the recommended work relative values; CPT 32220 (med RVW = 24.00); and CPT 32320 (med RVW = 24.50) would place these two procedures in proper rank order, which is greater than 32480 and less than 32440 (RUC recommended RVW = 25).

The RUC recommends a work relative value of 24.00 for code 32220.
The RUC recommends a work relative value of 24.50 for code 32320.

32482 Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)

This code was compared to 32440 *Removal of lung, total pneumonectomy;* (RUC recommended RVW = 25.00) and 32480 *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)* (RUC recommended RVW = 23.75). The STS data indicates that 32440 is less intraoperative work than 32482 but is more stressful and has a higher morbidity and mortality that demands greater and more complex postoperative work. Therefore, the total work for these two codes is comparable. Code 32480 is also a large operation, but involves slightly less intraoperative and postoperative work (due to lower morbidity) than codes 32482 and 32440. The RUC agreed that the correct ranking for these pulmonary resection codes is reflected in the recommended survey median RVW for each: 32482 (med RVW = 25.00); 32440 (RUC recommended RVW = 25.00); and 32480 (RUC recommended RVW = 23.75). This would create the proper rank order within the family.

The RUC recommends a work relative value of 25.00 for code 32482.

32500 Removal of lung, other than total pneumonectomy; wedge resection, single multiple

The STS data indicated that it is typical for patients to have two or more nodules resected, and possibly bilaterally. Considerable technical skill and interoperative planning is required to optimize the resection of the nodules, and to preserve, in optimal fashion, the pulmonary parenchyma. However, the postoperative care may be less intense than for a lobectomy (32480) or pneumonectomy (32440). Given the survey data and the recommended median relative values, the RUC agreed that the survey median RVW of 22.00 reflects the slightly less total work for 32500 compared with the reference codes 32440 and 32480.

The RUC recommends a work relative value of 22.00 for code 32500.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty

The STS presenters discussed that while 43107 avoids a chest incision, it requires neck and abdominal dissections and increased stress of dissecting up into the chest through the hiatus without actually opening the chest. This procedure was described as having greater intensity in comparison with 43117, however, the survey results did not support this conclusion. After considerable discussion by the RUC and obtaining a detailed description of the work involved, as well as a review of the accompanying literature contained in tab 16, the RUC was convinced that the intensity of the approach described was greater than the reference code 43117.

Of the four surveyed esophagectomy codes, 43112 requires the most intraoperative work (intensity, complexity, and time). This procedure requires three incisions (neck, chest, and abdomen) and possibly an intraoperative change in the position of the patient, including reprepping and redraping. The STS explained that the other three surveyed esophagectomy codes (43107, 43117, and 43122) have subtle differences in total work (pre-, intra-, and post-operative) that make ranking them difficult. Similar to 43112, they each include a gastric

drainage procedure, a feeding jejunostomy, and postoperative admittance to an intensive care unit. For those procedures requiring a thoracic incision, patients are generally placed on a ventilator and require several days of critical care monitoring. Both 43117 and 43122 require opening and closing abdominal and chest incisions and dissecting in both the chest and abdomen. Code 43122 can be done via a thoracoabdominal or abdominal approach, however, the abdominal approach would almost never be appropriate for cancer, and distal resections for benign disease are now exceedingly rare.

For this family of four "all inclusive" codes, the presenters stressed that there is more variability in the patients that present for a given operation than there is between the codes. That is, two patients with the same operation may vary more in the amount of total work that it takes to care for them, than in the difference between two or three similar CPT codes in a family of codes. The RUC discussed whether there should be some differentiation in value among these codes but agreed with the STS analysis and felt that using the survey median for each code: 43107 (med RVW = 40.00); 43112 (med RVW = 43.50); and 43122 (med RVW = 40.00) correctly rank orders this family of codes.

The RUC recommends a work relative value of 40.00 for code 43107.

The RUC recommends a work relative value of 43.50 for code 43112.

The RUC recommends a work relative value of 40.00 for code 43122.

X. Relative Value Recommendations for *CPT 2002*

Anesthesia Services (Tab 17)

The RUC reviewed the following anesthesia services for burn excisions and debridement at their April 2000 meeting. At that time, the RUC was concerned that percent of burn area should be clarified for codes 01951 and 01952 to report less than four percent in code 01951 and between four and nine percent in code 01952. The CPT Editorial Panel has included these changes in CPT 2002 as outlined below. **The RUC has reviewed this issue again and recommends that the base unit for 01952 be changed from 3 to 5.**

Arthroscopic Distal Claviculectomy (Tab 18)

Presenters: Laura Tosi, MD, American Academy of Orthopaedic Surgeons, and Thomas Degenhardt, MD, Arthroscopy Association of North American

A new CPT code 2928X *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface* has been created to describe this new technology. A survey of 43 orthopaedic surgeons indicated that the intra-service time and the intensity for this service is greater than the similar open code 23120 *Claviculectomy; partial* (work relative value = 7.11). The intra-service time for 2982X is estimated to be 60 minutes, 15 minutes greater than the 45 minutes of intra-service time for 23120. The survey respondents also indicated that the technical skill and physical effort required is much greater when this service is provided arthroscopically than using an open technique.

The specialty society also stated that this new service is similar to the work of two procedures, 23120 and 29815 *Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)* (work relative value = 5.89) combined. Utilizing the multiple procedures rule, a work relative value of 10.05 was calculated [7.11 x (50% of 5.89)].

The specialty also noted that the survey median of 8.25 for 2928X would value the code in the appropriate ranking with arthroscopy performed in other anatomic sites. An arthroscopy of the shoulder is more difficult than arthroscopy of the knee (CPT codes 29875-29879), but less intense than hip arthroscopy (CPT codes 29862 and 29863).

