**AMA/Specialty RVS Update Committee**
**Meeting Minutes**
**January 29-February 1, 2004**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, January 30, 2004 at 8:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD*
Dennis M. Beck, MD*
Michael D. Bishop, MD
James Blankenship, MD
James P. Borgstede, MD
Neil H. Brooks, MD
Norman A. Cohen, MD
James Denneny, MD*
John Derr, Jr., MD
Mary Foto, OT
John O. Gage, MD
William F. Gee, MD
Meghan Gerety, MD
Robert S. Gerstle, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
M. Douglas Leahy, MD*
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
James D Maloney, MD*
John E. Mayer, Jr., MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Sandra B. Reed, MD*
Chester W. Schmidt, Jr., MD
Joseph M. Schwartz, JR., MD*
Gary R. Seabrook. MD*
Daniel Mark Siegel, MD
J. Baldwin Smith, III, MD
Peter Smith, MD*
Holly Stanley, MD*
Susan M. Strate, MD
Trexler Topping, MD
Arthur Traugott, MD*
Richard Tuck, MD
Richard W. Whitten, MD
Maurits J. Wiersema, MD
Robert M. Zwolak, MD

* Alternate

II. Chair's Report

Doctor Rich welcomed the RUC and made the following announcements:

- Due to the volume of coding proposals scheduled for the February CPT meeting, specialty societies that have work and practice expense recommendations to be reviewed by the RUC in April are encouraged to have all of their materials to RUC staff on time (April 1, 2004).

- The RUC has been reviewing possible iterations of how to review practice expense inputs once the PEAC meeting have ended. Currently, the RUC has implemented some of these changes already

by encouraging existing PEAC members to attend RUC meetings as well as assigning various RUC members to solely review the practice expense inputs of RUC recommendations. In addition, the RUC will be hearing the report from the PEAC Transition Workgroup, as to how best transition the knowledge acquired by this group into the RUC meetings.

- CMS Staff attending the meeting include:
  - Edith Hambrick, MD, CMS Medical Officer
  - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, CMS Health Insurance Specialist

- New Presenters and New Staff in the meeting include:

| FirstName | LastName | Society |
|---|---|---|
| David H. | Ahrenholz, MD | American Burn Association |
| Robert | Barr, MD | American Society of Neuroradiology |
| David | Beyer, MD | American Society for Therapeutic Radiology and Oncology |
| Carolyn | Buppert | American Nurses Association |
| Jodi | Chappell | American Academy of Audiology |
| Bruce | Deitchman, MD | American Academy of Dermatology |
| D. Jefferey | Demanes, MD | American Society for Therapeutic Radiology and Oncology |
| Barbara | Goff, MD | American College of Obstetricians and Gynecologists |
| Robert | Guidos, JD | American College of Physicians |
| Robert | Harris, MD | American College of Obstetricians and Gynecologists |
| Richard J. | Kagan, MD | American Burn Association |
| John A. | Krichbaum, MD | American Burn Association |
| Jaime | Lopez, MD | American Academy of Neurology |
| Christine | Ren, MD | American Society of Bariatric Surgery |
| Clark | Rosen, MD | American Academy of Otolaryngology - Head and Neck Surgery |
| Tim | Shahbazian, MD | American Association of Oral & Maxillofacial Surgeons |
| Frank | Spinsoa, DPM | American Podiatric Medical Association |
| Charles | Tegeler, MD | American Academy of Neurology |
| Scott | Trerotola, MD | Society of Interventional Radiology |
| Eric | Whitacre, MD | American Society of Breast Surgeons |
| Victor | Zannis, MD | American Society of Breast Surgeons |

- All presenters must sign a Financial Disclosure Statement prior to their presentation to the RUC. Any presenter with a conflict of interest must verbally state his/her conflict of interest prior to their presentation. This policy will be strictly monitored.

- Coverage and Technology Assessment: In November, Doctor Rich met with Sean Tunis in follow up to the September Coverage Symposia at the RUC Meeting. Doctor Sean Tunis requested that the RUC collate all of the specialty societies' contact information. Enclosed in your materials is an inquiry requesting information from specialty societies as how they process issues regarding coverage and technology assessment.

- CPT staff has made a request to RUC participants to identify existing codes that have become obsolete or do not represent the current standard of care for consideration of deletion from CPT. Specialty societies should contact CPT regarding these deletions.

- Doctor Rich requested that no matter what methodology is used to derive a work recommendation that a comparison to other RUC surveyed codes from the database or MPC list also be utilized as it strengthens the overall rationale provided to CMS and announced the members of the facilitation committees:

Facilitation Committee #1
John Mayer, MD (Chair)
James Borgstede, MD*
Neil Brooks, MD
Richard Dickey, MD*
Mary Foto, OTR*
Meghan Gerety, MD
Charles Koopmann, Jr, MD
Greg Przybylski, MD*
Charles Shoemaker, MD*
J. Baldwin Smith, III, MD
Karen Smith, MS, RD
Richard Tuck, MD
Richard Whitten, MD

Facilitation Committee #2
Michael Bishop, MD (Chair)
Joel Brill, MD*
Norman Cohen, MD
Jonathan Cooperman, PT, JD
John Gage, MD
David Hitzeman, DO
Barbara Levy, MD
Scott Manaker, MD*
William Moran, MD*
Tye Ouzounian, MD*
Chester Schmidt, MD
Susan Strate, MD
Maurits Wiersema, MD

Facilitation Committee #3
J. Leonard Lichtenfeld, MD (Chair)
James Anthony, MD*
James Blankenship, MD
Manuel Cerqueira, MD*
John Derr, MD
William Gee, MD
Peter Hollmann, MD
Emil Paganini, MD*
Bernard Pfeifer, MD
Christopher Quinn, OD
Daniel Siegel, MD*
Trexler Topping, MD
Robert Zwolak, MD

**Current or former Practice Expense Advisory Committee (PEAC) member*

III. Director's Report

Patrick Gallagher made the following announcements:

- The next RUC meeting will be held April 22 - 25, 2004 in Chicago, Illinois at the Swissôtel. Please review the calendar of scheduled meeting dates. Because of the volume of RUC recommendations that will be reviewed for this meeting, the meeting will most likely end Sunday, April 25th at noon.

- Because of the volume of RUC recommendations to be reviewed at the April Meeting, RUC Workgroups and Subcommittees are advised to address all action items at the February Meeting so that additional time can be allotted at the April meeting for the review of these recommendations, if necessary.

IV. Approval of the Minutes for the September 18-21, 2004 RUC Meeting

Doctor Whitten had several editorial changes to the minutes which have been incorporated. **The minutes were reviewed by the RUC and were accepted.**

V. CPT Update

Doctor Peter Hollmann briefed the RUC on the following issues:

- Actions of the November CPT Meeting – Refer to the RUC Status on CPT Editorial Panel Coding Changes for CPT 2005 for recent actions.

- November Annual CPT Advisors Meeting – Several topics were discussed including: online evaluation and management services, XML hierarchy, work impairment assessments, and molecular genetics. The CPT HCPAC addressed the definition of qualified professionals for testing and therapeutic procedures. Doctors Rich and Whitten attended this meeting and added to the quality of the deliberations. The action items from this meeting can be found in Tab 3 of the February RUC Agenda book. One of these items includes the creation of a Category III code for Online Evaluation and Management Services.

- E&M Workgroup – The goal of this workgroup is to better describe the current practices and to develop less restrictive descriptors that do not rely strictly upon the history, physical examination and medical decision making hierarchy. The workgroup proposed to base these procedures on magnitude estimation and using clinical examples as an instructive tool. A preliminary submission of 330 clinical examples from 11 specialties is under review, specifically, to edit language that could imply levels of severity. This process will be expanded to include all specialties once the

review process is standardized. Next steps include implementing an internet survey to test the validity of the responses and then sending the clinical examples to Carrier Medical Directors for review. Finally, there will be cross-specialty analysis to determine work comparability across the clinical examples. At each phase of the evaluation, additional considerations might take place which could modify the process or the code clinical example process.

- Comment on Conscious Sedation – At the August CPT Editorial Panel Meeting, the Panel agreed with the RUC that a list should be developed for procedures where conscious sedation is inherent to the procedure. Doctor Hollmann informed the RUC that a CPT Workgroup including members from the RUC and PEAC has been formed to review this issue in regards to the stand alone CPT codes and instructions to precede the appendix.

- RUC members have volunteered to be RUC observers at the following CPT Meetings:
    - April 29 – May 2, 2004 Richard Whitten, MD
    - August 12 – 15, 2004 Richard Whitten. MD
    - November 4 – 7, 2004 J. Baldwin Smith, MD

VI. CMD Update

Doctor William Mangold, Carrier Medical Director for Arizona and Nevada, addressed the RUC and gave the following comments:

- The RUC working with the Carrier Medical Directors: Doctor Mangold stated some of the history of this relationship and expressed his desire to strengthen this relationship by working together during the Five Year Review Process.
- CMD Updates: Doctor Mangold will be giving updates from Carrier Medical Directors at all future RUC Meetings which will allow current information from the CMDs to be given to the RUC and will allow RUC members to ask specific coverage policy questions

VII. CMS Update

- Doctor Ken Simon announced that the CMS Administrator, Tom Scully, and the Director of the Center for Medicare Management, Tom Grissom, have resigned. Currently, the Director of the Medicaid Program, Dennis Smith, is the acting Administrator.
- With the passage of the legislation in November, there were a number of changes to the Program including:
    - Medicare Prescription Drug Card – This program will be effective in April and will remain in effect until 2006 at which time the drug benefits will commence. All Medicare beneficiaries that are enrolled in the program will be eligible to participate in at least two

of the Medicare endorsed drug cards. Under this new Part "D" program there will be a $250 deductible for the beneficiary. From $250-$2250, there will be a 75% coverage by Medicare with a 25% co-payment for the beneficiary. From $2250-$5700, the beneficiary is responsible for all costs. After $5700, catastrophic coverage will be applicable for the beneficiary.

- Drug Pricing – There have been changes in AWP, where presently CMS pays 95% of average wholesale price for drugs. There will be a transition over the next two years, where this percentage will decrease for sole source drugs to approximately 83% and for multiple source drugs to approximately 68%.
- Durable Medical Equipment (DME) – For DME there is a freeze on the equipment rates from 2004-2006. Next year, the GAO will review this area and make recommendations to CMS in regard to appropriate pricing for DME.
- New Medical Technology in the In-Patient Setting – Historically, CMS has added new technology in October of each year, however, with the passage of the new legislation, new technology will be added in April and October of each year. The DRG will only be re-calibrated once a year. There will be a mechanism put in place for public input so that the public have an opportunity to comment on new technology as well as the criteria that is utilized to determine what new technology will be added on the In-Patient setting.
- Therapy Services: For therapy services there will be a moratorium on therapy caps for 2004-05. By March 2004 there will be directives given at CMS in regard to therapy cap alternatives and additional information in regard to outpatient therapy utilization.
- Conversion Factor: There will be a 1.5% increase in the conversion factor for both 2004 and 2005. There has been a change in the SGR formula where there will be a 10 year rolling average of the GDP beginning with last year that may adversely affect physician payments in future years.
- End Stage Renal Disease: CMS has been designated to establish an advisory board to review ESRD policy.
- Laboratory Payments and ASCs: There will be a 5-year freeze on Laboratory Payments. In addition, there will be a 1% reduction in ASC payments beginning in 2004 and a 5-year freeze on payment rates for 2005-2009. The Secretary has been advised to develop a new payment system after review of the GAO study. However, due to legislation, changes cannot be made to the ASCs except every other year by statute. CMS is interested in creating an ASC payment methodology that will be similar to that of the Outpatient Prospective Payment System.
- Medicare Incentive Payment Program: This program will provide physicians who practice in underserved areas an additional 5%

bonus in payment for the services they render. This program is in place for January 1, 2005 – January 1, 2008. It has not been decided at this time the definition of an underserved area.

- Regulatory Relief: In the legislation, CMS is prohibited from placing penalties on providers who have been shown to reasonably react to written guidance from either contractors or CMS. There will be an Ombudsman Program developed to create a vehicle for the medical community at large to be able to express their concerns to CMS in the event they feel that their issues are inappropriately addressed by the program integrity section of CMS.

- A RUC member asked what are the short and long-term effects of the health savings account provisions on the entire Medicare system. Doctor Simon responded by stating that it is difficult to know at this time what cost savings, if any, will occur with the program over the next 2-5 years. There are a number of demonstration projects at this time and the Secretary has been interested in linking quality to payment, which is somewhat at variance with the RBRVS system. However, there has been considerable emphasis put in the issue of quality with the intent that if performance indicators were put in place and people provide quality care this would translate into fewer hospitalizations and better quality of care for the beneficiaries which would translate into medical savings for the program. This premise is still under review. Doctor Rich stated that there are two utilization estimates: one from the CMS and one from the CBO. The utilization data from CMS was higher than data collected by the CBO. The insurance industry has not decided whether they will develop and market a product with a high deductible due to the lack of consistent utilization data.

- A RUC member questioned CMS' reaction to the GAO Report regarding Assistants at Surgery. Doctor Simon stated that CMS cannot comment on this issue but will provide a report at the RUC Meeting in April. The final GAO report has not been made public which will contain CMS' formal response, however, the GAO report did not have any action items however, there are recommendations that all assisted surgery should be bundled into the hospital payment. This is a contentious issue because the effects of the physicians who bring their own staff to assist at surgery have not been studied.

- A RUC member questioned if any actions were being taken by CMS to reduce the vast difference in payment policies across the state Carrier Medical Directors. Doctor Simon addressed this issue by giving a brief history of the regional coverage policies of the Local Medical Review Process (LMRP) followed by the uniform coverage policies of the National Coverage Decision (NCD) Process. The NCD Process

was first met with great enthusiasm, however, later met with resistance due to physicians not wanting to embark on a process where there was national uniform coverage and thus appeals have been made to continue to use the LMRPs. As both processes continue to be used, however, there is mixed response to how CMS should proceed.

VIII. Washington Update

Sharon McIlrath addressed the following issues:

- Medicare Update: The AMA does not expect legislation on the update this year, however the AMA anticipates Congressional debate over a long term solution to the problems in the SGR formula next year. The AMA is working with specialties to get CMS to make certain administrative changes that would improve the situation and lower the cost of a long term fix. These changes include removing drugs from the SGR, including new CMS coverage decisions in the SGR allowance and taking a more comprehensive approach when calculating the impact of new Medicare screening benefits.
- Election Year: The current political climate in Washington is being affected by the fact that it is an election year. The effects of an election year include less time to legislate on any subject and a great deal of partisan politics. This climate will result in little legislative action, instead, more focus on implementing the actions created in the Medicare Prescription Drug, Improvement and Modernization Act (MMA).
- Shift in Leadership: As in CMS, there are many people in senior leadership resigning including Billy Tozan, Congressman from Louisiana sitting on the Energy and Commerce Committee and a huge supporter of the physician update. In addition, a number of the staff members who had expertise in Medicare legislation including John McManus, Staff of the Ways and Means Committee, will also be resigning. Potential candidates for the future CMS Administrator have also been suggested including Mark McClellan, MD, PhD, Commissioner of the Food and Drug Administration. *Staff Note: On February 20, 2004, President Bush nominated Mark McClellan to be the new Administrator of CMS and he recently was confirmed by the Senate.*
- Congressional Issues: The AMA is addressing the following issues to Congress: mental health parity, patient safety bill, and the professional liability bill. The AMA's Board has delegated significant funding to professional liability advocacy efforts..
- Professional Liability Reform: Professional liability reform is the AMA's top priority. The AMA has developed advertisements that are being used to promote professional liability reform and is permitting the use of these advertisements to any group that would like to have them to promote professional liability reforms to its members. If any RUC participant would like to acquire these advertisements, Sharon

McIlrath of the AMA Washington Office will be happy to provide a contact number. In addition to these advertisements, the AMA has compiled a patient e-mail list comprised of 77,000 patients which has increased communication to Congress about this issue. Professional liability reform strategists believe that the dynamic that will change the current political environment in its perception of professional liability reform will have to come from the patients. The strategy that the Senate leadership had developed to address this issue is an incremental approach by gaining the support and participation of specialty societies one-by-one. There is also controversy surrounding this methodology. Based on directives given by the House of Delegates in December, the AMA is trying to work together with state societies and specialty societies to form a consensus between both groups to identify the important issues within professional liability reform and continue this consensus building approach to determine future strategies.

- A RUC member told other RUC members about a website, www.ccemt.org, which is a coalition center of ethical medical testimony set up by a physician who has experienced professional liability law suits.

- Another RUC member stated that one of the big issues when addressing Congress is that they respond to two things: 1.) A compromise that all parties can agree upon or 2.) A crisis. Therefore, physicians either must show more symptoms of current professional liability policy being a crisis so that Congress acts or physicians will have to be willing to accept a compromise. The timing of this AMA campaign for professional liability reform is crucial and needs to be considered due to the potential change of national leadership in November. To CMS, the perception of the public is that with the positive physician update, the problem of physician payment is being solved. The professional liability component of RBRVS, the proportion of the MEI going from 3.2 to 3.8. However, this positive increase in PLI is being achieved by decreases in the work and practice expense components of the RBRVS, resulting in a negligible effect for physician payment. The pool of physician payment is too small and physicians need to educate lobbyists and politicians of this fact.