The RUC reviewed the survey data and the intensity for this new code and recommends a work relative value of 8.25 for CPT code 2928X.

Practice Expense

This service is only performed in a facility setting, therefore, there are no proposed direct practice expense inputs for the office setting. The RUC recommends that the standard developed for the 090-day major surgical procedures be applied for this code. The physician work survey indicated that the follow-up period would typically include 2, 99212 and 2, 99213 office visits. Therefore, the follow direct practice expense inputs should apply to services performed in the facility setting:

Clinical Staff: RN/LPN/MA pre-time: 60 minutes; post-time: 126 minutes
Medical Supplies: 4 Multi-specialty Minimum Supply Package for Visits
Medical Equipment: Exam Table

Ultrasound Guided Intravascular Thrombin Injection (Tab 19)

Presenters: Robert Vogelzang, MD, Society of Cardiovascular and Interventional Radiology, and James Borgstede, American College of Radiology
Facilitation Committee #3

A new CPT code 36XXX *Injection procedure (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm* has been created to describe a new service that has become widely used over the past two to three years.

The RUC reviewed survey data from 34 interventional radiologists and concluded that a submitted work relative value recommendation of 2.87 was too high. The RUC reviewed other injection codes, 47500 *Injection procedure for percutaneous transhepatic cholangiography* (work relative value = 1.96) and 50390 *Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous* (work relative value = 1.96), and determined that the work of 36XXX is similar to these injection codes. The physician time from the Harvard study for 50390 (38 minutes intra-time and 83 minutes total) is very similar to the time for 36XXX (30 minutes intra-time and 80 minutes total). The RUC also noted that the 25th percentile of the survey work relative value is 2.00, which is comparable to the 1.96 work RVU for these other injection codes. **The RUC recommends a work relative value of 1.96 for CPT code 36XXX.**

Practice Expense

The RUC recommended reductions in the estimated clinical staff time for this service. Modifications were also made to the medical supplies. The specific summary forms for the direct practice expense inputs for both the in-office and out-of-office will be attached to the recommendation.

Pediatric Venipuncture (Tab 20)

The RUC submitted a recommendation on CPT code 36400 *Venipuncture, under age 3 years; femoral, jugular or sagittal sinus* in the Five-Year Review of the RBRVS to increase the work relative value from 0.18 to 0.38. During the course of collecting data on this service, the pediatricians noted that this procedure is no longer performed with venipuncture of the sagital sinus and, therefore, asked CPT to delete this reference. **The RUC recommends that this change in nomenclature is editorial and does not change the previous RUC recommendation of 0.38 for this service.**

Immunization (Two or More Injections) (Tab 21)
Presenter: Joel Bradley, MD, American Academy of Pediatrics

The RUC approved a recommendation from pediatrics that the new codes to describe intranasal or oral administration of vaccines should be assigned the same work relative value as the existing CPT codes for immunization administration as outlined in the a letter from the AAP. **The RUC recommends a work relative value of .17 for code 90473 and .15 for code 90474.**

The RUC also recommends that the direct practice expense inputs should be the same for these codes, with an exclusion of a band-aid (1), a syringe (1), and needles (2) on the medical supply list for codes 90473 and 90474.

Laparoscopic Colon Procedures (Tab 22)
Presenter: Anthony Senagore, MD, American Society for Colon and Rectal Surgeons

The CPT Editorial Panel approved three new codes to describe laparoscopic colon procedures. The RUC reviewed codes 440X2 *Laparoscopy, surgical; colectomy, partial with anastomosis* and 4420X3 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy* at the February 2001 RUC meeting. The specialty will present a recommendation for code 4420X1 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* at the April 2001 RUC meeting.

4420X2 ***Laparoscopy, surgical; colectomy, partial with anastomosis:***

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 22.00. The survey time for this procedure (45 minutes pre, 180 minutes intra, 30 minutes immediate post, 4 hospital visits, discharge day management, and 3 office visits) was compared to the existing RUC database time for CPT code 44140 *Colectomy, partial; with anastomosis* (work RVU = 18.35) (90 minutes pre, 150 minutes intra, 40 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 4420X2 (180 vs. 150 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44140. **The RUC recommends a work relative value of 22.00 for CPT code 4420X2.**

Practice Expense:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the the summary form.

4420X3 ***Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy:***

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 19.50. The survey time for this procedure (47.5 minutes pre, 165 minutes intra, 30 minutes immediate post, 5 hospital visits, discharge day management, and 3 office visits) and compared it to the existing RUC database time 44160 *Colectomy, partial; with removal of terminal ileum ~~and~~ with ileocolostomy* [work RVU = 15.88 (2001 MFS); 18.62 (Five-Year RUC Rec.)] (63 minutes pre, 120 minutes intra, 45 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 4420X3 (165 vs. 120 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44160. **The RUC recommends a work relative value of 19.50 for code 4420X3.**

Practice Expense:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the summary form.

Staff Note: It appears that the RUC has created a rank order anomaly in reviewing these services at different sessions. The open procedures 44140 and 44160 were reviewed in the Five-Year Review. These codes were classified into two separate families at the October 2000 Workgroup meetings. The family with code 44160 was increased (RUC rec work = 18.62), the family with code 44140 (2001 work rvu = 18.35) was not increased as 44140 had previously been reviewed in 1995, in the first five-year review. The laparoscopic approach was reviewed at the February 2001 meeting, and at this meeting the RUC recommended that 4420X2 be valued higher than 4420X3, which is the opposite ranking of the current RUC recommendations pending from the Five-Year Review for the open codes.