IX. Relative Value Recommendations for CPT 2005

**Anesthesia Procedures – Congenital Heart Infant Bypass (Tab 4)**
**James D. Grant, MD, American Society of Anesthesiologists (ASA)**

The CPT Editorial Panel created a new code 0056X1 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest, with pump oxygenator, under one year of age* to differentiate between the work involved

in procedures normally performed on adults from those associated with surgical repair of congenital heart lesions in children less than one year of age. CPT code 00562 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator* (Base Unit = 20) was created more than 30 years ago. At that time, correction of these lesions occurred after the child grew for several years. Now complete repair is performed at the earliest possible time, frequently shortly after birth.

The RUC reviewed survey data from nearly 50 anesthesiologists who indicated that this new service described in 0056X1 is more intense than the service currently described in 00562. The survey responses on the intensity/complexity measures included a wide variance, with mental effort and judgment; technical skill and physical effort; and psychological stress all being at least 40% greater for the procedures performed on children under one year of age. Although the survey median was 27 base units, the specialty recommended the 25$^{th}$ percentile of 25 base units. The RUC agreed with this recommendation and the specialty's comparison to CPT codes 00563 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest* and 00566 *Anesthesia for direct coronary artery bypass grafting without pump oxygenator*. **The RUC recommends a base unit of 25 for CPT code 0056X1.**

The RUC discussed the issue of work neutrality and agreed that it could not be applied in this situation. The specialty estimates that the services currently reported under 00562 that will now be reported as 0056X1 will be less than 2% of the total utilization.

Practice Expense Inputs:
The service is performed in a facility setting only and, therefore, no direct practice expense inputs are applicable

**Placement of Breast Brachytherapy Radiotherapy Afterloading Balloon Catheter (Tab 5)**
**Bibb Allen, MD, American College of Radiology (ACR)**
**Richard Fine, MD, American Society of Breast Surgeons (ASBS)**
**Louis Potters, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)**
**Eric Whitacre, MD, American College of Surgeons (ACS)**
**Facilitation Committee #2**

For breast cancer patients, post-operative radiation can be delivered to the entire affected breast or, for appropriately selected patients, to the tissue immediately surrounding the resected tumor (partial breast irradiation). The specialty society believes that breast brachytherapy is the most widely accepted means of delivering partial breast irradiation. The availability of

balloon catheters to facilitate breast brachytherapy has made this therapeutic modality widely available to more women. The CPT Editorial Panel created three new codes to report the procedures involving the surgical insertion of radiotherapy afterloading balloon catheter into the breast for the radioelement application.

192XX1

The RUC had a lengthy discussion of the pre and post service time of ZZZ global code 192XX1 *Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)*. The presenters and RUC members agreed that for this unique procedure additional time in patient consultation in both the pre-service and post-service time periods was warranted, but a much lower amount of time than was presented by the specialty. **The RUC recommends the pre-service and post-service time for 192XX1 to 5 each.**

In addition, the RUC agreed that the work of 192XX1 is similar to the neurological code 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)* (work RVU = 1.70) and code 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU=1.72). 95975 and 15101 each have intra-service work intensities between 0.05 and 0.06, and the RUC believed this new family of codes had similar work intensities. The RUC then used a building block approach to justify and assign a relative value for 192XX1. The building block approach assumed a work intensity of 0.05 multiplied by the specialty's surveyed results for intra-service time, of 30 minutes. The physician work entailed in pre and post service time was then added for a total work relative value of 1.72. **The RUC recommends a relative work value of 1.72 for CPT Code 192XX1.**

192XX2

The RUC discussed at length, the physician work associated with code 192XX2 *Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy*. The RUC and the specialty society agreed that the surveyed results regarding the pre-service evaluation time survey were inaccurate, and

should be 30 minutes instead of 45 minutes. **The RUC recommends that the pre-service evaluation physician time be 30 minutes for 192XX2.**

The RUC and specialty society, in addition, believed that the physician work intensity is less than what the specialty society survey results indicated. The RUC reviewed surgical codes 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU = 3.69) and 43251 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 3.69), in relation to 192XX2 and agreed that the work intensity was much lower than the two other surgical codes, yet slightly higher than 192XX1. The RUC believed that a work intensity of 0.055 is appropriate for 192XX2, and used a building block approach to value the code. This service is typically performed with conscious sedation. The RUC believed a relative value of 3.63 was more appropriate for the physician work, time, and intensity involved. **The RUC recommends a work RVU of 3.63 for CPT code 192XX2.**

192XX3

The RUC reviewed the work relative value of 192XX3 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance.* The RUC believed that the work intensity of 192XX3 slightly higher than192XX2 with the use of brachytherapy cathethers. With this in mind, the committee reviewed code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.99). 52341 had been RUC reviewed recently, it is a 000 day global code, and had similar surveyed physician time and intensity. As in code 192XX2 the pre-service evaluation time was adjusted to reflect the true physician work time. **The RUC recommends a pre-service evaluation physician time for 192XX3 of 15 minutes.**

The RUC believed that the intensity of work and the physician time for 192XX3 is similar to code 52341, and that with the specialty society surveyed time which was slightly higher, the relative value for 192XX3 should be 6.00 relative work units. In addition, the RUC recognized that code 192XX3 would typically be performed with conscious sedation. **The RUC recommends a work RVU of 6.00 for CPT code 192XX3.**

| ***Building Block Analysis*** | **192XX1** | | **RUC Rec = 1.72** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| Pre-service | 5 | 0.0224 | 0.11 |
| ***Intra-service:*** | 30 | **0.050** | 1.50 |
| Post-Service | 5 | 0.0224 | 0.11 |

| ***Building Block Analysis*** | **192XX2** | | **RUC Rec = 3.63** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| Pre-service eval & positioning | 40 | 0.0224 | 0.89 |
| Pre-service scrub, dress, wait | 15 | 0.0081 | 0.12 |
| ***Intra-service:*** | 30 | **0.0546** | 1.64 |
| Immediate Post | 15 | 0.0224 | 0.34 |
| Post-Service Discharge Day | .5 | 1.28 | 0.64 |

| ***Building Block Analysis*** | **192XX3** | | **RUC Rec = 6.00** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| Pre-service eval & positioning | 45 | 0.0224 | 1.01 |
| Pre-service scrub, dress, wait | 15 | 0.0081 | 0.12 |
| ***Intra-service:*** | 60 | **0.0593** | 3.56 |
| Immediate Post | 30 | 0.0224 | 0.67 |

| | | | |
|---|---|---|---|
| Post-Service Discharge Day | .5 | 1.28 | 0.64 |

Practice Expense Inputs:
The practice expense inputs for the Placement of Breast Radiotherapy: Afterloading Balloon Catheter codes were assessed by the RUC separately with the specialty society. Changes were made to the specialty society's original PE recommendations to address issues involving clinical labor type, clinical labor time, supplies and equipment. The RUC's recommended direct practice expense inputs are attached to this report.

**Laryngoscopic Excision of Microscopic Non-Neoplastic Lesions (Tab 6)**
**James Denneny, MD, American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)**
**Facilitation Committee #3**

Due to technological advances and a better understanding of vocal fold submucosa preservation for normal voice production, the CPT Editorial Panel created two new CPT codes. These new CPT codes accurately describe microdissection within the lamina propria for the removal of lesions from the vocal fold surface and subsequent reconstruction with either uninvolved local mucosal flaps or implants of autogenous or alloplastic materials. The RUC believed that the two new codes descriptors should be revised to distinguish these procedures from existing codes intended to report removal of neoplastic lesions. The RUC also believed code descriptor for 315X2 should be revised to include the work of harvesting the graft in this procedure. The CPT Editorial Panel accepted the RUC's requests in February 2004 to: 1) revise code 315X1 in order to distinguish this procedure from existing codes intended to report removal of neoplastic lesions, and 2) revise the descriptor of code 315X2, deleting reference to the use of allograft material for flap reconstruction. The committee also approved the addition of two cross-references to instruct 1) the use of the unlisted procedure code to report allograft flap reconstruction procedures and 2) the inappropriate additional use of code 20926 to report autograft flap reconstruction.

315X1

The RUC reviewed the survey results presented by the specialty society for new CPT codes 315X1 *Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic leasion(s) of vocal cord: reconstruction with local tissue flap(s)* and 315X2 *Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic leasion(s) of vocal cord: reconstruction with graft(s) (includes obtaining autograft)* in relation to their reference code 31541 *Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope* (Work RVU = 4.52). In addition, due to the microsurgical precision of the

two new codes, it was understood that the two codes are performed only under general anesthesia, whereas code 31541 can be performed with local or general anesthesia. The RUC believed that inter-operatively, the new codes are more intense, and require more technical skill and additional work than code 31541. In addition to microsurgical lesion removal, 315X1 adds reconstruction with a local tissue flap to cover the defect and 315X2 adds reconstruction with an autograft or allograft to cover the defect. The RUC agreed with the specialty society's survey results and work relative value recommendation for code 315X1. **The RUC recommends a relative work value of 6.30 for code 315X1.**

315X2

In order to establish a work relative value for 315X2, the RUC agreed that the specialty society survey results should be used (which was without the harvesting of the graft), and the additional work of harvesting the graft would be then added. The RUC agreed to determine an appropriate increment of physician work to represent the harvesting of the graft by focusing on the intra service work of code 20926 *Tissue grafts, other (eg, paratenon, fat, dermis)* (Work RVU = 5.52). Using a building block approach the RUC determined that the intra-service work component of 20926 had a relative value of 1.23. The RUC then added this intra-service work component of harvesting tissue grafts to the specialty society recommended relative value of 8.50, for a total relative work value of 9.73. **The RUC recommends a relative work value of 9.73 for code 315X2.**

Practice Expense Inputs

The RUC reviewed and agreed with the specialty society clinical labor time recommended in the facility setting of 30 minutes pre-service and 6 minutes in the service period. There are no practice expense inputs in the non-facility setting as these services require that they be performed in the facility. The RUC recommended practice expense inputs are attached.

**Bronchoscopy Stent Revisions, Endobronchial Ultrasound (Tab 7)**
**Scott Manaker, MD, American College of Chest Physicians (ACCP)**
**Alan Plummer, MD, American Thoracic Society (ATS)**

The CPT Editorial Panel in November 2003 revised two bronchoscopy procedures and created four new codes, in order to create more specific bronchial and tracheal stent placement techniques. Some procedures involve dilation and placement of one or more stents, while others may involve a revision of an existing stent and therapeutic intervention.

The RUC reviewed the survey data separately for each of the new and revised codes. The RUC believed that the reference codes used in the surveys were appropriate for the services. The physician work for the new codes was believed by the RUC to be more intense and time consuming than the

reference codes, and the specialty society's recommended work values seemed appropriate. In addition, RUC understood that these new and revised procedures typically required general anesthesia in a facility setting, and therefore should not be on the conscious sedation list.

31630 and 31631

The specialty society's survey results for the two existing revised codes, 31630 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal or bronchial dilation or closed reduction of fracture* (Work RVU = 3.81) and 31631 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)* (Work RVU = 4.36) supported their current values and recommended no change in the work values. The RUC reviewed the physician time for each of the codes and recommended that the surveyed times be used, replacing the existing Harvard time, with one modification. The RUC believed that the intra-service time for 31630 should be 45 minutes instead of the surveyed 60 minutes, as the newly created family should reflect consistent time amongst its similar codes. **The RUC recommends that the specialty's physician surveyed time replace the existing Harvard time, and the intra-service time of 31630 be 45 minutes. The RUC also recommends no change in the existing physician work relative values for codes 31630 and 31631.**

316X1

The RUC reviewed the physician work of new code 316X1 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent (includes tracheal/bronchial dilation as required), initial* in relation to its reference codes 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80). The RUC believed that the work of the new code was more difficult and required more time and physician work than either of the reference codes and supported the specialty society's median surveyed work value. **The RUC recommends a 4.30 work relative value for code 316X1.**

316X3

The RUC reviewed the work and physician time of new code 316X3 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of a tracheal or bronchial stent inserted at a previous session (includes tracheal/bronchial dilation as required*) in relation to its reference codes 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung*

*biopsy(s), single lobe* (Work RVU = 3.80). The RUC believed the specialty's survey results were appropriate for the entire service, and understood that the additional intra-service time for this code was appropriate considering the family of codes and the reference codes. The RUC agreed with the specialty's recommended work value for 316X3. **The RUC recommends a work relative value of 4.88 for new code 316X3.**

Practice Expense Inputs

The RUC understood that these procedures would only be safely performed in the facility setting and therefore did not recommend practice expense inputs in the non-facility setting. The RUC reviewed the specialty society recommended practice expense inputs for the facility setting carefully, and altered the clinical labor staff type and lowered the time, to be consistent to similar practice expense inputs of 000 day global bronchoscopy procedures that have been through the RUC process. The revised practice expense inputs are attached.

**Endovenous Ablation Therapy (Tab 8)**
**Bibb Allen, MD, American College of Radiology (ACR)**
**Zachary Rattner, MD, Society of Interventional Radiology (SIR)**
**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**
**Gary Seabrook, MD, Society for Vascular Surgery (SVS)**
**Facilitation Committee #2**

Current CPT codes describe the contemporary treatment of extremity venous reflux and varicose veins as surgical vein ligation and stripping, phlebectomy, and pharmacologic sclerotherapy. Newer techniques using either laser or radiofrequency devices under imaging guidance and monitoring are now being used. The CPT Editorial Panel created four new codes to describe these newer medical techniques.

The RUC reviewed the survey results for the new Endovenous Ablation Therapy family of codes and did not agree with the specialty society's survey results indicating a high work intensity of the intra-service time period. The procedures involve identifying and mapping the specific incompetent veins through ultrasound imaging, and carefully applying radiofrequency energy. The RUC believed the work intensity for the family more accurately reflected the work intensity of code 34501 *Valvuloplasty, femoral vein* (Work RVU = 15.98, August 2000, 2nd Five Year Review), and code 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (Work RVU = 6.99; 000 day global). The RUC believed that because of the ultrasound guidance involved, the injections of anesthetic agents, and the risk of nerve injury, the intensity of work was comparable to these two codes.

The RUC then developed a building block approach based on the intra-service work per unit of time for this family of codes. The RUC believed intra-service

work intensity of code 34501 was similar to 364X1, 364X2, and 364X4 of approximately 0.075. The work intensity of 0.075 was then used within a building block approach for these codes using the specialty society's surveyed physician time. For Code 364X3 a slightly higher intensity was used to account for the use of the laser, and the building block approach was applied. In addition, the RUC however recommended that for 364X2 and 364X4 the pre-service and post-service physician time components should be eliminated from the building block calculations, because specialty society's original CPT coding proposal did not account for the time. **The RUC recommends only the intra-service physician time reported on the specialty's survey results for ZZZ global codes 364X2 and 364X4**

The resulting building block approach indicated that the relative values of the family of codes were lower than the 25$^{th}$ percentile of the specialty society's surveyed values. The RUC was comfortable with the following building block approaches:

| ***Building Block Analysis*** | **364X1** | | **RUC Rec = 6.72** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| Pre-service eval & positioning | 50 | 0.0224 | 1.12 |
| Pre-service scrub, dress, wait | 15 | 0.0081 | 0.12 |
| ***Intra-service:*** | 60 | **0.075** | 4.50 |
| Immediate Post | 15 | 0.0224 | 0.34 |
| Post-Service Discharge Day | .5 | 1.28 | 0.64 |

| ***Building Block Analysis*** | **364X2** | | **RUC Rec = 3.38** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| ***Intra-service:*** | 45 | **0.075** | 3.38 |

| ***Building Block Analysis*** | **364X3** | | **RUC Rec = 6.72** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| Pre-service eval & positioning | 50 | 0.0224 | 1.12 |
| Pre-service scrub, dress, wait | 15 | 0.0081 | 0.12 |
| ***Intra-service:*** | 55 | **0.082** | 4.50 |
| Immediate Post | 15 | 0.0224 | 0.34 |
| Post-Service Discharge Day | .5 | 1.28 | 0.64 |

| ***Building Block Analysis*** | **364X4** | | **RUC Rec = 3.38** |
|---|---|---|---|
| | **Survey Data** | **RUC Std.** | **RVW** |
| | **Time** | **Intensity** | **(=time x intensity)** |
| ***Intra-service:*** | 45 | **0.075** | 3.38 |

Practice Expense Inputs
The RUC reviewed the practice expense inputs for this new family of codes, and made reductions to the clinical labor staff type and time to reflect the typical service. Medical supplies and equipment were adjusted as well. The practice expense inputs recommended by the RUC in the facility and non-facility settings are attached

**Gastric Restrictive Procedures (Tab 9)**
**Michael Edye, MD, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)**
**Christine Ren, MD, American Society of Bariatric Surgeons (ASBS)**
**Pre-Facilitation Committee #1**

CPT created three new codes to describe gastric restrictive procedures. The specialty presented only two of the codes and will present the remaining code in April. These two procedures, 4XXX4 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* and 4XXX5 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* achieve the same results as the open procedures 43846 *Gastric*

*restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy* (work RVU = 24.01) and 43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption* (work RVU = 26.88) but there is considerably less post operative pain for the patient and a less lengthy incision. Over the past 10 years, the field of bariatric surgery has rapidly expanded and the new codes revise and enhance the existing code set for bariatric surgery.