Placement of Anal Seton and Excision of Ileoanal Resevoir (Tab 23)
Presenter: Anthony Senagore, MD, American Society for Colon and Rectal Surgeons

460XX *Placement of seton:*

Code 460XX was created to describe placement of a seton as a stand-alone procedure, as this service is being more frequently performed as separate procedure and not in conjunction with other procedures.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 20 minutes of pre-time, 35 minutes intra-time, 20 minutes immediate post-op, 18 minutes (50% of discharge day mgt), and 2 office visits. The survey respondents indicated that this service was similar in time and intensity to 46230 *Excision of external hemorrhoid tags and/or multiple papillaw* (work RVU = 2.57). **The RUC recommends the survey median of 2.90 for code 460XX.**

Practice Expense:

The RUC requested that the specialty return with a revised recommendation for the practice expense inputs for both the office and out-of-office settings for code 460XX.

451XX *Excision of ileoanal reservoir with ileostomy:*

A new CPT code was created to describe the removal of an ileoanal pouch due to problems with function or sepsis. The ileoanal pouch procedure is a relatively new surgery and there is currently no way to report this removal.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 40 minutes or pre-time, 240 minutes intra-time, 30 minutes immediate post-operative time, one critical care visit, 7 hospital visits, discharge day management, and 4 office visits. The data from the survey derived a survey median of 25.00, however, the specialty society compared this service to code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 22.59 (2001 MFS), 25.36 (RUC Five-Year Rec.) and recommends a work relative value of 27.30. 44626 was recently surveyed in the Five-Year Review and requires the following time: 60 minutes pre-time, 150 minutes intra-time, 30 minutes immediate post-time, 7 hospital visits, discharge day management, and 2 office visits. The RUC considered the significantly higher intra-service time for 451XX (240 minutes vs. 150 minutes) and agreed that a work relative value

of 27.30 is appropriate. **The RUC recommends a work relative value of 27.30 for code 451XX.**

Practice Expense:

The RUC reviewed the direct practice expense inputs for this code and suggests revisions to be consistent with the standards proposed by the PEAC for 90 day major surgical procedures. A summary sheet listing these inputs is attached.

Lesion of Testis (Tab 24)

The RUC reviewed this issue to ensure that 54512 *Excision of extraparenchymal lesion of testis* (work RVU = 8.58) was appropriately valued as 54510 *Excision of local lesion of testis* (work RVU = 5.45) will now be deleted and physicians will be instructed to report code 54512. The RUC noted that the deleted code 54510 is infrequently performed (1999 Medicare Utilization = 165). The CPT Editorial Panel had acted to create a new code 54512 for *CPT 2001,* but did not realize that 54510 should be deleted as it described a duplicative procedure. The AUA conducted a RUC survey for 54512 and the survey median was accepted by the RUC. The RUC agreed that this value is appropriate and the deletion of 54510 should have no effect on this code.

Implantation of Sacral Nerve Neurostimulators (Tab 25)

The American Urological Association is re-surveying this issue and will re-present data at the April 2001 RUC meeting.

Gynecological Oncology Procedures (Tab 26)
Presenters: Michael Berman, MD, American College of Obstetricians and Gynecologists

The CPT Editorial Panel approved four new gynecological oncology procedures for CPT 2002 to correct current gaps in coding that would 1) allow the physicians who insert uterine tandems, vaginal ovoids, or Heyman capsules so that a radioelement for brachytherapy may be inserted by the radiation oncologist to report their services; and 2) provide more accurate description of bilateral salpingo-oophorectomy procedures.

571XX *Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy:*

The RUC reviewed survey data from 24 gynecologists for 571XX. This data indicates that this service requires 47.5 minutes pre-time, 55 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1 hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the tandems and ovoids remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The RUC agreed that the survey median was appropriate. **The RUC recommends a work value of 6.27 for CPT code 571XX.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 major surgical procedures. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

583XX Insertion of Heyman capsules for clinical Brachytherapy:

The RUC reviewed survey data from 22 gynecologists for 583XX. This data indicates that this service requires 50 minutes pre-time, 60 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1 hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the capsules remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The specialty felt that the survey median of 8.34 was overstated as the procedure is rare and the survey respondents may have been unfamiliar with the procedure. 583XX requires slightly more work than 571XX, therefore, the RUC recommends the 25th percentile

of the survey. **The RUC recommends a work value of 6.75 for CPT code 571XX.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 major surgical procedures. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

CPT Codes 5895X1 and 5895X2 will be reviewed at the April 2001 RUC Meeting.

Allergy Immunotherapy (Definition of Dose) (Tab 27)

The definitions for these codes have been extensively discussed by the CPT Editorial Panel, the PEAC, and the RUC. The RUC agrees that the CPT modification are consistent with the description and work related to this service. The RUC recommends that these changes are editorial and did not involve a change in the service.

XI. Practice Expense Advisory Committee (PEAC) Report

Doctor Bill Moran presented the direct practice expense input recommendations for 156 CPT codes developed by the PEAC at their October 2000 meeting. These recommendations were made available on a CD-ROM to all RUC participants. **The RUC approved the PEAC recommendations without revision.**

Doctor Moran also briefed the RUC on the January 30 – February 1, 2001 PEAC meeting. Recommendations resulting from this meeting, and the March 22-24 meeting, will be presented to the RUC in April 2001.

XII. Administrative Subcommittee Report

Doctor Alexander Hannenberg presented the report of the Administrative Subcommittee. The subcommittee discussed the CPT-5 Project and the implications for the RUC. As the CPT Editorial Panel implements the CPT-5 recommendation to make CPT codes more granular (eg, eliminate the with or without terminology), the subcommittee agreed that these codes should remain work neutral with the family. The RUC extensively discussed the process of splitting CPT codes to achieve greater specificity and was informed by CPT staff

that specialty societies would retain the responsibility of developing coding proposals and proposing specific coding nomenclature.