The presenters discussed code 4XXX5 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* first and stated that although the survey respondents chose the corresponding open codes 43846 and 43847 as the reference code, the presenters felt that a better comparison would be between the new codes and other laparoscopic codes. The presenters felt that the open codes may be misvalued and were not based on complete RUC survey data, while the laparoscopic codes do have complete RUC survey data. The presenters stated that code 4XXX5 is very similar in terms of breadth and depth and total work to another laparoscopic procedure, CPT 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (work RVU= 29.96). New code 4XXX5 involves dividing both stomach and small intestine and completing two anastomoses in the technically challenging surgical terrain of the morbidly obese. The pre-, intra-, and post-times and work are very similar to 44207. Also a value of 29.96 correctly places 4XXX5 greater than another similar laparoscopic code, 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04), which includes only one anastomosis. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 45 minutes was assigned to evaluation and 30 minutes for positioning. This would not change the total pre-service time. **The RUC recommends a physician work RVU of 29.96 for code 4XXX5.**

4XXX4 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* was reviewed in comparison to 4XXX5. The RUC agreed that code 4XXX4 has the same intraoperative complexity/intensity as 4XXX5 however, there is 20 minutes less intraoperative time. The presenters recommended an RVU of 27.83 based on subtracting 20 minutes of intraservice time (at an intensity of .106 from code 4XXX5) from the recommended value for 4XXX5 of 29.96 (20 x 0.106). This RVW correctly places new code 4XXX4 less than 4XXX5 and relative to 44207. The RUC agreed with this methodology. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 30 minutes was assigned to evaluation and 30 minutes for positioning. This would not

change the total pre-service time. **The RUC recommends a physician work RVU of 27.83 for code 4XXX4.**

Practice Expense Inputs:
The RUC recommended the standard inputs for a 90 day global period code that is performed only in the facility setting.

**Stapling Hemmorrhoidopexy (Tab 10)**
**David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)**
CPT created a new code 4694X Hemorrhoidopexy, *(e.g. for prolapsing internal hemorrhoids by stapling)* to describe the repair of hemorrhoidal prolapse utilizing a stapling technique because current CPT nomenclature does not accurately describe this procedure. This procedure is different than other internal hemorrhoidectomy codes, which involve either excision and suture ligation or rubber band ligation.
Although the survey responses met the minimum RUC standards, the presenters stated that the survey respondents estimated a relative value that was too high and would have created a rank order anomaly. The presenters argued that a value that was below the survey minimum value was necessary. The survey respondents chose code 46260 *Hemorrhoidectomy, internal and external, complex or extensive* (work RVU= 6.36) as the reference service but the specialty society consensus committee felt that the new code should be valued less that the reference code. The specialty society consensus committee reviewing the current survey agreed that new code 4694X is more complex and requires additional technical skill, compared with the treatment options such as 46221 *Hemorrhoidectomy, by simple ligature (e.g., rubber band)* (work RVU= 2.04) or *46255 Hemorrhoidectomy, internal and external, simple* (work RVU = 4.59). In terms of total work, 4694X fits well above 46221 and 46255, but below 46260. Although the survey's lowest value of 6.00 fit this rank order, the presenters stated that the specialty consensus committee believes that the resulting IWPUT of 0.086 would be inconsistent with other comparable codes. The specialty then calculated a relative value that would place the new code in proper rank order.

The intra-service work/intensity of the new code was believed to be .060 which was similar to intensities calculated for 45150 *Division of stricture of rectum (work RVU 5.66),* 38305 Drainage of lymph node abscess or lymphadenitis; extensive ( work RVU = 5.99), and 49585 *Repair umbilical hernia, age 5 years or over; reducible* (work RVU = 6.22) Utilizing an IWPUT of 0.060 which is similar to these three codes, an RVW of 5.20 was calculated based on a total time of 168 minutes. Other CPT codes with similar total time and/or intra-service time/work were reviewed such as 43244 *Upper GI endoscopy w-esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices* (work RVU = 5.04 and total time = 147 minutes) also code 58600

*Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (work RVU = 5.57, total time = 164). The RUC agreed that a value of 5.20 would place 4694X in a correct "total work" relative position to 46221, 46255, and 46260. This value also correlates well to the intra-service intensity of 45150, 38305, and 49585. **The RUC recommends a work RVU of 5.20 for code 4694X.**

Practice Expense Inputs:
The inputs approved by the RUC are the standard inputs for a 90 day global period code performed only in the facility setting. The RUC also approved some additional supplies for the post operative office visits.

**BSO Omentectomy with TAH for Malignancy (Tab 11)**
**Barbara Goff, MD, Society of Gynecologic Oncologists (SGO)**
**George Hill, MD, American College of Obstetricians and Gynecologists (ACOG)**
**Sandra Reed, MD, American College of Obstetricians and Gynecologists (ACOG)**

The CPT Editorial Panel created a new code to describe a bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy, a procedure for women who do not need to have lymph node dissection for staging because the disease has already spread intra-abdominally.

589XX
It was determined by the RUC that the work associated with the new code 589XX *Bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy* is less intense than that of the work associated with the reference code 58953 *Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking* (Work RVU=31.95) The survey median value of 25.00 RVU was not consistent with the values of other related codes. By using a building block approach, the RUC approved the specialty society recommendation of 20.78 for 589XX. This recommendation was formulated by adding the work of two previously RUC reviewed codes, 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)* (Work RVU=15.22) and half of the work associated with 49255 *Omentectomy, epiploectomy, resection of omentum (separate procedure)* (Work RVU=11.12). The office time/visits were modified to include three 99213 visits. **The RUC recommends a work relative value of 20.78 for 589XX.**

When the RUC decided the work RVU for 589XX it took into consideration that this included only *bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy*. The CPT

Editorial Panel Executive Committee voted to accept this recommended revision to the new code 589XX, to preclude reporting this code for those procedures in which partial omentectomy procedures are performed.

Practice Expense Inputs:
The RUC reviewed and modified the practice expense inputs for 589XX. The post-op visits were changed to three, 99213 visits and a post-op incision care kit was added. The RUC recommends the practice expense inputs as defined in the attached spreadsheets, for this facility-based service. No practice expense inputs were recommended in the non-facility setting.

**Vaginal Extra and Intraperitoneal Colpopexy (Tab 12)**
**Robert Harris, MD, American Urogynelogical Association (AUGS)**
**George Hill, MD, American College of Obstetricians and Gynecologists (ACOG)**
**Sandra Reed, MD, American College of Obstetricians and Gynecologists (ACOG)**

The CPT Editorial Panel revised an existing code and created a new code to describe vaginal extra and intraperitoneal colpopexies, procedures that describe the suspension of the apex of the vagina in women with prolapse of the vaginal vault apex via an extraperitoneal approach (outside the peritoneum) or an intraperitoneal approach (inside or within the peritoneum).

57282
The RUC considered changes made to 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* (Work RVU=8.85), and considered these changes to be editorial since this revision intended to more accurately describe the physician work involved in code 57282. **The RUC recommended maintaining the current work relative value of 8.85 for 57282**.

572XX
The RUC reviewed the survey results for 572XX *intra-peritoneal approach (uterosacral, levator myorrhaphy)*. The survey respondents indicated that this procedure is more complex, requires more mental effort, technical skill and psychological stress than its reference service code, 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* (Work RVU=8.85). In addition, 572XX requires more time to complete (335 minutes total time) than its reference code 57282 which has a total time of 240 minutes. The RUC noted that 572XX requires 25 more minutes of intra-service work. In addition, the pre-service work for 572XX is more work as it includes an examination of the vaginal defect. The RUC agreed that the median RVU was appropriate and reflected the differences in work with the reference service. **Therefore, the RUC recommends the median 14.00 work RVU for 572XX.**

Practice Expense Inputs:
The RUC reviewed the practice expense inputs for 572XX. These inputs were assessed and the RUC agreed that they met PEAC accepted standards of clinical labor time, supplies and equipment. The RUC recommends the practice expense inputs as defined in the attached spreadsheets.

**Pediatric-Specific Immunization Administration (Tab 13)**
**Steven Krug, MD, American Academy of Pediatrics (AAP)**

The CPT Editorial Panel has created four new pediatric immunization administration codes to identify these services when provided to patients under eight years of age. In addition to differentiating these services from the existing CPT codes 90471 – 90474, which also describe immunization administration, the Panel editorially revised these codes to exclude "jet injections." The clinical vignettes for these existing services have been revised to describe patients older than eight years of age.

The RUC has reviewed immunization administration on multiple occasions, including our May 1999 and February 2001 meetings. In addition, the RUC has submitted formal comments to CMS requesting the publication of work relative value units for these services. We have attached our prior recommendations and comments to this submission and reiterate our position that there is indeed physician work involved in the administration of vaccines. The RUC has reviewed the new CPT codes 9047X1-9047X4 for immunization administration provided to children under eight years of age and recommends that the RUC's previous recommendations for physician work, time, and direct practice expense inputs be adopted for these new services.
**The recommended work relative values and physician time elements are as follows:**

| CPT Code | Descriptor | Work RVU | Intra-Time | Crosswalked from Code |
|---|---|---|---|---|
| **9047X1** | **Immunization administration under 8 years of age(includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day** | **0.17** | **7** | **90471** |
| **9047X2** | **each additional vaccine** | **0.15** | **7** | **90472** |
| **9047X3** | **Immunization administration under age 8 years(includes intranasal or oral routes of administration) when the physician counsels the patient/family; first** | **0.17** | **7** | **90473** |

| | | | | |
|---|---|---|---|---|
| | **administration (single or combination vaccine/toxoid), per day** | | | |
| **9047X4** | **each additional vaccine** | **0.15** | **7** | **90474** |

Practice Expense Inputs:
The direct practice expense inputs for these new codes are crosswalked from the existing codes, which have been through the refinement process in February 2001 and March 2002 at the Practice Expense Advisory Committee (PEAC) meetings. The recommended practice expense direct inputs for the new codes are attached to this recommendation.

**Gastroesophageal Reflux Procedures and Esophagus – GE Junction Impedance Test (Tab 14)**
**Joel Brill, MD, American Gastroenterological Association (AGA)**
**Michael Levy, MD, American Society for Gastrointestinal Endoscopy (ASGE)**
**Facilitation Committee #2**

CPT created four new codes and deleted two existing codes to describe a new method of monitoring intra-esophageal pH levels. This new technology is a telemetry-based system for measuring acid reflux involving the placement of a monitoring capsule that is temporarily inserted and attached to the patient's esophagus. The capsule monitors the presence of acid and transmits pH levels via radiofrequency telemetry to an external receiver that the patient wears for up to 72 hours. Current codes do not accurately describe this procedure.

The RUC voted that this family of codes should have a 000 day global period rather than an XXX global period requested by the presenters. The RUC was unconvinced that the codes included physician intra-service work for the placing of the catheter and concluded that this is included in the clinical staff work for three of the four codes. For these codes, 9103X0, 9103X2, and 9103X3, only pre-service and post-service physician work should be included in the value of the code.

9103X0 and 9103X2
The RUC identified other codes that would serve as a proxy for the pre and post service work for codes 9103X0 *Esophagus, gastroesophageal reflux test, with nasal catheter pH electrode(s); recording, analysis and interpretation* and 9103X2, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s), recording, analysis and interpretation*. The RUC agreed that the preservice work for all four codes under review was equivalent to a 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= .45; total time=15 minutes). The post service work was equated to the physician interpretation work associated with code 93224 *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning*

*analysis with report, physician review and interpretation* (work RVU= .52; total time16 minutes). Therefore, the recommended RVU and physician time would be a combination of the values from these two reference codes (.45 + .52 = .97 and 15 minutes + 16 minutes =31 minutes). **The RUC recommends a work RVU of .97 and total physician time of 31 minutes for codes 9103X0 and 9103X2**

9103X3

For code 9103X3 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s), recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* a slightly higher value is warranted since it describes prolonged monitoring. The RUC agreed that an extra 10 minutes of monitoring time is typically needed for this procedure. The value assigned was determined to be 25% of the value of the reference code used previously for the post service work, code 93224 (.25 x .52rvu = .13). The total value would be .97 + .13=1.10. **The RUC recommends a work value of 1.10 and total physician time of 41 minutes for code 9103X3.**

9103X1

For code 9103X1 *Esophagus, gastroesophageal reflux test, with mucosal attached telemetry pH electrode, recording, analysis and interpretation* the RUC agreed that the physician typically places the catheter and therefore this code should include a physician work value reflecting this activity. The pre and post service work for this code is the same as codes 9103X0 and 9103X2 for a total work RVU of .97. The RUC concluded that the intra-service work time should equal 20 minutes as the survey results indicated and the intensity would be equivalent to E/M intensity at .031 for an RVU of .62 (20 x.031). **The RUC recommends a work RVU of 1.59 and total physician time of 51 minutes for code 9103X1.**

Practice Expense Inputs:

The RUC revised the practice expense direct inputs by reducing the clinical labor times for certain activities to better reflect current standards

**ECG Vest (Tab 15)**

**James Blankenship, MD, American College of Cardiology (ACC)**

The CPT Editorial Panel created code 937XX *Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events.* The specialty indicated that they did not have a sufficient sample size of physicians who had been trained with this product to ensure a successful RUC survey validation for the September 2003 RUC meeting. In February 2004, the specialty indicated that they attempted a

survey of 75 physicians, whose contact information had been provided by the manufacturer of the ECG vest. However, only ten physicians responded to the survey. Those that responded indicated that they had minimal experience with the service (1 to 5 services performed within the year). The specialty requested that the RUC recommend that the service be carrier priced. The RUC, however, was concerned that based on the few number of physicians who are actually providing this service, that this should be described as a Category III CPT code. *At a subsequent meeting of the CPT Editorial Panel, the Panel agreed with the specialty to implement the code as a Category I.* **The RUC offers no recommendation for this service.**

**Intracranial Artery Transcranial Doppler Studies (Tab 16)**
**James Anthony, MD, American Academy of Neurology (AAN)**
**Gary Seabrook, MD, Society for Vascular Surgery (SVS)**
**Charles Tegeler, MD, American Academy of Neurology (AAN)**
**Practice Expense- Facilitation Committee #1**

The CPT Editorial Panel created three new codes to describe a cerebrovascular reactivity test and an emobolus detection monitoring test not provided for in the standard complete transcranial doppler examination.

9389X1
The RUC reviewed the survey results for code 9389X1 *Transcranial Doppler study of the intracranial arteries; vasoreactivity study.* The survey respondents indicated that this new service described in 9389X1 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition, the total time for the surveyed code (35 minutes) is longer than that of the reference code (25 minutes). Therefore, the RUC agreed with the specialty societies' recommendation of the survey median for 9389X1. **The RUC recommends a work relative value for 9389X1 of 1.00.**

9389X2
The RUC reviewed the survey results for 9389X2 *Transcranial Doppler study of the intracranial arteries; emboli detection without IV microbubble injection*. The survey respondents indicated that this new service described in 9389X2 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition the total time for the surveyed code (40 minutes) is longer than that of the reference code (25 minutes). Therefore the RUC agreed with the specialty societies' recommendation of the survey median for 9389X2. **The RUC recommends a work relative value for 9389X2 of 1.15.**

9389X3

The RUC reviewed the survey results for 9389X3 *Transcranial Doppler study of the intracranial arteries; emboli detection with IV microbubble injection.* The survey respondents indicated that this new service described in 9389X3 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition the total time for the surveyed code (40 minutes) is longer than that of the reference code (25 minutes). Although the survey median was 1.00 RVUs, the specialty societies advised the RUC that this survey median was inappropriate because it would lead to a rank order anomaly. This rank order anomaly is illustrated in the IWPUT calculations. Using the societies' recommended RVU and survey times, the specialty societies calculated the IWPUT for the new codes: 9389X1 – 0.0368, 9389X2 – 0.0351 and 9389X3 – 0.0351. Using the survey median RVU and survey times, the IWPUT for the codes would be 9389X1 – 0.0368, 9389X2 – 0.0351 and 9389X3 – 0.0276.

| CPT Code | IWPUT Using the Survey Median and Survey Times | IWPUT Using the Societies' Recommended RVU and Survey Times |
|---|---|---|
| 9389X1 | 0.0368 | 0.0368 |
| 9389X2 | 0.0351 | 0.0351 |
| 9389X3 | 0.0276 | 0.0351 |

The societies demonstrated and the RUC agreed that the median survey times for 9389X2 and 9389X3 are the same and they have similar intensity and complexity. Therefore, the RUC recommended the same work value for 9389X2 for 9389X3**. The RUC recommends a work relative value for 9389X3 of 1.15.**

The RUC when reviewing these codes was informed by the specialty society that the new codes would never be billed with 93888 *Transcranial Doppler study of the intracranial arteries; limited study*. Therefore, a request was made to the CPT Editorial Panel to add a parenthetical note to this section to preclude reporting codes 9389X1-9389X3 in addition to code 93888.

Practice Expense Inputs:
The RUC reviewed the practice expense inputs for 9389X1, 9389X2 and 9389X3. These inputs were modified to reflect PEAC accepted standards of clinical labor time, supplies and equipment. The RUC recommends accepting the practice expense inputs as defined in the attached spreadsheets

**High Altitude Hypoxia Simulation Test (Tab 17)**
**Scott Manaker, MD, American College of Chest Physicians (ACCP)**
**Alan Plummer, MD, American Thoracic Society (ATS)**
**Facilitation Committee #3**

CPT created two new codes to accurately describe a high altitude simulation test (HAST). To identify patients at risk of hypoxia during routine commercial flights, (HAST) was developed almost 20 years ago, however there isn't a code to describe the test. The presenters explained that HAST is now routinely performed in many hospital pulmonary function laboratories and in large group practices; and all commercial airlines have policies and procedures for providing in-flight supplemental oxygen to patients based upon the results of HAST. As a result of more widespread use, code 94XX1 *High altitude simulation test (HAST), with physician interpretation and report* and code 94XX2 *High altitude simulation test (HAST), with physician interpretation and report; with supplemental oxygen titration* were created.

The RUC examined these codes in detail and focused on identifying existing codes with similar physician work to serve as reference points. The RUC discussed the physician work involved in 94XX1 and concluded the work was less than the reference code 94450 *Breathing response to hypoxia (hypoxia response curve)* (work RVU=.40). However, the RUC agreed that this was an appropriate reference for 94XX2. The RUC also identified other services that had work similar to 94XX1. In particular the RUC agreed that code 94060 *Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)* (work RVU = .31) was similar to 94XX1. Also examined was code 94240 *Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method* (work RVU=.26) The RUC agreed that 94XX1 had more physician work and time in comparison to 94240. In particular there is more physician skill and stress due to the possibility of risk to the patient. Code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU=.30) also was felt to have similar physician work. The RUC concluded that the code 94060 (work RVU = .31) was the best reference and code 94XX1 should have the same work value as 94060. This value would also place the code in proper rank order with the other codes used as references.

**The RUC recommends a work RVU of .31 for code 94XX1.**

After examining the work involved in 94XX1 the RUC agreed that 94XX2 should be valued at a higher RVU and agreed with the original recommendation of .40, which is the 25$^{th}$ percentile survey value. This value is also the same as the survey reference code of 94450 *Breathing response to*

*hypoxia (hypoxia response curve)* (work RVU=.40), which the RUC thought was an appropriate code comparison.

**The RUC recommends a work RVU of .40 for code 94XX2.**

Practice Expense Inputs:
The RUC reviewed the practice expense inputs and made minor adjustments to the clinical labor activities to remove any duplication with physician work and added equipment required for performing these tests. The RUC recommends zero practice expenses in the facility setting.

**Central Motor Evoked Potential Study (Tab 18)**
**James Anthony, MD American Academy of Neurology**
**Jaime Lopez, MD, American Academy of Neurology**
**American Clinical Neurophysiology Society**
**American Association of Electrodiagnostic Medicine**

The CPT Editorial Panel created two new codes 959X1 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* and 959X2 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* to describe the procedure of transcranial electrical motor stimulation. The RUC understands that these services would not typically be performed on the same day. The RUC reviewed survey data from over 30 physicians who perform this procedure, who indicated that these new services described in 959X1 and 959X2 are more intense and complex than the selected reference service, 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (Work RVU=0.96). In addition, while 959X1 and 959X2 had an intra-service time of 60 minutes and 55 minutes respectively, the reference services code, 95860, had an intra-service time of 34 minutes. Due to the greater intensity and extensively longer intra-service time of the two surveyed codes, the RUC agreed with the specialty societies' recommendation of the survey median for both of these new procedures. **The RUC recommends a work relative value of 1.50 for both 959X1 and 959X2.**

Practice Expense Inputs:
The RUC reviewed in great detail the practice expense inputs of 959X1 and 959X2. When reviewing the clinical labor time, there was some concern expressed by the RUC about coil and electrode placement. The societies informed the RUC that while the physician applies head coils to the brain to stimulate the hand region of the cortex or the leg region of the cortex, the technologist is applying electrodes to the head and peripheral locations including the hand or the leg. The RUC also questioned the intra-service times of the clinical labor. The specialty society explained that the clinical labor is assisting the physician for the entirety of the physician intra service time (60 minutes for 959X1 and 55 minutes for 959X2). However, in addition

to these times, the specialty society has recommended an additional 8 minutes for 959X1 and 23 minutes for 959X2 to initiate a baseline nerve conduction study. The RUC agreed with this rationale and determined that it was best to separate this baseline nerve conduction study from the intra-service time. In addition the RUC modified the specialty societies' recommended medical supplies to reflect the addition of a multi-specialty supply package and a laser printer. The RUC approved the revised practice expense inputs, which are attached to the recommendation for these codes.

X. Special Requests from CMS

**Excision of Benign and Malignant Lesions (Tab 19)**

In *CPT 2003*, the CPT Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646 utilizing the size of the actual skin removed, rather than the size of the lesion only. The RUC then reviewed a proposal from the specialties who perform these services to adjust the work relative values for work neutrality only. CMS agreed with this approach and published the RUC's recommendations in the Final Rule for the 2003 Physician Payment Schedule.

However, in *Proposed Rule* for the 2004 MFS, CMS indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units. The RUC and several specialties commented in opposition to this proposal and requested CMS to seek additional input on this issue. In the *Final Rule* for the 2004 MFS, CMS agreed to postpone consideration of this issue until the specialties had opportunity to survey these codes and present data to the RUC.

The specialties provided an update to the RUC at the February 2004 meeting. The specialties indicated that they plan to survey a representative number of codes from each family of codes to offer evidence that there is a difference in physician work between the excision of benign and malignant lesions. The RUC extensively discussed this issue and raised a number of issues including whether pathology is known prior to the excision and if coding changes would be appropriate to change benign/malignant to superficial/deep. The RUC approved a methodology where the societies would survey one benign and malignant code from each of the three anatomic families (six codes total) to answer the question whether there is a difference in work or not. This survey data will be presented to the RUC at the April 2004 meeting.

**End Stage Renal Disease Services (Tab 20)**

In the *Final Rule* for the 2004 MFS, CMS finalized its proposal to make CPT codes 90918, 90919, 90920, and 90921 invalid for Medicare and to create G codes to replace these CPT codes. In this *Final Rule*, CMS requested the

RUC to review the relative value for these new G codes. The RUC has urged CMS to work with the specialty, CPT Editorial Panel, and the RUC toward a long-term solution that involves the input of all appropriate entities.

Emily Paganini, MD, RUC Advisor representing the Renal Physicians Association (RPA), met with the RUC to discuss this issue. Doctor Paganini provided an overall history of the CPT codes for end stage renal disease services and the capitated payment policies for these services. He also reviewed the RUC's previous review of these services. Doctor Paganini explained the new system, based on these new G codes, which is essentially a graded capitated payment system, dependent upon the number visits with the dialysis patient. He emphasized that CMS had developed this system without the advice of nephrology. In follow up to CMS proposal, numerous organizations commented that CMS should not finalize and implement this new system without more significant input from the specialty. Doctor Paganini emphasized many of the flaws in this new payment system and cautioned that CMS may attempt to carry this type of graded payment system forward to other specialties (eg, dismantling the global periods for surgical services).
The specialty recommends that the RUC not consider evaluating the valuation of the G codes until RPA can establish the service and find what the resources (work and practice expense) inputs are in these services. RPA also asks for the RUC's continued support of restoring the CPT coding system until all of the issues have been more fully discussed with the physicians who perform these services.

RUC members asked Doctor Paganini if the number of face-to-face encounters between physician and dialysis patient had decreased since the time that the RUC had initially reviewed these services. Doctor Paganini acknowledged that the number of physician/patient encounters had declined. However, mid-level practitioners employed by the nephrologists have replaced some of these encounters and in most cases; the patients have more interaction with either the physician or the mid-level practitioner. It was noted that the previous RUC recommendation was not based on the number of visits alone, but the overall care of the patient for the month. RUC members again raised concern that CMS perceived a payment issue and rather than working through existing process, used quality as a justification to make changes in the system without seeking input of the medical profession.

Doctor Ken Simon discussed the decision making policy and deliberations that occurred within CMS in proposing this new system. He also indicated that although CMS had requested the RUC to review the valuation of the G codes in the Final Rule, CMS would now request a deferral of this review until these G codes and the policies surrounding their implementation are further refined. CMS will contact the RUC when it is appropriate to seek the

RUC's input. The RUC, therefore, will not comment further on this issue at this time.

XI. Five-Year Review Workgroup Report

Doctor Meghan Gerety presented the report of the Five-Year Review Workgroup. The workgroup met via conference call on December 17, 2003 and face-to-face on January 29, 2004. The Workgroup considered a number of different issues, including: development of compelling evidence standards; finalization of a time-line for the review; and other procedural issues. The workgroup will finalize a proposal to CMS at the April meeting and this document will be submitted in late April.

The workgroup discussed the development of a uniform list of compelling evidence standards. The RUC reviewed this list of compelling evidence standards and made minor changes to the document. Several RUC members cautioned that reviewers must consider relative changes in data points such as length of stay, rather than just pick an individual CPT code that has a change since the initial evaluation. The following recommendations were approved by the RUC:

- **A draft list of compelling evidence standards that will be circulated for review and potentially modified prior to the April RUC meeting.**

- **The RUC should request that CMS include the RUC compelling evidence standards in its notice of proposed rule making announcement.**

- **The RUC should request that CMS specify the format of comment letters to include documentation of compelling evidence and other items recommended in the RUC's proposal to CMS.**

- **CMS should review and screen comment letters to make sure that they meet minimal standards regarding compelling evidence prior to submission to the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted.**

- **The existing work relative value for the code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.**

The Workgroup considered comments regarding the timeline of the five-year review and has finalized their review.

**The RUC approved timeline for the Five-Year Review and recommends inclusion in the Proposal on the Five-Year Review currently under development.**

The workgroup discussed the Appeals processes and agreed that they currently provide appropriate flexibility for the specialty societies. However, the Workgroup recommends that the RUC formalize changes in procedure prior to the initiation of the next Five-Year Review, including:

- **All specialties will have equal opportunity to collect and present data to the Workgroup meetings in August 2005. Specialties will not be provided with additional opportunity to collect new data following these meetings.**

- **A change in the voting rules is recommended for the consent calendar process. The current procedure states "The item initially on the table for each code will be the workgroup's recommendation." The RUC recommends that this be re-stated to read "If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value to be voted upon."**

- **The RUC also recommends a change in assignments to Facilitation Committees. The procedures currently state, "If a facilitation committee is needed for an issue, the issue will be referred to a workgroup other than the one to which it was originally** assigned**. This facilitation committee may be augmented with other specialty or HCPAC members as appropriate." In accordance with comments following the previous Five-Year Review that it was disruptive to require a specialty to re-present their entire argument to a new group of individuals, the RUC recommends that the procedures be changed to read, "If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the society, the workgroup, or the RUC chair.**

- **The RUC does not recommend an automated screening process be used in the third Five-Year Review. However, the Five-Year Review Workgroup will convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.**

**The approved Five-Year Review Workgroup Report, draft list of compelling evidence standards, and timeline are attached to these minutes.**

XII. Professional Liability Insurance Workgroup Report

Doctor Greg Przybylski presented the report of the Professional Liability Insurance (PLI) Workgroup. Doctor Przybylski reviewed action items from the September meeting. He indicated that CMS will not use the RUC's recommendation to use estimated 2004 data to compute the PLI geographic practice cost indices (GPCIs) and will continue to use a three year rolling average; CMS has indicated that tail coverage is included in the PLI costs; (*Staff Note: CMS has retracted this statement as tail coverage has not been included)* CMS also indicated that they had asked their contractor to review the RUC's suggested dominant specialty approach in using utilization data. He also said that CMS continues to be open regarding other data available on PLI premium data. He noted that the RUC has requested, and would still like, information from CMS on what their standards are regarding these data.

CMS has shared the PLI premium data utilized in computing the new PLI GPCIs with the RUC. The RUC had several questions regarding this data, including the absence of anesthesiology and obstetrics from these data. Mr. Rick Ensor indicated that he would review this issue and provide further information to the RUC at the April meeting.

Doctor Przybylski also noted that the CMS has promised to share the report from their contractor on the Five-Year Review of the PLI relative values. He also explained that CMS utilizes risk factors based on the surgical versus non-surgical risk factor categories. In general, CMS assumes that all CPT codes in the 10000-69999 series are surgical and all other codes are in the non-surgical category. However, CMS does allow certain "special cases" in the assignment of risk factors.

**AMA staff will circulate the PLI contractor report, including the current methodology for assigning risk factors to each CPT code, to all RUC participants. RUC participants will have the opportunity to review this information and provide comment to the PLI Workgroup for consideration at a future meeting.**

A question arose regarding the assignment of risk categories for anesthesia services and more generally, the approach that CMS employs to evaluate the anesthesia relative values for these services. Mr. Ensor indicated that he would send additional information regarding this methodology to the AMA. **The PLI Workgroup Report was approved and is attached to these minutes.**

XIII. PEAC Transition Workgroup Report

Doctor Moran presented the PEAC transition Workgroup report. The workgroup was charged with identifying possible ways for the PEAC members to participate in RUC meetings to assist in the review of practice expense direct inputs. The workgroup felt that the RUC could benefit from the expertise that the PEAC has gained over the last few years. One option that the RUC should explore is having a subset of PEAC members attend each RUC meeting and be assigned to facilitation committees. This way the PEAC members can assist in reviewing the direct inputs for the new and revised codes. While the details of the PEAC member participation will need to be worked out in the future, the workgroup felt that this would be a good start at integrating PEAC members into the RUC process. The workgroup made the following recommendation to the RUC:

**A subset of PEAC members would meet via conference call before each RUC meeting to identify codes that may have practice expense issues that need to be addressed. AMA staff would convey the PEAC concerns to the appropriate specialty societies and ask specialties to respond by revising the practice expense inputs or to resolve the issue through a prefacilitation committee comprised of PEAC and RUC members. Several PEAC members will then be assigned to each RUC facilitation committee. They would be members of the committee specifically to review the practice expense issues for codes sent to either pre-facilitation or facilitation.**

Doctor Rich complemented Doctor Moran and the PEAC members for making the practice expense project such a success. Doctor Rich acknowledged that the RUC has responsibility for evaluating the practice expense for new and revised codes and will continue to refine the methodology for conducting this review. Doctor Rich added that the RUC has three objectives concerning PE issues and they are to review the inputs for new/revised codes, develop PE policies, and determine how to review those codes that the PEAC has not refined. **The PEAC Transition Workgroup Report was approved and is attached to these minutes.**

XIV. Multi-Specialty Points of Comparison Report

James Blankenship, MD, Chair of the Multi-specialty Points of Comparison (MPC) Workgroup, presented a report that was generated from a conference call on January 20, 2004 and a face-to-face meeting on January 29, 2004.

The Research Subcommittee had requested the MPC Workgroup solicit specialty societies regarding their desire to have the specialty's 090 day global period codes that have RUC time available (Type A codes) listed with the

intra-work per unit time (IWPUT) data point listed on the MPC. The MPC workgroup received comments from the following specialties to NOT list the IWPUT for their services:

| | |
|---|---|
| **American Academy of Ophthalmology** | **Do NOT include IWPUT** |
| **American Society for Therapeutic Radiation Oncology** | **Do NOT include IWPUT** |
| **American Urological Association** | **Remove IWPUT for 53850 and 50590** |

**The RUC noted that a previous action at the September 2004 allowed specialties to exclude the IWPUT for these services and therefore, these individual requests will be honored. The remaining CPT codes with 90 day global periods and RUC time (Type A) will have the IWPUT listed on the MPC list. This list will be used for RUC internal purposes only and will not be shared outside the RUC process.**

The MPC Workgroup discussed the MPC in relation to the next Five-Year Review of the RBRVS. The RUC adopts the following recommendations from the workgroup:

**The RUC recommends that all specialties review the MPC before the September 2004 RUC meeting.**

**The RUC recommends that specialties be encouraged to replace MPC codes that have not been reviewed by the RUC (Type B or C) with codes that have been RUC surveyed (Type A), where possible.**

The RUC also approved a series of improvements to the MPC as follows:

**The RUC recommends adding the date at which each code was last RUC reviewed to the information on each code in the MPC list.**

**The RUC recommends that the MPC should be ordered and presented in two ways: 1) by CPT Code order; and 2) by global period, then work value in ascending order.**

**The RUC recommends that the MPC in the database form be included in the Agenda CD for each RUC meeting.**

The MPC Workgroup also discussed ways to better incorporate the MPC into the RUC work valuation process and the RUC approved the following:

**The RUC should request that specialty societies include, in their Summary of Recommendations for new codes, comparisons of RVU recommendations for new codes against codes with the same global**

**periods from the MPC list. Reference codes from the MPC list should be chosen that have RVUs higher and lower than the requested RVUs for the code under review. This requires a revision in the Summary of Recommendation form by the Research Subcommittee.**

**The RUC should request that each Facilitation Committee Report include at least one comparison a code on the MPC. The MPC Workgroup Report was approved and is attached to these minutes.**

XV. Ad Hoc Pre-Time Workgroup

Doctor Topping presented the report of the RUC Ad Hoc Pre-Time Workgroup. Doctor Topping stated that the CMS and RUC definitions of pre-service time do not reflect the current practice of medicine where patients are admitted the day of surgery, not the day before. The workgroup agreed that the pre-service time definition should change to begin from just after the final decision for surgery rather than the day before surgery or the day of surgery. The workgroup felt that this definition should apply to 000, 10, and 90 day global periods. Several RUC members expressed concern that this change in the pre-service time definition would make it more difficult for physicians to separately bill for E/M visits that occur between the decision for surgery and the procedure.