The RUC agreed to reaffirm its normal process of treating families of codes in a work neutral fashion as follows:

> **The RUC will continue to treat codes that have been unbundled in a work neutral fashion unless a specialty provides compelling evidence to do otherwise.**

As the PEAC will continue to meet for two more years, it is necessary to hold elections again for the rotating seats. The RUC agreed that specialty societies that currently hold these rotating seats should be eligible for another term and, therefore, agreed to the following:

> **The RUC should suspend the following rule in the election of the PEAC rotating seat in 2001: "Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle." (Nominating Subcommittee Report, Attachment A-Tab F of Structure and Functions Binder)**

The Administrative Subcommittee also discussed the HCPAC Review Board Process and agreed that the current opportunities, as provided in the RUC's Structure and Function, should be utilized by the HCPAC to provide comment to the RUC on issues of interest to these non-MD health care professionals. **The Administrative Subcommittee report was approved and is attached to these minutes.**

XIII. Multi-Specialty Points of Comparison Workgroup Report

Doctor Charles Koopmann presented the report of the Multi-Specialty Points of Comparison Workgroup. The workgroup will continue to review the submission of specialty societies at future meetings, after the draft compilation of codes has been reviewed by the specialty societies. The workgroup agreed that certain criteria should be required and that specialties should consider this criteria when the list is reviewed. The RUC approved the following recommendation:

The MPC should be established based on the absolute criteria (listed below). Other codes that the specialties accept as valid may be added and identified with a separate designation.

- **The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by HCFA.**
- **The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC.**
- **Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.**

The Multi-Specialty Points of Comparison Workgroup report was approved without modification and is attached to these minutes.

XIV. Practice Expense Subcommittee Report

Doctor John Gage presented the report of the Practice Expense Subcommittee. The Subcommittee completed its review of the physician time data for codes where the level of E/M visits was missing from the database. The RUC is now able to compute "total" time for each code that has been reviewed by the RUC. The Subcommittee recommended that this data now be forwarded to HCFA. After an objection was noted from Doctor Mayer, the RUC approved the following recommendations:

1. **For codes under review for missing post operative time where specialty societies have not submitted the number and level of post operative office visits, AMA staff will assign the office visits a code of 99211 as an interim value. The specialties may provide additional information on these codes to the committee in the future if they wish this level to be changed.**

2. **As the RUC physician time data is currently a more valid time database than times utilized by HCFA, the RUC recommends the RUC time database to supplant the current HCFA total physician time.**

The Practice Expense Subcommittee report was approved without modification and is attached to these minutes.

XV. Research Subcommittee Report

Doctor Bruce Sigsbee presented the Research Subcommittee report.

RUC Survey Issues

Doctor Sigsbee summarized the discussion relating to the definitions for the 000 and 10 day global periods. The Subcommittee discussed changing the RUC definitions of the pre-service period to match the HCFA definitions. Currently the RUC instructions define the pre-service period as beginning day before the procedure, but HCFA defines the pre-service period as beginning the day of the procedure. After being informed by Doctor Rudolf that such a change might affect the values of codes with 10 day global periods that the RUC has already examined, the Subcommittee determined that given the unknowns consequences of a change in definition, the Subcommittee recommended maintaining the current definitions.

> **The RUC approved maintaining the current pre-service definitions as contained in the RUC survey for codes with 000 and 10 day global periods**.

Doctor Sigsbee explained that the Subcommittee proposed to retain question 3 on the RUC physician work survey.

> **The RUC approved maintaining question 3 on the RUC physician work survey.**

While the RUC approved the Subcommittee recommendation to maintain question 3 on the RUC physician survey, several RUC members requested that the Subcommittee examine possibly expanding the Likert scale to 10 levels for those questions utilizing the scale.

The Subcommittee recommended that the RUC should no longer collect time data for the reference services, however, the RUC did not agree to provide time data to the survey respondents. Some RUC members stated that the recently surveyed reference service data are valid and allow an accurate comparison with the new/ revised codes. Other RUC members felt that the surveyed times of the reference services fluctuate too much and vary each time the reference code is used. Therefore, it would be preferable to provide standard times from either the RUC process or from the Harvard times when RUC times are not available. The issue of providing times data for reference services generated a great deal of discussion. Some RUC members stated that providing the time data would assist respondents to develop time estimates for the codes under review. Other RUC members stated that the time data may not be accurate, especially the older Harvard time data.

There might be many instances where a reference code has an accurate work relative value and is appropriate as a reference service, but the physician time data may be inaccurate. Therefore, the RUC agreed to not survey times for the reference services, not provide time for these services to respondents, but specialty societies should include RUC or Harvard time on the summary of recommendation form for the reference services.

The RUC survey instrument will no longer ask survey respondents to provide time estimates for the reference services.

Doctor Sigsbee also asked the RUC to approve adding a statement to the instructions for questions 3 and 4 to clarify that respondents are being asking to rank codes based on services the respondent is familiar with performing. The RUC approved adding a statement that the rankings should be based on the universe of codes your specialty performs.

The RUC recommends that the instructions for questions 3 & 4 are clarified by the inclusion of the following statement: "Please base your rankings on the universe of codes your specialty performs."

SMS Data Collection

The RUC discussed the status of SMS data collection efforts and many of the RUC members expressed their concern that the SMS was on hold. The Subcommittee recommended that the RUC Chair write a letter to AMA leadership expressing support for the continuation of the SMS. Doctor Hoehn invited Jim Rodgers of the AMA to address the RUC. Dr. Rodgers stated that the SMS survey has been revised and scaled down to keep the costs low, however the critical questions that are essential for practice expense data collection have been retained. Approval for the survey is on hold due to a delay in the AMA approval process, but AMA management is aware of the issues and is working to resolve the issue by reexamining the financial resources required for the survey. The RUC members stated that continuation of the SMS survey should be one of the highest AMA priorities since it directly affects physician reimbursement. The RUC also requested that Doctor Hoehn invite Board of Trustees representative to attend the April RUC meeting so the RUC members may discuss this issue with AMA leadership.