It was argued that changing the definition would then require numerous surgical codes to be revaluated to account for the significant amount of physician work that occurs before the surgery and that is now sometimes separately billable. There are a variety of codes that may require several visits before surgery to counsel the patient and discuss options. The RUC members discussed this issue further and felt that these would be separately billable visits because the decision for surgery is not finalized until all options are discussed and finalized. Therefore, when the final decision for surgery is made by the physician, the pre-service time should begin. To better account for the physician work that occurs after the decision for surgery until the time of the procedure, the RUC passed the following recommendation:

**The RUC requests CMS to change the pre-service definition for 000, 010, and 090 day global periods to the following: The pre-service period includes physician services provided following the visit at which the decision for surgery is finalized until the time of the operative procedure. A letter was sent to CMS on March 5, 2004 and is attached to these Minutes. The Ad Hoc Pre-Time Workgroup Report was approved and is attached to these minutes.**

XVI. Administrative Subcommittee Meeting Report

Doctor John Mayer presented the Administrative Subcommittee report to the RUC. The Administrative Subcommittee met to address two issues. The first issue was the review and final approval of Rotating Seat and Election Rules policy. The final approval of Administrative Subcommittee was tabled at the last meeting pending review from the AMA Legal department to determine if these rules are consistent with Preferential Voting as described in Sturgis Fourth Edition. The Administrative Subcommittee was advised by AMA staff that in fact these two documents are in agreement. These documents are attached to this report. The Subcommittee gave final approval of these rules.

**The RUC approved the Rotating Seat and Election Rules Policy**

The second issue addressed by the Administrative Subcommittee was the request made by Medicare Carrier Medical Directors (CMD) to provide them with RUC database CD. The subcommittee reached a consensus that the RUC should engage in a dialogue with the Medicare CMDs, which might include attendance by one or more of RUC members at Medicare CMD Meeting. This meeting would allow the RUC to voice its concern to the CMDs about the RUC database's potential for use and misuse.

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

XVII. Research Subcommittee Report

Doctor James Borgstede presented the Research Subcommittee Meeting Report and discussed the three action items presented to the RUC for approval. Doctor Borgstede discussed the first issue pertaining to adding a question on conscious sedation to the RUC survey instrument and the summary of recommendation form. This will allow the RUC to identify those codes that typically use conscious sedation as an inherent part of the procedure**.** The intent is to add a new question 6 and change the numbering of the remaining questions.

**The RUC agreed to add the following question to the RUC survey:**

**BACKGROUND FOR QUESTION 6**

Conscious sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal or intranasal routes. For purposes of the following question, sedation and analgesia delivered separately by an anesthesiologist or other anesthesia provider not performing the primary procedure is not considered conscious sedation.

**QUESTION 6: Do you or does someone under your direct supervision typically administer conscious sedation for these procedures?**

New/Revised Code Yes ❒ No ❒ Reference Code Yes ❒ No ❒

**The RUC also agreed to add the following questions to the summary of recommendation form:**

**Does your reference CPT code selected for physician work serve as a reasonable reference for a PLI crosswalk?**
Yes ❒ No ❒

**If no, please select another crosswalk and provide a brief rationale.**

The second issue was a recommendation to add a question on PLI crosswalks and risk factors to the summary of recommendation form. The RUC approved without discussion the following questions:

**Indicate what risk factor (e.g., surgical, non-surgical) the new/revised code should be assigned to determine PLI relative value.**

The RUC also approved without discussion the following recommendation regarding the reference service lists.

**The reference service lists should be provided to survey respondents in either ascending CPT code order, or ascending RVU order, or both code and RVU order.**

Finally, several RUC members discussed the development and maintenance of reference service lists. There was a concern that RUC members had various understandings as to the ability of specialty societies to adjust the reference service lists. It was reported that some members were of the understanding that the reference service lists could not be changed while others understood that the specialties could change the lists depending on the code being surveyed. It was suggested that this issue needs to be examined in the future

to balance the needs for consistency with the needs of having a relevant reference service list.

In the RUC survey instructions there is language directing specialties to contact RUC staff if the specialty needs to change the codes on the reference service list. However, in recent years many specialties have maintained their own reference service lists and the AMA no longer maintains specialty society reference lists. Additionally, the RUC's standard methodological requirements state that:

> Any specialty involved in developing relative values for physician work RVW must, therefore, begin by developing a list of reference services from the current Medicare RVS. This list of reference services should include a broad range of services and RVWs for the specialty. Services on the list should be those which are well understood and commonly provided by physicians in the specialty. In developing its recommendations, the society or its RVS committee should determine which key reference services were used by survey respondents to rate the new or revised codes and the key reference service should be clearly understood and described to the RUC.

It was noted that this does not imply that the AMA maintains the reference service lists but states that a specialty should develop a list. The RUC survey instructions then explain how to change the list. It was suggested that the process needs to be reviewed by the research subcommittee. Other RUC members felt that the issue of the development of reference service lists should be left up to the specialty to select those codes that are relevant for the particular survey.

The RUC approved the following recommendation:

**The RUC Research Subcommittee will review the language related to the development and maintenance of reference service lists that is contained in the RUC's survey instructions and the RUC's standard methodological requirements and propose a revision to clarify the issue of development and maintenance of reference service lists. The Research Subcommittee Report was approved and is attached to these minutes.**

XVIII. Practice Expense Subcommittee Report

Doctor Robert Zwolak presented the Practice Expense Subcommittee Report. The Practice Expense Subcommittee met to discuss the allocation of physician time components, two practice expense methodologies used by CMS, and the removal of survey data in the RUC database.

**Physician Time Allocations**

For this meeting, AMA staff obtained physician time allocations for 4 CPT codes. RUC members first reviewed two surveyed codes presented by the American Burn Association, American Society of Plastic Surgeons, and American Podiatric Medical Association. The RUC believed that the total time being presented, 173 minutes for CPT 15342 and 77 minutes for CPT 15343, did not equate to the physician work value, of 1.0 and 0.25 respectively. RUC members rejected the time components recommended by the specialty societies and recommended the following to the RUC for approval:

**The RUC recommends that the specialty society should request that CMS make a recommendation concerning the global period and the society consider performing a full RUC survey for codes 15342 and 15343. This review includes physician time and work recommendations. In addition, the two codes will be taken off the March 2004 PEAC agenda.**

The RUC also reviewed two other codes presented by the society of American Academy of Otolaryngology – Head and Neck Surgery. The RUC agreed with the specialty's time allocation. This time allocation is shown below.

| | | | | "PR" total time split | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Hosp Visits (992-) | | | | Office Visits (992-) | | | | |
| CPT | Descriptor | glob | "PR" Time | pre time | intra time | Im-SD | 33 | 32 | 31 | 38 | 15 | 14 | 13 | 12 | 11 |
| 64885 | Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length | 090 | **384** | 60 | 151 | 30 | | | 2 | 1.0 | | | 3 | | |
| 64886 | Nerve graft (includes obtaining graft), head or neck; more than 4 cm length | 090 | **440** | 60 | 177 | 30 | | 1 | 2 | 1.0 | | | 3 | | |

**CMS's Scaling Factors between CPEP data and SMS Survey Data:**.

RUC members discussed the practice expense direct input methodology in detail and expressed concern regarding these scaling factors and the implications to the practice expense methodology. The RUC recommends the following:

**The RUC express a note of grave concern regarding aberrations in some PE RVUs brought about by the current PE methodology.**

**The RUC should continue to explore and suggest improvements in CMS's practice expense methodology, in order to minimize anomalies in CMS's scaling factors.**

**Removal of Rejected RUC Survey Data from the RUC Database**

The American Society for Surgery of the Hand (ASSH) and the American Academy of Orthopaedic Surgery (AAOS), requested that the RUC remove the rejected RUC survey data of code 64718 from the RUC database and any AMA/CPT product containing this information. ASSH and AAOS considered the data in the database to be misleading and inaccurate.
RUC members agreed with the specialty society's recommendation to remove the data, and made the following recommendation.

**The AAOS survey vignette, service descriptions, and RUC survey data for CPT code 64718 should be removed from the RUC database. The Practice Expense Workgroup Report was approved and is attached to these minutes.**

XIX. Site-of-Service Practice Expense Workgroup Report

Doctor Neil Brooks presented the Site-of Service Practice Expense Report. The Practice Expense Subcommittee met during the February 2004 RUC meeting to discuss the shifting of services from the facility to the non-facility setting.

In August, 2003, and January 2004 the PEAC created non-facility practice expense direct inputs for these percutaneous endovascular codes, however the PEAC is uncomfortable forwarding its recommendations to the RUC for approval until an economic impact analysis is performed and reviewed. PEAC members believed that these codes can be priced in the office; however, they should not be priced at the expense of other services.

The PEAC was concerned that assigning new office based practice expense relative values could result in an increase in the Sustainable Growth Rate system (SGR) spending without a corresponding increase in the SGR target. A reduction in overall reimbursement could occur if there is an increase in spending that is subject to the SGR target. The PEAC therefore wanted to closely examine this issue since establishing office based practice expense inputs for these procedures could set a precedent.

A December 2003 request was sent to CMS asking for an analysis predicting non-facility practice expense relative values and payment for the endovascular services if the PEAC inputs were to be accepted. CMS responded to this request verbally questioning the precedent that this may create, and refused to provide an analysis. Therefore, AMA staff supplied the RUC with a list of the ten codes that had recently been priced in the office and illustrated the analysis for this smaller subset of services.

RUC members learned that many of these services were priced in the office setting through the PEAC or RUC process, and that it is the specialties choice to price the services in the non-facility setting. Several of these codes have

expensive disposable medical supplies which caused the code to have higher practice expense relative values in the office setting.

Although RUC members expressed concern over the high non-facility practice expense relative values, CMS representatives mentioned that these values may fall over time. As the RUC refines practice expense inputs and CMS re-prices these inputs the variation in practice expense relative values between the physician's office and facility setting may narrow. The RUC made the following recommendations to the PEAC:

**The RUC requests the PEAC to forward its recommendations for the endovascular codes (and other codes that have been put on hold pending further analyses), to the RUC for consideration.**

Moving Medicare dollars from one section of Part B funds to another section of Part B funds does not require a statutory or legislative change, as does the movement of Part A funds to Part B funds. RUC members believed that funds may be added to the physician office Part B pool through a recognition that a newly priced in-office service is a change in the law and regulation component of the SGR allowed expenditures. The RUC made the following recommendation.

**The RUC will send a letter to CMS and advocate that the publication of new practice expense of relative values for a service in the non-facility setting is a change in the law and regulation and should be accounted for in the SGR allowed expenditures formula. The Site of Service Practice Expense Workgroup Report was approved and is attached to these minutes.** Staff Note: The RUC letter was sent March 31, 2004, and is attached to these minutes

XX. RUC HCPAC Review Board Report

Ms. Mary Foto, RUC HCPAC Co-Chair, presented the HCPAC report to the RUC. The RUC HCPAC Review Board met to address several administrative issues including the Conflict of Interest form and potential modifications to the HCPAC MPC list. HCPAC members were instructed to complete the Conflicts of Interest forms and send to AMA staff before the April 2004 meeting. The HCPAC also discussed their MPC list and requested that societies should review this list for potential changes. These potential changes will be discussed at the April 2004 Meeting.

In addition, the HCPAC reviewed the recommendations for Acupuncture/ Electroacupuncture, Negative Pressure Wound Therapy and Wound Care – Removal of Devitalized Tissue. The HCPAC Review Board was updated on the American Chiropractic Association's progress on the development of recommendations for the Acupuncture/Electroacupuncture codes. These

recommendations will be readdressed at the April 2004 meeting. Work relative value and practice expense input recommendations for Negative Pressure Wound Therapy and Wound Care – Removal of Devitalized Tissue recommendations were assessed, modified and approved by the HCPAC. These recommendations can be found in the RUC HCPAC Review Board Report.

**The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.**

XXI. PEAC Report

Doctor Bill Moran, Jr., Chair of the PEAC, presented the PEAC report. The PEAC refined almost 500 CPT codes at its January 2004 meeting. In addition, the PEAC had forwarded practice expense recommendations from its August 2003 meeting for approval.

The American College of Radiology (ACR) requested extraction of two mammogram codes, 76091 and 76092 from the consent calendar. These mammogram codes were reviewed by the PEAC, however ACR disagreed with the recommendations. ACR gathered additional information and presented revised practice expense inputs to the RUC. ACR requested an additional 6 minutes above the four minutes already approved by the PEAC related to MQSA activities. The RUC agreed with this request for 6 minutes related to following activities:

- MQSA required accreditation applications/updates/completing data logs/FDA inspection specific to mammography service (4 Minutes)
- Maintain physician qualifications, outcomes and CMS (1 Minute)
- Daily, weekly and monthly quality checks mammography units and processors, daily sensitometry/densitometry performance (1 Minute)

The RUC agreed with the modified recommendations and agreed to submit them to CMS. The revised recommendations are attached to these minutes.

**The RUC approved the remainder of the codes reviewed at the August 21-23, 2003 Meeting and will submit to CMS. The PEAC Report was approved and is attached to these minutes.**

XXII. Other Issues

AMA RUC staff has collated information from specialty societies on their primary staff contact, society committee information, and LMRP review processes related to coverage issues. This document has been provided to CMS coverage staff. In addition, Doctor Rich will be sharing the document with the Medicare Carrier Medical Directors at their May meeting. The document is attached to these minutes. If specialty societies would like to

either add their information or edit the current document, AMA RUC staff will be collecting comments until May 3, 2004.

**AMA.Specialty Society RVS Update Committee**
**Five-Year Review Workgroup Report**
**January 29, 2004**

The following Five-Year Review Workgroup members met via conference call in December 2003 and then face-to-face on January 29, 2004 to review the scope, compelling evidence standards, appeals process, screening criteria, and timeline for the next Five-Year Review : Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, James Maloney, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Scope of Review

AMA staff summarized the results of an e-mail survey to specialty societies, regarding the scope of next Five-Year Review. Thirty-two specialty societies had responded to date. Of those responding, none indicated an intention to request an alternative methodological approach. The following were the responses regarding the expected number of codes to be submitted via comment:

| | |
|---|---|
| We do not expect to submit any codes | 6 specialty societies |
| We expect to submit very few codes (1-10) | 16 specialty societies |
| We expect to submit several codes (11-50) | 5 specialties societies |
| We expect to submit a large number of codes (greater than 50) | 2 specialty societies |
| Completely Unknown at this time | 3 specialty societies |

Compelling Evidence Standards

The RUC's current definitions regarding compelling evidence were formulated at the initiation of the RUC process and have were modified prior to a previous Five-Year Review process. These definitions are contained in the *Instructions to Specialties Developing Work Relative Value Recommendations* on page 7.

The workgroup discussed these definitions of compelling evidence and made several observations, including:

- The review and acceptance of compelling evidence arguments should be applied uniformly in the Five-Year Review process.
- The list of compelling evidence parameters should be finalized prior to submission of the Five-Year Review Proposal to CMS.
- Documentation that there has been a significant change in the patient population should serve as compelling evidence.
- Documentation that there has been a change in the site-of-service should be included as compelling evidence
- Documentation that there has been a significant change in hospital length of stay may serve as compelling evidence
- Documentation that technology has diffused to other providers that were not originally included in the survey may be used as compelling evidence.

The workgroup discussed several aspects of the Five Year Review procedures and made several recommendations:

- **The RUC should request that CMS include the RUC compelling evidence standards in its notice of proposed rule making announcement.**
- **The RUC should request that CMS specify the format of comment letters to include documentation of compelling evidence and other items recommended in the RUC's proposal to CMS.**
- CMS should review and screen comment letters to make sure they meet minimal standards regarding compelling evidence prior to submission to the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted
- **The Workgroup agreed that the existing work relative value for the code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.**
- The draft definitions of compelling evidence should be shared with specialty societies, CMS, and carrier medical directors (CMDs) for comment prior to finalization.

**Attached is a draft list of compelling evidence standards that will be circulated for review and potentially modified prior to the April RUC meeting.**

Appeals Process

The RUC has a formal appeals (re-consideration) process included in the RUC's Rules and Procedures document (pages 4 and 5).

In addition, the Five-Year Review processes utilized in the past allows for a specialty to extract a Workgroup recommendation from the consent calendar for presentation to the RUC. These processes are outlined in the Five-Year Plan and Five-Year Procedures documents from the previous review

**The workgroup discussed the Appeals processes and agreed that they currently provide appropriate flexibility for the specialty societies. However, the Workgroup recommends that the RUC formalize several issues prior to the initiation of the next Five-Year Review, including:**

- **All specialties will have equal opportunity to collect and present data to the Workgroup meetings in August 2005. Specialties will not be provided with additional opportunity to collect new data following these meetings.**

- **Workgroup members recommend a change in the voting rules for the consent calendar process. The current procedure states "The item initially on the table for each code will be the workgroup's recommendation." The**

**Workgroup recommends that this be re-stated to read "If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value to be voted upon."**

- **The Workgroup also recommends a change in assignments to Facilitation Committees. The procedures currently state, "If a facilitation committee is needed for an issue, the issue will be referred to a workgroup other than the one to which it was originally assigned. This facilitation committee may be augmented with other specialty or HCPAC members as appropriate." In accordance with comments following the previous Five-Year Review that it was disruptive to require a specialty to re-present their entire argument to a new group individuals, the Workgroup recommends that the procedures be changed to read, "If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the society, the workgroup, or the RUC chair.**

Additionally, a Workgroup member strongly recommended that the Five-Year Review Workgroups meet prior to the initiation of the full RUC meeting in September to review any codes that have been pulled from the consent calendar. This occurred in the previous Five-Year Review at a luncheon meeting, as stated in the procedures document, "A lunch meeting will be arranged for each workgroup on Thursday, October 5. At that time, the groups will meet in executive session to discuss the codes to be extracted, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and October meetings."

<u>Screening Criteria</u>

Upon receipt of the comment letters and list of codes for review by CMS, the AMA staff will conduct a Level of Interest (LOI) process, distributing this material to all specialty societies and HCPAC organizations on the RUC Advisory Committee, and assessing their interest in developing recommendations. After the completion of the LOI process, AMA staff will organize these lists for review by the RUC at the April meeting.

In the first Five-Year Review process, the RUC agreed to prioritize codes for review and convened their Five-Year Review Workgroup to screen the codes that had been submitted. The result of the discussions at this meeting was to implement the following screening criteria:

- Frequency is less than 1,000 annual Medicare claims per 1994 BMAD data
- Overall change in work is +/- 10% or less
- No request to survey (ie, no interest expressed by any specialty during the LOI process)

- Service has recently been reviewed by the RUC (interpreted as any review by the RUC since the inception of the RBRVS)

Codes that met the above criteria were excluded from further review.

In the second, Five-Year Review process, the RUC refined these criteria to be as follows:

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

The Workgroup has reviewed this information and determined that codes should not be excluded from the Five-Year Review if an adequate rationale has been provided in the comment letter (ie, an argument from the RUC's list of compelling evidence**). The Workgroup, therefore, does not recommend an automated screening process be used in the third Five-Year Review.** However, the Workgroup would like to convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.

Finalize Timeline of Five-Year Review

**The Workgroup approved the attached timeline and recommends that the RUC finalize this document for inclusion in the Proposal on the Five-Year Review currently under development.**

Identification of Potentially Identified Mis-Valued Codes

The Workgroup discussed the identification of potentially mis-valued codes and determined that the RUC should focus on developing the compelling evidence standards. These standards could then be utilized by an entity that chooses to identify potentially undervalued and overvalued services.

Compelling Evidence Standards - DRAFT

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the revised codes. This evidence must be provided in the comment letter to CMS and to the RUC in writing along with the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been significant changes in physician work due to one or more of the following:

  - technique
  - technology
  - patient population
  - site-of-service
  - length of hospital stay

- An anomalous relationship between the code being valued and multiple key reference services. For example, if code A describes a service that requires significantly more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services should be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

  - a misleading vignette, survey and/or flawed crosswalk assumption in a previous evaluation;

  - a seriously flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values;

  - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data;

**Timetable for the Five-Year Review**

| | |
|---|---|
| April 2004 | Submission of RUC Proposal on Five-Year Review to CMS |
| December 30, 2004 | Comment period closes on public solicitation of codes to be reviewed. *Assumes publication date of CMS Final Rule of November 1, 2004* |
| February 1, 2005 | CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation. |
| February 3-6, 2005 | Research Subcommittee to review any changes to the existing RUC survey instrument. |
| February 15, 2005 | AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1. |
| April 1, 2005 | Responses to the LOI due to the AMA. |
| April 28 – May 1, 2005 | Initial screen of all codes at the April RUC meeting.<br><br>Research Subcommittee to review any alternative methodologies introduced. |
| May 9, 2005 | Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying. |
| August 2, 2005 | Recommendations due to the AMA from specialty societies. |
| August 25-28, 2005 | Five-year review workgroups meet and review recommendations. |
| September 14, 2005 | Workgroup recommendations and consent calendars sent to the RUC. |
| September 29 – October 2, 2005 | RUC meeting to review workgroup recommendations and consent calendars |
| October 31, 2005 | RUC recommendations submitted to CMS. |
| November 2005-February 2006 | CMS Review |
| March 2006 | Notice of Proposed Rulemaking (NPRM) on Five-Year Review |
| November 2006 | Final Rule on Five-Year Review |
| January 1, 2007 | Implementation of new work relative value units. |

**AMA/Specialty Society RV S Update Committee**
**Professional Liability Insurance Workgroup**
**January 29, 2004**

The following members of the Professional Liability Insurance (PLI) Workgroup met on January 29, 2004 to discuss data utilized by CMS in establishing both PLI geographic practice cost indices and relative values: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Stephen A. Kamenetzky, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith

CMS Update

The PLI Workgroup spoke with Mr. Rick Ensor, Centers for Medicare and Medicaid Services (CMS), via teleconference. Mr. Ensor indicated that CMS has initiated work on the five-year PLI relative value refinement to be implemented on January 1, 2005. CMS is utilizing the services of BearingPoint. A July 24, 2003 Written Technical Proposal will be shared with the RUC and distributed to RUC participants in February 2004. Providing the methodology to the RUC was felt to be crucial to the Workgroup's ability to evaluate how the PLI RVUs are developed in order to allow for additional recommendations to be made. In the RUC's comment letter on the 2003 *Proposed Rule* the RUC requested that in developing the new PLI relative values, CMS consider the use of the dominant specialty rather than a weighted average of all specialties that perform the service. Mr. Ensor indicated that CMS had instructed their contractor to examine this approach.

Mr. Ensor also indicated that he will provide the RUC with the CMS requirements for any PLI premium data collection activities. He explained that CMS had utilized, for the first time, predictions for 2003 premium data. However, CMS did not feel comfortable utilizing these predictions only and preferred the approach of blending the 2001-2003 data. Mr. Ensor did clarify that the cost of tail coverage was incorporated into the determination of PLI actual premium data. *Staff Note: Mr. Ensor later retracted this statement. Tail Coverage is not included in the premium data*. Mr. Ensor reiterated the Agency's interest in considering other data sources to better reflect current PLI costs.

Review of Summary Professional Liability Insurance Data Utilized in 2004 PLI GPCIs

CMS did share data utilized in establishing the 2004 PLI GPCIs with the RUC. AMA staff collated these files into one database and has shared this information with all RUC participants. AMA staff also provided summary information on this data. Several questions were raised regarding this data:

- The twenty specialties included in the data did not include anesthesiology and obstetrics and gynecology. Mr. Ensor indicated that he would explore the rationale for this and provide further information to the RUC.

- Doctor Stephen Kamenetzky discussed the limitations in the state PLI premium data and suggested that other data collections would provide more reliable and more recent data.

- There was a lengthy discussion concerning the disparity between the data provided and the actual PLI costs currently incurred by physicians. Although Mr. Ensor assured the Workgroup that the data was actual raw data, the process of averaging the data which is highly variable state by state and even for regions within a state does not provide an appropriate reflection of costs incurred by practitioners in high-risk states.

- It was pointed out that statute limits the GPCI to account for less then half of the actual difference among geographical regions. This was felt to again unfairly compress the actual range of costs, thereby penalizing physicians in "high-risk" states. For example, data based on state averages had lower medians than the aggregate median of all data points.

Discuss Process for Reviewing Risk Classifications for Individual CPT Codes

CMS utilizes risk factors based on the surgical versus non-surgical risk factor categories. In general, CMS assumes that all CPT codes in the 10000-69999 series are surgical and all other codes are in the non-surgical category. However, CMS does allow certain "special cases" in the assignment of risk factors. The PLI Workgroup recommends the following:

**AMA staff will circulate the PLI contractor report, including the current methodology for assigning risk factors to each CPT code, to all RUC participants. RUC participants will have the opportunity to review this information and provide comment to the PLI Workgroup for consideration at a future meeting.**

A question arose regarding the assignment of risk categories for anesthesia services and more generally, the approach that CMS employs to evaluate the anesthesia relative values for these services. Mr. Ensor indicated that he would send additional information regarding this methodology to the AMA.

Other Issues

The PLI Workgroup continued its discussion regarding how PLI premium data provided by individual physicians can be utilized. Specifically, Workgroup members remain interested in pursuing a methodology for paying physicians for their share of the individual physician's professional liability insurance premium in a more direct manner than on a per service basis.

**AMA/Specialty Society RVS Update Committee**
**PEAC Transition Workgroup Report**
**January 29, 2004**

The PEAC Transition workgroup met to develop recommendations regarding PEAC participation in the RUC review of direct inputs of new and revised codes. The following members participated: Willard Moran, MD, Chair; Joel Brill, MD; James P. Borgstede, MD; Mary Foto, OTR; Barbara Levy, MD; Daniel Mark Siegel, MD; and Richard Whitten, MD.

Doctor Moran opened the meeting by discussing the following ideal goals the workgroup should consider:

1. The review of PE and physician work should occur at the same RUC meeting.
2. The same level of PE expertise review should be applied to the new codes as was applied to all of the existing codes.
3. Minimize costs to specialty societies.
4. Decrease workload on RUC and increase efficiency.
5. Allow PEAC to periodically examine outlier codes and reexamine expensive disposable supplies or equipment costs periodically, as well as develop or refine PE standards.

The Workgroup agreed that the PEAC expertise that has been developed over the last few years should not be lost. Although the workgroup was presented with two potential options for involving the PEAC in RUC review, a third option was discussed. This new option would involve convening a subset of PEAC members by conference call to identify those codes on a RUC agenda that would need further review such as those with non-standard inputs. Any concerns identified during the conference call would be communicated by AMA staff to the affected specialty society and then the specialty would be given the opportunity to make changes to the presentation or seek a pre-facilitation committee. The pre-facilitation committees would be comprised of a combination of PEAC and RUC members. The PEAC members would then become members of RUC facilitation committees and attend the RUC meeting to assist with any other codes that may be sent to facilitation.

It was pointed out that there is a very short time frame between a CPT meeting and the following RUC meeting. The short time between the February CPT meeting and the April RUC meeting was discussed in particular. In order for a pre-facilitation committee comprised of PEAC members to meet by phone prior to a RUC meeting would possibly require moving up the due date or require a very fast turn around between the time of the conference call and preparation of revised specialty society PE inputs. Since RUC members receive their agenda material two weeks before a RUC meeting, the conference call and revisions would need to occur in that short time frame. The workgroup agreed that once the due dates are established, specialty societies will need to provide their recommendations by the set deadline for this proposal to be a success.

Doctor Moran explained that during the PEAC meeting earlier in the week, PEAC members stated they were willing to assist the RUC and attend at least one RUC meeting a year. The PEAC also felt that it would be necessary for the PEAC to meet once a year to refine or develop additional standards.

The workgroup discussed the possibility of the PEAC meeting as a whole each year and some felt that a meeting each year is needed to look at major PE issues such as the changing site of service and changes in the use of expensive supplies. The workgroup agreed that there should be a periodic review of standards and the mechanism of how to do this should be determined later in the year by the RUC. It was noted that RUC members also felt it was important to periodically review all standards and processes, and would find it important to participate in such a review of practice expense issues. CMS representatives stated that they would like a mechanism to quickly review PE for services performed in a new setting such as procedures moving into the office setting.

The workgroup makes the following recommendation to the RUC:

**A subset of PEAC members would meet via conference call before each RUC meeting to identify codes that may have practice expense issues that need to be addressed. AMA staff would convey the PEAC concerns to the appropriate specialty societies and ask specialties to respond by revising the practice expense inputs or to resolve the issue through a prefacilitation committee comprised of PEAC and RUC members. Several PEAC members will then be assigned to each RUC facilitation committee. They would be members of the committee specifically to review the practice expense issues for codes sent to either pre-facilitation or facilitation.**

**AMA/Specialty Society RVS Update Committee**
**Multi-Specialty Points of Comparison (MPC) Workgroup Report**
**January 2004**

The following members of the Multi-Specialty Points of Comparison (MPC) Workgroup met on January 20, 2004 via conference call and on January 29, 3004 to review various issues related to the Multi-Specialty Points of Comparison (MPC). Doctors James Blankenship (Chair), John Derr, William Gee, Marc Lenet, John Mayer, Chester Schmidt, Susan Strate, and Maurits Wiersema.

Review of Specialty Society Comments Regarding IWPUT on MPC

In follow-up to actions by the Research Subcommittee at the September 2003 meeting, AMA staff sent an e-mail to all RUC participants with the updated 2004 MPC lists. These lists included an IWPUT calculation for each Category A (RUC survey time available) code with a global period of 90 days. The specialty societies were asked to review the codes on the list with IWPUT calculated and indicate whether or not the specialty would like IWPUT listed on the MPC for their codes. The responses to this e-mail are attached to this report. Two societies requested that IWPUT *not* be listed with their 90 day global codes, one society requested that IWPUT be listed with some but not all of their codes, and six societies approved listing IWPUTs.

The Workgroup discussed these responses on their call and again at the face-to-face meeting and did not reach a consensus on the following issues:

- Is it appropriate to list the IWPUT for some 090 day global codes, but not others? Within a specialty, is it appropriate to list IWPUT for some 90 day global codes but not others? Or should it be an all or none decision? The Workgroup noted the Research Subcommittee's intention that specialties be afforded the maximum flexibility in selecting whether or not their codes should have an IWPUT listed on the MPC. **The RUC reviewed the September 2003 Research Subcommittee Report and concluded that the specialty society requests to delete IWPUT information from specific CPT codes are consistent with the actions of the RUC in September.**

- **The MPC understands and reaffirms previous RUC policy that IWPUT should only be included on the MPC that is internal to the RUC. Any distribution of the MPC to CMS or others should not include IWPUT information.**

Five-Year Review Considerations for MPC

The Workgroup discussed the MPC in relation to the next Five-Year Review of the RBRVS. **The Workgroup recommends that all specialties review the MPC before the September 2004 RUC meeting.** The MPC Workgroup will meet in September 2004 to consider requests to add or delete codes from the MPC. The MPC that is finalized at the September 2004 meeting will be the list utilized by the RUC during the third Five-Year Review of the RBRVS to be initiated in November 2004.

In September 2003 the RUC decided that any new codes added to the MPC should be RUC-surveyed (Type A) codes. The Workgroup notes the RUC's trend toward using RUC-surveyed codes as reliable benchmarks for new codes. **The Workgroup recommends that specialties be encouraged to replace MPC codes that have not been reviewed by the RUC (Type B or C)**

**with codes that have been RUC surveyed (Type A), where possible.** At present the MPC list contains approximately 188 A codes (67%), 32 B codes (11%), and 61 C codes (22%).

In September 2003 RUC members expressed concern that external requests may be made to review all codes on the MPC in the next Five-Year Review. The MPC Workgroup discussed this and reaffirms the RUC position that specialty societies be provided an opportunity to pull their codes from the MPC if such a request is made.

Additional Data Elements to be Added to MPC

In September, the Research Subcommittee requested that the MPC Workgroup consider additional data elements that may be useful to add to the MPC list. The Workgroup considered several data points, including RUC meeting date, length of stay, intensity measure results from the RUC surveys, and others. **The Workgroup recommends adding the date at which each code was last RUC-reviewed to the information on each code in the MPC list.**

At present the MPC list is ordered by ascending CPT code order and by ascending physician work RVU order. **The Workgroup recommends that the MPC should be ordered and presented in two ways: 1) by CPT Code order; and 2) by global period, then work value in ascending order.** The workgroup agreed that when evaluating a new code, it is most helpful to first find codes with the same global period and then look amongst those codes for codes with similar work values.

The Workgroup also recommends that the MPC in database form be included in the Agenda CD for each RUC meeting.