The RUC recommends that the RUC chairman write a letter to the AMA expressing the RUC' concern over the possibility

of not continuing the SMS survey and indicating the RUC's support for continuing the SMS survey.

Doctor Hayes asked if the revised SMS survey would include revised questions pertaining to work hours for emergency medicine. Sara Thran clarified that the SMS survey would not contain this level of detail. The new practice level survey pilot test did not include all specialties such as emergency medicine. If the new practice level survey is implemented, the comments from emergency medicine will be considered, since it is recognized that certain hospital based specialties may need separately designed surveys. Ms. Thran suggested that the RUC review the practice level survey once it is developed.

Doctor Sigsbee reported that the American Society of Anethesiologists developed a standardized survey instrument to utilize when surveying new and revised anesthesia codes. The Research Subcommittee made some minor modifications to their proposed survey.

The RUC approves the ASA survey with minor modifications.

The Society of Thoracic Surgeons had requested that they be permitted to utilize recently approved RUC recommendations from the Five-Year Review when surveying new and revised codes. The Subcommittee did not agree and recommends that current policy be reaffirmed.

The RUC reaffirms that that reference codes be listed with the established Medicare Payment Schedule published relative values.

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

XVI. RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report

Don Williamson, OD presented the report of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report. Dr. Williamson explained that the RUC HCPAC Review Board reviewed relative value recommendations related to Athletic Training; Active Wound Care Management; and Health Behavior and Assessment. Dr. Williamson also noted that the American Dietetic Association has applied for membership on the HCPAC.

The RUC HCPAC Review Board report was filed and is attached to these minutes.

The RUC meeting concluded on Saturday, February 3 at 6:30 pm.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 1, 2001

The following members of the Administrative Subcommittee met on Thursday, February 1: Doctors Alexander Hannenberg (Chair), James Blankenship, James Hayes, Charles Koopmann, David Regan, William Rich, Paul Schnur, Richard Whitten, Boyd Buser, and James Georgoulakis, PhD.

CPT-5 and Implications for the RUC

Michael Beebe, Director of CPT Strategic Development discussed the current CPT-5 activities surrounding the issue of adding clarity and granularity to CPT codes currently described as services performed "with or without" or "and /or" other services. Mr. Beebe explained that CPT currently includes approximately 1200 services with this nomenclature and therefore, there is the potential to create hundreds of new CPT codes. However, Mr. Beebe explained that the CPT Editorial Panel intends to implement these changes gradually and after proposals are submitted by specialties. It was also clarified that the recent survey of specialties on their analysis of which codes should be split out will be re-done. The Editorial Panel suggested new criteria for the specialties to consider in the second survey on this issue.

The subcommittee also discussed approaches to review these codes as they are adopted by the Editorial Panel. The subcommittee agreed that these codes should remain work neutral within the family. Considerable discussion was held regarding the best methods to apply work neutrality. The subcommittee agreed that in many instances the specialties will be able to provide data on frequency of these services utilizing credible sources (e.g., ICD-9 data, literature). However, individual specialties may wish to request that the values for the split codes retain identical values until Medicare utilization data are collected. Both approaches are consistent with current RUC methodology. However, the committee agreed that it is important to recognize the differences in work relative values for these split codes and it would not be appropriate to retain the same values indefinitely.

Reaffirmation: **The RUC will continue to treat codes that have been unbundled in a work neutral fashion unless a specialty provides compelling evidence to do otherwise.**

<u>PEAC Rotating Seats</u>

The PEAC has been extended to meet over the next two years. The terms of the representatives for the three rotating seats on the PEAC end in 2001. It has been suggested that the learning curve for the PEAC activities is high and it may be desirable to retain the same representatives for the next two years of the PEAC. The Administrative subcommittee agreed that an election should still be conducted and specialties should have the opportunity to nominate an individual for consideration.

However, the subcommittee agrees that the current representatives should also be eligible for this election.

Recommendation: **The RUC should suspend the following rule in the election of the PEAC rotating seat in 2001: "Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle." (Nominating Subcommittee Report, Attachment A-Tab F of Structure and Functions Binder)**

Letters to specialty societies to request nominations for the PEAC and the RUC Rotating seats will be sent out in the next few weeks. The RUC "other" rotating seat and one of the internal medicine seats shall be two year terms. The other internal medicine rotating seat will hold a 3-year term so that the terms of these seats may be staggered.

Assignment of New CPT Codes to the RUC or HCPAC Review Board

The HCPAC Review Board asked that the process of assigning issues to either the RUC or the Review Board be reviewed. The Administrative Subcommittee discussed this issue and agreed that the current process where the MD organizations have the right of refusal should be maintained. The Administrative Subcommittee agreed that the HCPAC should formalize its functions described in III.C.(5)a) and b) by discussing any issues that are on the RUC agenda and of interest to the HCPAC. Any comments from these discussions would be included in the HCPAC's report to the RUC, which would be provided early in the RUC meeting.

RUC 10 Year Anniversary – September 2001 Event

The Administrative Subcommittee suggests that the celebration of the RUC's 10 year anniversary be held on Saturday, September 15, 2001 (during the Fall RUC meeting). The RUC will meet at the Swissotel in Chicago and the dinner may be held on the top floor of the hotel. The subcommittee recommends that all RUC members, RUC alternates, past RUC members, Advisors, and staff be invited to attend this celebration.