Review of Potential Uses for the MPC

**The MPC Workgroup discussed ways to better incorporate the MPC into the RUC work valuation process and recommends the following:**

- **The RUC should request that specialty societies include, in their Summary of Recommendations for new codes, comparisons of RVU recommendations for new codes against codes with the same global periods from the MPC list. Reference codes from the MPC list should be chosen that have RVUs higher and lower than the requested RVUs for the code under review.** This would require a revision in the Summary of Recommendation form by the Research Subcommittee.

- **The RUC should request that each Facilitation Committee Report include at least one comparison to a code on the MPC.** This would strengthen the rationale of the work relative value recommendation for the new code.

## *E-Mail Sent January 8, 2004*

"Attached are the most recent versions of the RUC's Multi-Specialty Points of Comparison (MPC) documents, in CPT code and work value order. These lists incorporate the new 2004 CPT codes and the work relative values, as well as the utilization data for 2002.

The Research Subcommittee requested that this list be circulated an additional time to all specialties so that you may notify AMA staff if you do not wish the IWPUT to be listed next to your 090 day global code. Per action at the September RUC meeting (report attached), only category A codes (RUC approved time) with 90 day globals will include IWPUT. Accordingly, please review the attached lists. Please respond to Sherry_Smith@ama-assn.org no later than Monday, January 19 to state whether or not you would like the IWPUT information removed from your code on the MPC list. The MPC Workgroup will meet via conference call on January 20 and we would like to provide this information to them at that time.

Although, any specialty on the RUC Advisory Committee or HCPAC is welcome to respond, according to our review of the utilization data, we would expect a response from the following specialties:

| **Specialty Society** | **Response** |
|---|---|
| American Academy of Dermatology Association | No Response |
| American Academy of Ophthalmology | **May NOT be included** |
| American Academy of Orthopaedic Surgeons | May be included |
| American Academy of Otolaryngology – Head & Neck Surgery | No Response |
| American Association of Neurological Surgeons | No Response |
| American College of Cardiology | **Remove code 33235 completely from MPC** |
| American College of Obstetricians and Gynecologists | No Response |
| American College of Radiology | May be included |
| American College of Surgeons | No Response |
| American Podiatric Medical Association | May be included |
| American Society of Cataract and Refractive Surgeons | No comment |
| American Society of Colon and Rectal Surgeons | May be included |
| American Society of Plastic Surgeons | May be included |
| American Society for Therapeutic Radiation Oncology | **May NOT be included** |
| American Society for Surgery of the Hand | May be included |
| American Urological Association | **Remove IWPUT from 53850 and 50590** |
| Society of Thoracic Surgeons | No Response |
| Society of Vascular Surgeons | No Response |

**AMA/Specialty Society RVS Update Committee**
**Ad Hoc Pre-Time Workgroup Report**
**January 29, 2004**

The following members of the Ad Hoc Pre-Time Workgroup met to review the RUC and CMS definitions of pre-service time for 000 and 10 day global periods: Trexler Topping, MD, Chair, Norm Cohen, MD, John Gage, MD, J. Leonard Lichtenfeld, MD, Richard Tuck, MD, and Maurits Wiersema, MD.

The workgroup was formed to resolve the differences between the RUC and CMS 000 and 10 day global period pre-service time definitions. After an initial conference call, the workgroup has focused on changing the RUC and CMS pre-service time definitions to better reflect current medical practice. The workgroup agreed that there is a substantial amount of physician work that occurs after the decision for surgery, but before the procedure. This is the work that previously would have been performed the day before the procedure when patients were admitted to the hospital on the day prior to the procedure. The workgroup felt that the RUC has been very flexible in reviewing the pre-service work of new and revised codes. Several workgroup members stated that although the RUC survey definitions limit the time period to a day before the procedure, the RUC has recognized that the work that occurs between the decision for surgery and the procedure is valid physician work to be included in the procedure. The practical effect therefore in term of RUC review of codes has been to assume that all pre-service work occurs on the day before the procedure.

The workgroup tried to identify any scenarios where physicians would be disadvantaged by changing the pre-service time definition such as not being allowed to bill for separate E/M visits prior to the procedure. Doctor Gage explained that if the test results indicated that the surgery should be cancelled, then the patient would be seen and a separate E/M visit would be billed, and there would be no conflict. Alternatively, if a patient would need to been seen for a separate condition prior to the surgery, then the physician should be able to code for an E/M visit using a modifier. Also, if a patient is seen the day before a procedure, then that E/M visit would be the decision for surgery and should be separately coded. The workgroup realized that this issue would need to be closely reviewed by CMS, but felt it was appropriate to make the request to CMS so that CMS can begin to analyze the request.

The workgroup discussed requesting CMS to provide data that would identify E/M codes billed by the same physician for the same patient prior to a procedure. Ideally the workgroup would want to know if physicians were billing for separate E/M visits between the decision for surgery and the day before the procedure. Since the decision for surgery can not be determined from claims data the only alternative would be to identify if there are E/M visits that occur within a certain time period prior to a procedure. Even this data would probably require some type of further analysis such a chart review to determine when the decision for surgery occurs. Therefore, the workgroup did not formally request data, but would be willing to work with CMS further is specific data needs are identified.

The workgroup agreed to make the following recommendation to the RUC:

**The RUC requests CMS to change the pre-service definition for 000, 010, and 090 day global periods to the following:**
**The pre-service period includes physician services provided following the visit at which the decision for surgery is finalized until the time of the operative procedure**.

*Approved by the RUC – January 2004*

Pre-Service Time Variability

The workgroup agreed that it would be worthwhile to look at the pre-service times that have been assigned by the RUC to determine the extent that the times vary. The workgroup suggested that the data be grouped according to the global period to determine if it would be worthwhile to begin exploring the possibility of obtaining more standardization in pre-service times. The workgroup would examine this data the next time it meets.

**AMA/Specialty Society RVS Update Committee**
**Administrative Subcommittee Report**
**January 29, 2004**

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Michael Bishop, John Derr, David Hitzeman, Peter A. Hollmann, John E. Mayer, J. Baldwin Smith, III, Richard W. Whitten and Robert Fifer, PhD

I. Review and Final Approval of Rotating Seat and Election Rules for the Administrative Subcommittee

The RUC tabled approval of the Rotating Seat and Election Rules pending AMA Legal Department review of this document to determine if it was consistent with Preferential Voting as described in Sturgis Fourth Edition and referred this issue back to the Administrative Subcommittee. AMA staff advised the Subcommittee that these documents are in agreement. The Subcommittee gave final approval of these rules. **These documents are attached to this report for approval by the RUC.**

II. Other Issues

The progress of the request made by Medicare Carrier Medical Directors to provide them with the RUC database CD was discussed by the Subcommittee. Discussion included which portions of the database are currently public information; internal AMA discussions regarding AMA copyright policy and possible future discussions with Carrier Medical Directors to explore the best mechanism of sharing this information. This issue will be discussed formally by the Administrative Subcommittee at the April Meeting.

**AMA/Specialty Society RVS Update Process**
**Rotating Seat Policies and Election Rules**

Societies Eligible for Nomination

- Only those specialty societies which have appointed a physician Advisor to the RUC should be eligible. Any specialty society seated in the AMA House of Delegates may choose to appoint an advisor.

- The solicitation for nominations for the three rotating seats should be sent to the Executive Director of each specialty society represented on the RUC Advisory Committee, including those represented on the RUC. Those specialty societies in the AMA House of Delegates that have chosen not to appoint a physician representative to the RUC Advisory Committee will not receive an invitation.

- 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.

- A specialty cannot run for both an Internal Medicine rotating seat and an "any other seat".

Individual/Coalition Seats on the RUC

A specialty society may only be listed once on the ballot, either individually or as a part of a coalition. The RUC Staff will review the nominations and work with the nominated specialty societies to revise the ballot as necessary to avoid duplicate nominations and resolve other problems that may arise.

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, internal medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.

- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.

- The "other rotating seat" on the RUC shall not be open to internal medicine subspecialties.

Candidate Eligibility

The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.

Election Process

- All eligible specialty societies should be notified that they should attend the RUC meeting to make their presentation.

- Candidates will be allowed to present a two page biographical sketch or abbreviated CV. In addition to the biographical sketch, candidates will have two minutes, or less (at the discretion of the RUC Chair depending on the number of candidates) to present their qualifications before the entire RUC.

- There must be a quorum to hold the election and **a majority is considered 50 percent plus one vote** of the total number of valid ballots cast. The RUC utilizes rank voting, as follows:

  - In the case of **four or more candidates**, there could be up to three ballots. The first ballot will list all contending candidates. Voters will rank the candidates by assigning points to their choices as follows:

    | | |
    |---|---|
    | First choice | = 3 points |
    | Second choice | = 2 points |
    | Third choice | = 1 points |

    No points will be assigned for unranked candidates. A candidate with a majority vote (i.e. greater than 50 percent of the RUC members indicate the candidate as the first choice) will be awarded the seat. In the case of no majority vote, the three candidates garnering the highest number of points will be placed on a second ballot. Voters will then use the process described above to rank the candidates. The candidate with a majority vote will be awarded the seat. In the case of no majority vote, the two candidates garnering the highest points will be placed on a third ballot. From that ballot, the candidate with the majority vote will be elected to the seat.

  - In the case of **three candidates**, there will be two ballots. The first ballot will use the ranking process described above and the second ballot will identify the two candidates with the most points from the first ballot.

  - In the case of **two candidates**, the candidate with the majority vote will be elected to the seat.

  - An election will be unnecessary in the case that there is an **unchallenged seat** and the seat will be awarded to the unchallenged candidate by voice vote.

Voter Eligibility

All current members of the RUC with voting seats are eligible to vote.

Ballot Validity

Names will be placed on the ballot to ensure that AMA staff can return any invalid ballot (e.g. an incomplete ballot) to the voter. Only AMA staff should have access to these ballots and they should otherwise be confidential.

**AMA/Specialty Society RVS Update Committee**
**Research Subcommittee Report**
**January 29, 2004**

The following members of the Research Subcommittee participated: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Megan Gerety, David Keepnews, PhD, Barbara Levy, J. Leonard Lichtenfeld, Bernard Pfeifer, Alan Plummer, Trexler Topping, and Richard Tuck.

Practice Expense Effects on Code Development

The RUC previously identified this issue because there was a concern that a substantial number of new codes might need to be developed in the future to differentiate among medical devices that can be used for the same procedure. These would be codes where the procedure described would be the same with the same physician work but the practice expense differed according to the device used. The Subcommittee agreed that either expensive disposable supply items or expensive equipment could drive the development of codes leading to several codes describing the same procedure.

Currently, expensive disposable supplies are not separately reimbursable and are included as direct expenses in the methodology used to create practice expense relative values. The Subcommittee was in favor of establishing a system that would allow CMS to separately price these items and allow physicians to code for these items through a J code type system. The goal would be to have CMS price the items and negotiate a competitive price directly with the manufactures so that physicians would not be affected by the cost of the items. The CMS representatives were receptive to explore the development of such a system, but stressed that any items that would qualify for separate pricing would need to meet specific criteria such as a certain cost threshold as well as needing to be a supply that is typically used.

Currently there does not appear to be a significant number of high cost disposable items contained in the PE methodology. However, it is predicted that as more services move into the office setting, the list of items will grow. According to the CMS contractor responsible for repricing supplies, the CMS supply list contains only 28 items over $100 and these are assigned to 59 codes representing a total office based claim volume of 64,263. The Subcommittee agreed to discuss this issue further at its next meeting but would like to examine a list of those supplies equal to or greater than $50 and also to receive further input from CMS regarding potential criteria that could be established to determine if an item would be eligible for a separate HCPCS code. An explanation by CMS on the HCPCs process might also be needed. Additionally, the Subcommittee would like to receive input from specialty societies and would like AMA staff to solicit specialty societies on their views of establishing a separate HCPCs codes for expensive supplies. The specialty society input would be reviewed at the next meeting.

Conscious Sedation

The Research Subcommittee agreed that the RUC should add a question to the RUC survey instrument and the summary of recommendation form. This will allow the RUC to identify those codes that typically use conscious sedation as an inherent part of the procedure**. The Subcommittee recommends the RUC add the following question to the RUC survey:**

**BACKGROUND FOR QUESTION 6**

Conscious sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal or intranasal routes. For purposes of the following question, sedation and analgesia delivered separately by an anesthesiologist or other anesthesia provider not performing the primary procedure is not considered conscious sedation.

**QUESTION 6: Do you or does someone under your direct supervision typically administer conscious sedation for these procedures?**

New/Revised Code Yes ❒ No ❒ Reference Code Yes ❒ No ❒

Addition of PLI Information to the Summary of Recommendation Form

During the last RUC meeting, the PLI Workgroup concluded that the RUC should take a more active role in the establishment of PLI relative value units and provide additional information to CMS to assist in the development of PLI RVUs for new and revised codes. Currently CMS staff assign PLI RVUs with limited physician input. New and revised codes are temporarily assigned a PLI relative value based on CMS staff analysis of an appropriate crosswalk. This analysis usually includes a review of the frequency estimations on the RUC's *Summary of Recommendation* form and often the key reference service used to determine physician work. CMS staff also determines if the CPT code should be assigned a specific risk factor.

There is an opportunity for RUC input into this process by providing CMS with both an appropriate crosswalk and the appropriate risk factor determination. These questions would not be added to the RUC survey, but instead would be completed by the specialty after reviewing the survey results. It was clarified that the specialty would only be providing a crosswalk and would not be evaluating the adequacy of the PLI RVU assigned to the reference code. These crosswalks would only be used temporarily until CMS collects enough claims data to calculate a PLI RVU**. The subcommittee recommends adding the following questions to the RUC summary of recommendation form:**

**Does your reference CPT code selected for physician work serve as a reasonable reference for a PLI crosswalk?**

Yes ❒ No ❒

**If no, please select another crosswalk and provide a brief rationale.**

**Indicate what risk factor (e.g., surgical, non-surgical) the new/revised code should be assigned to determine PLI relative value.**

Reference Service Lists

The RUC has historically provided reference service lists to specialty societies in ascending work RVU order so that the survey respondents can examine a range of work values to assist them in recommended a RVU for the new and revised code. A number of RUC members commented that providing the lists in code order makes it easier for respondents to select a reference code. The subcommittee was not aware of any studies on this topic that would indicate if either method would influence a survey. However, the subcommittee did not want the lists to be provided in random order. Therefore, the Subcommittee recommends that:

**The reference service lists should be provided to survey respondents in either ascending CPT code order, or ascending RVU order, or both code and RVU order.**

The Subcommittee also discussed the maintenance of reference service lists and the implications of using either fixed lists or allowing specialties to customize lists depending on the code under review. The Subcommittee members had different interpretations regarding the RUC policy and the ability of specialty societies to change their reference service lists. Some members thought that the lists could not be changed, while others stated that the RUC has always allowed specialties to develop their own reference service lists. It was suggested that the lists would need to be customized based on the code under review, because otherwise a standard list for some specialties would contain several hundred codes. Since the maintenance of lists had not been identified as a problem that has adversely affected RUC surveys, the Subcommittee passed a motion to not discuss the issue any further.

**AMA/Specialty Society RVS Update Committee**
**Practice Expense Subcommittee Report**
**January 29, 2004**

The Practice Expense Subcommittee met during the February 2004 RUC meeting to discuss the allocation of physician time components, two practice expense methodologies used by CMS, and the removal of survey data in the RUC database. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Przbylski, Siegel, Strate, and Wiersema.

**Physician Time Allocations**

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes, which have only total physician time within CMS's database. The PEAC has assigned post operative practice expense inputs according to existing codes through RUC and CMS physician time components. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide all the necessary time components for each of the identified codes. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

The Subcommittee and the RUC have expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs and should have no bearing on physician work. With this in mind, the RUC has directed AMA staff to clearly identify these codes within the RUC database to indicate to RUC members that the physician time from this exercise is not to be considered when making work recommendations.

For this meeting, AMA staff obtained physician time allocations for 4 CPT codes. Two have been surveyed and two have been allocated to existing "PR" (CMS cross-walked) time. Subcommittee members first reviewed two surveyed codes presented by the American Burn Association, American Society of Plastic Surgeons, and American Podiatric Medical Association. The Subcommittee believed that the total time being presented, 173 minutes for CPT 15342 and 77 minutes for CPT 15343, did not equate to the physician work value, of 1.0 and 0.25 respectively. A comment was made by a CMS observer that the global period should be reconsidered. The two codes had previously been G codes and the work value had been cross-walked to new CPT codes in 1999. Subcommittee members rejected the time components recommended by the specialty societies and recommended the following to the RUC for approval:

> **The RUC recommends that the specialty society should request that CMS make a recommendation concerning the global period, the society consider performing a full RUC survey for codes 15342 and 15343. This review includes physician time and work recommendations. In addition, the two codes will be taken off the March 2004 PEAC agenda.**

The Subcommittee then reviewed two other codes presented by the society of American Academy of Otolaryngology – Head and Neck Surgery. The Subcommittee agreed with the specialty's time allocation. This time allocation is shown below.

| CPT | Descriptor | glob | "PR" Time | "PR" total time split | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | pre time | intra time | Im-SD | Hosp Visits (992-) | | | | Office Visits (992-) | | | | |
| | | | | | | | 33 | 32 | 31 | 38 | 15 | 14 | 13 | 12 | 11 |
| 64885 | Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length | 090 | **384** | 60 | 151 | 30 | | | 2 | 1.0 | | | 3 | | |
| 64886 | Nerve graft (includes obtaining graft), head or neck; more than 4 cm length | 090 | **440** | 60 | 177 | 30 | | 1 | 2 | 1.0 | | | 3 | | |

**CMS's Scaling Factors between CPEP data and SMS Survey Data:**

CMS has requested the RUC to begin a general discussion of the scaling factors CMS uses to equate the CPEP derived cost pools with the Socioeconomic Monitoring System derived pools, to identify where anomalies might exist and what future actions to take. Doctor Zwolak made a presentation on the derivation of the CMS scaling factors in the top down practice expense methodology. If the SMS data and the CPEP data were identical, for any particular specialty group, the scaling factor would be 1.00. If the scaling factor is shown to be less than 1.00, the CPEP data would be indicating higher specialty costs than the SMS survey data indicates. If the scaling factor is shown to be greater than 1.00, the CPEP data would be indicating lower costs than the SMS survey data indicates.