AMA/Specialty Society RVS Update Committee Multi-Specialty Points of Comparison Workgroup
February 1, 2001

The following members of the Mult-Specialty Points of Comparison (MPC) Workgroup met on Thursday, February 1, 2001: Doctors Charles Koopman (Chair), Robert Florin, William Gee, J. Leonard Lichtenfeld, David McCaffee, David Regan, Robert Zwolak, Stephen Bauer, and Jerilyn Kaibel, DC.

Specialty Society Submissions on Draft MPC

Sherry Smith reported that 38 specialties responded to the request to submit codes for consideration on the MPC. A total of 250 codes were submitted and detailed information on this initial submission is included in the insert provided for Tab 30 of the RUC agenda book.

Review of Criteria for MPC

The workgroup discussed the criteria developed at its previous meeting to determine if these criteria should serve as guidelines/suggestions or as absolute requirements. The committee agreed that the criteria should be applied as follows:

Requirements:

- The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by HCFA.
- The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC.
- The Workgroup was particularly concerned that a specialty that performs a service a small percentage of total utilization may nominate a code while a specialty that is the predominant specialty may not agree that the work RVU is valid.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

This issue was discussed extensively by the workgroup. Several members argued that a code on the MPC must have RUC time data to make it a valuable tool in reviewing other codes. Another argument, however, was made that a code that was reviewed by the Harvard studies only should not necessarily be excluded as these are the codes that have stood the test of time and specialties have accepted the values as valid.

Other Suggested Criteria (not Absolute Requirements):

- Codes submitted should represent a range of low to high work RVUs within the specialty services.
- The submitted codes should include the range of global periods for services provided by the specialty.
- Codes should be reflective of the entire spectrum of services provided by a specialty society.
- Codes that are frequently performed should be reflected on the MPC.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC should be understood and familiar to most physicians.

Workplan and Process to Develop the MPC

To address the issue of allowing services that do not meet the required criteria listed in the third bullet above to be included in the MPC process, the workgroup recommends the following:

The MPC should be established based on the absolute criteria (listed above). Other codes that the specialties accept as valid may be added and identified with a separate designation.

Staff will apply these criteria to the submitted codes and redistribute the draft list out to specialty societies to review and suggest additions or subsitutions based on these clarifications. The MPC workgroup will meet again at the April RUC meeting to continue its review and development of the MPC.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
Thursday, February 1, 2001
Approved at the February 1-3, 2001 RUC Meeting

On Thursday, February 1, 2001 the Practice Expense Subcommittee to discuss the issues of Physician Time Data and the Draft Report on HCFA's Practice Expense Methodology by the Lewin Group. The following RUC members participated in the discussion, doctors John O. Gage (Chair), Melvin C. Britton, Robert E. Florin, John E. Mayer Jr., David L McCaffree, J. Leonard Lichtenfeld, Sandra B. Reed, Daniel M. Seigel, and Walter Smoski, PhD, CCC-A.

Physician Time Data

The Practice Subcommittee's first task was to take action on the physician time data. Doctor Gage explained the history of this Subcommittee's work of first correcting the RUC database for any database errors, and then collecting missing post operative data elements from the specialties, since HCFA requested total physician time for all codes reviewed by the RUC. The Practice Expense Subcommittee was presented with a table of 396 codes where specialty societies provided missing post operative data elements. It was explained that these 396 codes were reviewed by the RUC prior to the first five year review, when the number and level of post operative ICU, hospital, and office visits were not captured in the RUC survey instrument. Without this post operative information for each code, total RUC time could not be calculated.

The task of the Practice Expense Subcommittee was to decide how to review the data presented and whether or not to then forward the time to HCFA. The specific data for the subcommittee to review are the level of E/M visits provided in the post-operative period as indicated by the specialty societies. The subcommittee members agreed that it was important that the levels of post-operative visits be correct. The Subcommittee heard a report from staff that a level of 99213 was utilized when a response was not received by the specialty. The Subcommittee expressed concern in automatically assigning a 99213 for these codes, especially since many of those "non-response" codes involve services with minimal physician time for the actual procedure. The Subcommittee, therefore, decided to assign a 99211 to these codes as an interim solution.

The methodology that HCFA used to provide total physician time has never been thoroughly explained by HCFA and not been accepted by the RUC. The Chair and other members reminded the group that physician time is under continuous review just as the work RVU is during the 5 year reviews, and that the RUC survey process provides a methodology to estimate physician time. The Subcommittee agreed that the RUC time data is preferable to HCFA/Harvard time data and serves as a better database of physician time.

The Practice Expense Subcommittee agreed to the following recommendations to the RUC.

- **For codes under review for missing post operative time where specialty societies have not submitted the number and level of post operative office visits, AMA staff will assign the office visits a code of 99211 as an interim value. The specialties may provide additional information on these codes to the committee in the future if they wish this level to be changed.**

- **As the RUC physician time data is currently a more valid time database than times utilized by HCFA, the Practice Expense Subcommittee recommends the RUC time database to supplant the current HCFA total physician time.**

AMA staff is working with Doctors Florin and McCaffree to correct approximately 30 codes for the correct physician time.

<u>The Lewin Group Inc. Draft Report on Resource Based Practice Expense Methodology</u>
The Practice Expense Subcommittee reviewed and discussed the content of The Lewin Group Inc. Draft Report on HCFA's Resource Based Practice Expense Methodology. A Subcommittee member representing Vascular Surgery expressed their disappointment in the results of supplying HCFA with supplemental data. The society took on the expense of surveying their members and submitting practice expense data to HCFA, resulting in no identifiable change in RVUs despite a 18% difference in practice expense per hour. The society is still pursing the issue with HCFA, however the society wanted to warn other societies against doing their own supplemental survey. HCFA representatives mentioned that; 1) the data is pooled with other data from specialties who perform the same procedures, and 2) HCFA combined this new data with existing three years of SMS data.

Subcommittee members were also concerned about whether or not the SMS survey will continue, and if not, what HCFA would use in its place. HCFA representatives stated that they still have an additional year of SMS data and they had never expected that SMS data would be used to make annual changes. HCFA representatives also mentioned that they are currently contracting with The Lewin Group Inc. concerning the further refinement of the design of the practice expense survey and to explore the different options for collecting practice expense data.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
February 1, 2001
Approved at the February 1-3, 2001 RUC Meeting

On February 1, 2001, the Research Subcommittee met to discuss a variety of issues relating to the RUC Survey instrument, a specific survey for anesthesia codes, a discussion of the use of IWPUT, an update on future SMS data collection activities, and the use of reference codes in RUC surveys. The following subcommittee members were in attendance: Doctors Bruce Sigsbee (Chairman), Robert Florin, William Gee, Richard Haynes, David Hitzeman, David Massinari, James Moorefield, Bill Moran, and Don Williamson, OD.

Pre service time period for the 000 and 10 day global period

The Subcommittee discussed the difference between the RUC and HCFA definitions for the pre-service time period for the two global periods. While the RUC currently defines the global period as beginning the day before surgery, HCFA defines the global period as beginning the day of surgery. Although the RUC has been using this definition in its data collection activities since 1995, the subcommittee was inclined to make the RUC definitions consistent to those listed in the Medicare Carrier's Manuel. The HCFA representatives discussed that the potential impacts of making this change would possibly result in the reduction in RVUs for those codes passed by the RUC that may have included physician time prior to the day of surgery. This would probably only apply to codes with 10 day global periods, that had physician time on the day prior to surgery, however it is very unlikely that 000 day globals would have included physician work prior to the day of the procedure. The Subcommittee was very concerned that an arbitrary reduction in codes already approved by the RUC and HCFA according to definitions accepted by both groups would result from this definition change.

The RUC approves maintaining the current pre-service definitions as contained in the RUC survey for codes with 000 and 10 day global periods.

Question 3 Pre, Intra, and Post-Service Intensity-- RUC Survey

The RUC referred the issue of deleting question 3 from the RUC survey back to the Research Subcommittee for further discussion. Some members of the Subcommittee questioned the usefulness of including the question on the intensity of the pre, intra, and post-service periods, and recommended deletion to simplify the survey. After considerable discussion the Subcommittee voted to maintain the question since it does provide useful data for some services and is a necessary data element for calculations involving IWPUT.

The RUC approves maintaining question 3 on the RUC physician work survey.

Collection of Physician Time data for Reference services

The current RUC survey instructs respondents to select a reference service and provide time estimates for the reference service as well as the code being reviewed. The Subcommittee discussed the need for providing respondents with stable time data for reference services, just as a stable RVU is provided. Doctor Florin demonstrated that the time data collected on the reference services vary greatly for the same code depending on the survey that used the reference service. The Subcommittee agreed on the need to provide stable time data and recognized that provided RUC time data for reference services would enhance the RUC survey process.

The RUC survey instrument will no longer ask survey respondents to provide time estimates for the reference services.

Instructions for Survey

Questions 3 and 4 on the current RUC survey asks respondents to rank the new/revised code in comparison to a reference code, however, the instructions do not assist respondents in determining the universe of codes that should be considered in making a ranking. The RUC felt that the instructions should be clarified so that the new/revised codes are ranked in comparison to codes the respondent performs.

The RUC recommends that the instructions for questions 3 & 4 are clarified by the inclusion of the following statement: Please base your rankings on the universe of codes your specialty performs.

Anesthesia Survey Instrument

Doctors Hannenberg, Becker, and Novak, from the American Society of Anesthesia presented a RUC survey instrument tailored specifically for the surveying of anesthesia codes. The ASA developed its survey from the existing RUC survey, but designed it to be more relevant for obtaining information on anesthesia base units. Because the anesthesia payment system allows time to be added to the base units, the ASA survey does not place as much emphasis on time as the RUC survey. Instead the survey focuses on intensity to determine the base unit value. The Subcommittee found the survey to be of high quality but recommended placing more emphasis on the statements that respondents should not report time or work related to separately billable services by bolding that section of the instructions and also including that statement prior to question 2 of the survey.

The RUC approves the ASA survey with minor modifications.

Use of IWPUT Methodology

Doctor Florin provided an update on the use of IWPUT in the five year review as well as recent paired comparison studies. Doctor Florin reported that expanding the use of IWPUT measurements would provide a useful alternative to the RUC survey instrument although he cautioned that the use of IWPUT is currently a work in progress. The Subcommittee discussed in detail the use of IWPUT and how it can be used to supplement the RUC survey in developing work relative value recommendations. While the Subcommittee discussed that in the future the use of IWPUT could enhance comparison across specialties and within families of codes, the Subcommittee was equally divided in actually endorsing a recommendation that would encourage specialty societies to use IWPUT analysis in their presentation of relative value recommendations. The RUC will continue to examine this issue.

SMS Future Data Collection Activities

Sara Thran summarized the recent activities with the Socioeconomic Monitoring System (SMS) and plans for the new practice survey. The 2000 SMS survey was eliminated as part of the AMA repositioning last year. The survey had become increasingly difficult to administer in the last few years and would have been too expensive to conduct in its original format. The Board, aware of the importance of this data collection program, asked staff to examine alternative strategies and develop a less fiscally taxing survey.

Staff developed a plan for a scaled-down SMS that will accomplish much of what the original SMS did. The plan is to conduct a shorter mixed-mode survey of physicians that will be collected in alternating years; there will be fewer respondents to the new survey.

A request for proposals for the new survey was prepared and sent to seven survey firms. A survey firm was selected and plans for the survey were on the fast-track. However, the project has been put on hold for Senior Management review, and hopefully will be approved soon so that data collection can be completed in 2001.

The AMA is still committed to developing a new practice-level survey of practice managers rather than physicians to collect needed detail on practice expenses, revenues, staffing, and productivity. The plan is to collect the physician survey and practice survey in alternating years. Because there were so many problems with the pilot practice survey (e.g. low response rate, poor item response to expense questions, and lack of response from large practices), much design work remains. A team of AMA staff are working on the practice survey design issues. The survey will not be done unless it is externally funded; there are several possibilities that appear promising. The practice survey may be fielded as early as 2002.

The Subcommittee members were very supportive of the SMS survey and very concerned that the survey has not been approved yet. To provide support for the continuation of the SMA survey the Subcommittee passed the following motion:

The RUC recommends that the RUC chairman will write a letter to the AMA expressing the RUC' concern over the possibility of not continuing the SMS survey and indicating the RUC's support for continuing the SMS survey.

Reference Service List Codes

The committee discussed the RUC policy of only using the HCFA approved relative values for codes on a specialty society reference service list. To ensure a stable value, specialty societies should not use RUC recommended values until they are approved by HCFA. For codes that have RUC recommended values due to the five year review, but are on specialty society reference service lists, the specialty can not use the new RUC approved value until HCFA approves the value. This policy helps to ensure that the values associated with reference service list codes are established values since there is the possibility that HCFA could change the RUC recommended value. The subcommittee felt that specialties should not use codes recently reviews by the RUC until approved by HCFA, but if they are used, the current HCF approved values be used.

The RUC reaffirms that that reference codes be listed with the established Medicare Payment Schedule published relative values.

RUC Health Care Professionals Advisory Committee Review Board
February 1, 2001

The RUC HCPAC Review Board met on Thursday, February 1, 2001. The Review reviewed relative value recommendations related to athletic training, active wound care management, and Health Behavior and Assessment.

Athletic Training

97005X Athletic Training Evaluation
97006X Athletic Training Reevaluation

The HCPAC recommended that this issue be tabled as the group was unable to evaluate the work or resources required as the description and vignette for these services are unclear. In addition, the National Athletic Trainers Association did not participate or comment on the survey conducted by the American Physical Therapy Association.

Active Wound Care Management

The American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) developed relative value recommendations for two new services:

9701X Removal of devitalized tissue from wound, selective debridement, without anesthesia (eg, high pressure interject, sharp debridement with scissors, scalpel and tweezers), including topical application(s), would assessment, and instructions(s) for ongoing care, per session. (work rvu = .50)

97602X Removal of devitalized tissue from wound, non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic abrasion) including topical application(s), would assessment, and instruction(s) for ongoing care, per session.(work rvu = 0.32)

The committee agreed that 9701X described the same service as 11040 Debridement; skin, partial thickness (work RVU=0.50). The physical therapists indicated that 20-30% of all cases will involve Debridement; skin, full thickness. The Review Board suggested that the organizations develop a proposal to describe this more complex service.

The survey respondents had indicated that 97602X was approximately 63% of the work of 9701X. The Review Board utilized the same relativity of the survey medians for 97601X and 97602X to recommend a work RVU of 0.32 for 97602X. The survey respondents indicated a median intra-service time of 20 minutes for this service.

The Review Board referred the practice expense input recommendations back to APTA/AOTA for additional revision and will review again at the April meeting.

Health Behavior and Assessment

The Review Board reviewed recommendations submitted by the American Psychological Association and the National Association of Social Workers and accepted the following work RVUs:

909X1	Health and Behavior Assessment (eg, health focused clinical interview, behavioralobservations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment. (work rvu =.50)
909X2	re-assessment (work rvu = 0.48)
909X3	Health and behavior intervention, each 15 minutes, face-to-face; individual (work rvu = 0.46)
909X4	group (2 or more patients) Refer back for further data
909X5	family (with the patient present) (work rvu = 0.45)
909X6	family (without the patient present) (work rvu = 0.44)

(For health and behavior assessment and/or intervention performed by a physician, see Evaluation and Management or Preventive Medicine service codes)

These services are all reported in increments of 15 minutes. The typical number of units reported will be 4 (one hour), therefore all of the time data on the summary forms will be modified to capture only the 15 minute increment. The Review Board agreed that the work RVUs for the assessment codes (909X1 and 909X2) are appropriate relative to the psychiatric interview codes 90801 (2.80) and 90802 (3.01) which are typically one hour in length of service.

The Review Board also agreed that the intervention codes (909X3, 909X5, and 909X6) are valued appropriately in relation to the psychotherapy codes. The group intervention code (909X4), however, was not accepted. The APA/NASW will collect data on the typical number of patients in a group and compare the code to other group codes in CPT. This recommendation will be reviewed in April.

The Review Board agreed that these services do not require any clinical staff or equipment. The typical supplies (when performed in-office) will be provided to AMA staff.

Other Issues

- The Review Board reviewed the Administrative Subcommittee proposal regarding the assignment of codes to the RUC or the HCPAC Review Board and agreed that the proposal was reasonable.
- The AMA has received a request from the American Dietetic Association (ADA) to be represented on the RUC HCPAC. AMA staff informed the HCPAC that as a result of recent legislation, nutritionists will now be able to directly bill Medicare services and be paid at 85% of the physician payment schedule for medical nutrition therapy. As the HCPAC has included representation all non-MD/DO organizations that perform services with a direct benefit from Medicare, the HCPAC recommends that the AMA consider this request from the ADA.
- The current term of the HCPAC co-chair concludes at the April meeting. All HCPAC organizations will receive notification that they may nominate an individual for the election of the co-chair in April.