CMS representatives explained that, over time, the clinical labor portion of the scaling factors have come closer to equality due to the PEAC's efforts to refine direct inputs. CMS suggested that specialty societies and the RUC continue to seek the true cost of medical services, either through supplemental surveys, and other methods through the RUC process.

Subcommittee members discussed the practice expense direct input methodology in detail and expressed concern regarding these scaling factors and the implications to the practice expense methodology. The Subcommittee recommends the following to the RUC:

> **The RUC express a note of grave concern regarding aberrations in some PE RVUs brought about by the current PE methodology.**
>
> **The RUC should continue to explore and suggest improvements in CMS's practice expense methodology, in order to minimize anomalies in CMS's scaling factors.**

**Removal of Rejected RUC Survey Data from the RUC Database**

The American Society for Surgery of the Hand (ASSH) and the American Academy of Orthopaedic Surgery (AAOS), requested that the RUC remove the rejected RUC survey data of code 64718 from the RUC database and any AMA/CPT product containing this information. The RUC had included the data from this code in the RUC database despite the rejection of survey data during the initial 5-year review. ASSH and AAOS considered the data in the database to be misleading and inaccurate, since it was rejected by the RUC. AMA staff searched the RUC database for any code where 64718 had been used in a RUC rationale for a new or revised code and found none. Subcommittee members agreed with the specialty society's recommendation to remove the data, and made the following recommendation.

> **The AAOS survey vignette, service descriptions, and RUC survey data for CPT code 64718 should be removed from the RUC database.**

AMA staff will communicate this change to other AMA publications since it was rejected by the RUC.

*Approved by the RUC – January 2004*

## Overview of Practice Expense Scaling Factors

Warning: These slides have not been reviewed by CMS for Accuracy

Scaling is Major Step in Determining PE RVUs

The Goal of scaling is to make the Sum of all of a specialties practice expenses equal what the SMS survey determined that we actually spend

SMS Survey data is the current "Gold Standard" for Practice Expense

## Definition: Unscaled Input Cost Pool

= Sum across all procedures of direct inputs (CPEP or PEAC) X frequencies X cost, for each of three categories, for each specialty

This value in $ is what the CPEP/PEAC methods says it costs the specialty to practice

This represents a bottom up approach to PE, meaning that expenses for each procedure are calculated then added across all codes.

## Definition: SMS-Based Cost Pool

= Total Dollars spent by a Specialty on Practice costs for clinical labor, medical supplies and medical equipment

Calculated by total costs from SMS survey in each direct cost category

This is what CMS uses as the best estimate of what we really spend

## How Does Unscaled Input Cost Pool Relate to SMS-based Cost Pool?

In the best of worlds these should be exactly equivalent because they are two different methods to calculate the very same thing

## Why Do We need Two Different Methods?

The Unscaled Input Cost Method is the only method to distribute PE RVUs to individual codes since direct inputs are determined for each code

The SMS-based Cost Pool is the most accurate method, according to CMS to obtain Total Overall Annual Expense

## Why Is There a Problem?

For Almost All Specialties the Cost-based Pool is NOT Equal to the SMS-based pool

An important step in PE methodology is to adjust PE RVUs based on Unscaled Input costs to meet SMS Overall Cost.

### Clinical Labor Example

Based on SMS survey, Gen Surg spends $436 million per year on clinical labor.

Based on Unscaled Input Costs (CPEP/PEAC) General Surgery spends $736 million per year on clinical labor. Unscaled Inputs must be adjusted to match SMS

Clin Labor scaling factor = 436/736 = 0.59

### Comparison of Clinical Scaling Factors

Inf Dis Clinical Scaling Factor is 1.65

Psychiatry Clinical Scaling Factor is 0.33

New ID service with 60 minutes of RN service = $30.60 x 1.65 = $50.49
$50.49/$37.34 = 1.35 RVUs

New Psychiatry w 60 minuntes of RN service is $30.60 x 0.33 = $10.10
$10.10/$37.34 = 0.27 RVUs

### Medical Supply Example

According to SMS Cardiology spends $770 million per year on supplies

According to CPEP/PEAC Cardiology spends only $263 million per year on supplies

Cardiology supply Scaling factor
= $770/$263 = 2.93

### Medical Supply Example Cont'd

For Cardiology CPT code the CPEP/PEAC supplies will be multiplied by 2.93 as an integral step in calculation of the PE RVUs for this code.

### What is Impact of Supply Scaling Factor?

New Cardiology CPT code does not involve massive physician work but does use an expensive new disposable catheter.

RUC approves RVW 4.0 RVUs

RUC approves disposable catheter that costs $1,000

### What is Impact of Supply Scaling Factor

Disposable catheter costs $1,000

In reality catheter costs $1,000/$37.34
= 26.8 RVUs

With Cardiology Supply Scaling factor of 2.93, the Scaling Factor adjustment step multiplies $1,000 by 2.93 = $2,930

$2,930/$37.34 = 78.5 RVUs

**What Is Impact of Supply Scaling Factor?**

New Cardiology Service Without Scaling
- Work RVU = 4.0 RVUs
- PE RVU = 26.8 RVUs
- Total RVU = 30.8 RVUs

New Cardiology Service With Scaling
- Work RVU = 4.0 RVUs
- PE RVU = 78.5 RVUs
- Total RVU = 82.5 RVUs

**What is Impact of Supply Scaling Factor?**

Catheter is Direct Input paid to physician only in "Out of Facility" setting.

MFS payment for new service performed in facility is RVW of 4.0, plus small PE RVUs – does not include catheter

MFS payment for new service performed in office is RVW 4.0 *Plus* 82.5 PE RVUs

**Why Is There a Difference between Unscaled Input Cost and SMS Cost?**

Initially felt that CPEP data was inaccurate and in many cases inflated.

Now that PEAC is almost done, more accurate, the SMS data becomes suspect.

If scaling factor is >> 1.0, SMS pool estimate is much more than CPEP/PEAC Inputs. How can that be?

Bad SMS Survey data?

Systematic inclusion in SMS that is not in CPEP/PEAC data? Clinical labor or Supplies that are separately billable were included in SMS – not excluded

**Important Details**

These examples are VERY simplified

Budget neutralization steps excluded

Blending if multiple specialties provide service has not been addressed in this presentation

CMS has NOT reviewed these slides for accuracy

**Where does RUC go from here?**

Is this important for RUC to address?

How do we attack the problem?

Look at Very Low or Very High Scaling factors?

Limit impact of high/low scaling factors?

**AMA/Specialty Society RVS Update Committee**
**Site of Service Workgroup Report**
**January 29, 2004**

The Practice Expense Subcommittee met during the February 2004 RUC meeting to discuss the shifting of services from the facility to the non-facility setting. The following Workgroup members participated: Doctors Brooks, (Chair), Anthony, Borgstede, Maloney, Derr, and Moran.

## Background

The Practice Expense Subcommittee agreed in January 2003 that there should be a mechanism to establish non-facility practice expense RVUs as practice patterns change. Subsequently during the March 2003 PEAC meeting the Society for Interventional Radiology (SIR) recommended several percutaneous endovascular codes to be priced in the non-facility setting. These codes have historically only been performed in the hospital setting. In August, 2003, and January 2004 the PEAC created non-facility practice expense direct inputs for these percutaneous endovascular codes, however the PEAC is uncomfortable forwarding its recommendations to the RUC for approval until an economic impact analysis is performed and reviewed. PEAC members believed that these codes can be priced in the office, however, they should not be priced at the expense of other services.

The PEAC was concerned that assigning new office based practice expense relative values could result in an increase in the Sustainable Growth Rate system (SGR) spending without a corresponding increase in the SGR target. A reduction in overall reimbursement could occur if there is an increase in spending that is subject to the SGR target. This means that as procedures that historically have been hospital based now move to the office setting, SGR spending may increase, but the spending target would not. If spending exceeds the target the results can be a decrease in the Medicare conversion factor. The PEAC therefore wanted to closely examine this issue since establishing office based expense inputs for these procedures could set a precedent.
The RUC agreed in September 2003 that the RUC should work to resolve this issue and recommended the following approach:

1. The RUC should form a workgroup to address this issue, with involvement of PEAC members.
2. The RUC will ask CMS to conduct an impact analysis on pricing these percutaneous endovascular codes and other services newly priced in the office, that have been proposed to shift major resources from facility to the non-facility setting.
3. For services transitioning from the facility to the non-facility settings, the RUC will advocate that CMS consider a regulatory change in the SGR update formula to increase allowed expenditures.
4. The issue of shifting services from the inpatient setting (ie, hospital visits to office visits) is an issue that needs focus and encourages CMS to continue to consider this issue.

## Workgroup Discussion

Doctor Brooks began the discussion with an explanation of the issues before the group. He explained that a December 2003 request was sent to CMS asking for an analysis predicting non-facility practice expense relative values and payment for the endovascular services if the PEAC inputs were to be accepted. Also, an analysis comparing this predicted payment to OPPS payment and ASC payment was requested. CMS responded to this request verbally questioning the precedent that this may create. Therefore, AMA staff supplied the Workgroup with a list of the ten codes that had recently been priced in the office and illustrated the analysis for this smaller subset of services.

Workgroup members learned that many of these services were priced in the office setting through the PEAC or RUC process, and that it is the specialties choice to price the services in the non-facility setting. Several of these codes have expensive disposable medical supplies which caused the code to have higher practice expense relative values in the office setting. A member questioned. It was also mentioned that specialties are under significant pressure from device manufacturers to price specific CPT codes in the office setting.

CMS representatives explained the payment methodology for new technology. With the development of the Outpatient Prospective Payment System (OPPS) in the year 2000, CMS provided additional payments for new technology with pass-through payments. The pass-through payments to hospitals off-sets the cost high cost of new devices, and provides a payment for not less than 2 but not more than 3 years. For Ambulatory Surgical Centers (ASC) some devices may qualify for separate payment under the DME post fee schedule. Otherwise, the maximum for an ASC facility payment is $1,339.

Although workgroup members expressed concern over the high non-facility practice expense relative values, CMS representatives mentioned that these values may fall over time. CMS periodically re-prices the various components of its direct inputs. CMS recently has re-priced much of its medical supplies, and will re-price its equipment file for 2005. Workgroup members and CMS representatives believed that over time as lower cost units of medical supplies and equipment become available, and CMS should re-price these items. As the RUC refines practice expense inputs and CMS re-prices these inputs the variation in practice expense relative values between the physician's office and facility setting may narrow. The Workgroup also understands that the Research Subcommittee is also reviewing the supply price issue and may recommend alternatives. The Site of Service Workgroup made the following recommendations to the RUC:

> **The RUC requests the PEAC to forward its recommendations for the endovascular codes (and other codes that have been put on hold pending further analyses), to the RUC for consideration.**

Workgroup members also understood that the SGR target is based on CMS estimates of expenditures for physician services due to changes in prices, fee-for service enrollment, gross domestic product, and laws and regulations. Moving Medicare dollars from one section of Part B funds to another section of Part B funds does not require a statutory or legislative change, as does the movement of Part A funds to Part B funds. Workgroup members believed from the discussion that funds may be added to the physician office Part B pool through a recognition that a newly priced in-office service is a change in the law and regulation component of the SGR allowed expenditures. The Site of Service Workgroup recommends the following to the RUC:

> **The RUC will send a letter to CMS and advocate that the publication of new practice expense of relative values for a service in the non-facility setting is a change in the law and regulation and should be accounted for in the SGR allowed expenditures formula.**

**AMA/Specialty Society RVS Update Committee**
**RUC HCPAC Review Board Meeting**
**January 29, 2004**

Members Present:

Richard Whitten, MD, Chair,
Mary Foto, OT, Co-Chair
Mirean Coleman, MSW, LICSW, CT
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
David Keepnews, PhD, JD, RN, FAAN
Marc Lenet, DPM
Bernard Pfeifer, MD
Christoper Quinn, OD
Karen Smith, MS, RD, FADA
Arthur Traugott, MD

On January 29th, the RUC HCPAC Review Board met to discuss several administrative issues and assess the recommendations for Acupuncture/Electroacupuncture (977X1-977X4), Negative Pressure Wound Therapy (977XX3-977XX4) and Wound Care – Removal of Devitalized Tissue (97601 and 97XXX).

I. Administrative Issues

The RUC HCPAC Review Board reviewed several administrative issues including the Financial Disclosure and Conflict of Interest Policies. The members were instructed that the Conflict of Interest forms need to be signed and received by AMA staff by the April meeting. In addition, the HCPAC discussed the MPC list and requested that societies should review this list for potential changes. These possible changes will be discussed at the April meeting.

II. Relative Value Recommendations for CPT 2005

Acupuncture/Electroacupuncture (977X1-977X4)

The American Chiropractic Association updated the Review Board on the progress of developing recommendations for these codes and stated that these recommendations will be presented at the April Meeting.

Negative Pressure Wound Therapy (97XX3-97XX4)

Mr. Cooperman of the American Physical Therapy Association presented the relative value recommendations for the Negative Pressure Wound Therapy codes. These codes were created to describe the work associated with negative pressure wound therapy, a distinctive selective debridement procedure. In the extensive discussion of the relative value recommendation for 97XX3 and 97XX4, it was determined that these codes are more intense and take more time to complete than their reference service codes, 97002 *Physical therapy re-evaluation* (Work RVU= 0.60) and 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (Work RVU=0.45), respectively. Therefore, the HCPAC approved the society recommended 0.55 work RVU recommendation for 97XX3 and 0.60 work RVU recommendation for 97XX4. Additionally, supplies and equipment for all of the codes were assessed, modified and approved by the HCPAC.

Wound Care- Removal of Devitalized Tissue (97601 and 97XXX)

Mr. Cooperman presented the relative value recommendations for the Wound Care – Removal of Devitalized Tissue codes. These codes were created to describe the work for selective debridement based on total surface area of wound sizes(s) with possible use of a whirlpool. It was determined that the work associated with 97601 was comparable to the work associated with 11040 *Debridement; skin, partial thickness* (Work RVU=0.50). In addition, the society agreed that a whirlpool would be utilized in 50 percent of patients. Therefore, by using a building block approach, the HCPAC approved a recommendation of 0.58 for 97601 by adding the work of 11040 and half of the work

associated with 97022 *Application of a modality to one or more areas; whirlpool* (Work RVU = 0.17).

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**AMA/Specialty Society RVS Update Committee**
**RUC HCPAC Review Board Meeting**
**January 29, 2004**

Members Present:
Richard Whitten, MD, Chair,
Mary Foto, OT, Co-Chair
Mirean Coleman, MSW, LICSW, CT
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
David Keepnews, PhD, JD, RN, FAAN
Marc Lenet, DPM
Bernard Pfeifer, MD
Christoper Quinn, OD
Karen Smith, MS, RD, FADA
Arthur Traugott, MD

On January 29th, the RUC HCPAC Review Board met to discuss several administrative issues and assess the recommendations for Acupuncture/Electroacupuncture (977X1-977X4), Negative Pressure Wound Therapy (977XX3-977XX4) and Wound Care – Removal of Devitalized Tissue (97601 and 97XXX).

I. Administrative Issues

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**AMA/Specialty Society RVS Update Committee**
**Ad Hoc Pre-Time Workgroup Report**
**January 29, 2004**

The following members of the Ad Hoc Pre-Time Workgroup met to review the RUC and CMS definitions of pre-service time for 000and 10 day global periods: Trexler Topping, MD, Chair, Norm Cohen, MD, John Gage, MD, J. Leonard Lichtenfeld, MD, Richard Tuck, MD, and Maurits Wiersema, MD.

The workgroup was formed to resolve the differences between the RUC and CMS 000 and 10 day global period pre-service time definitions. After an initial conference call, the workgroup has focused on changing the RUC and CMS pre-service time definitions to better reflect current medical practice. The workgroup agreed that there is a substantial amount of physician work that occurs after the decision for surgery, but before the procedure. This is the work that previously would have been performed the day before the procedure when patients were admitted to the hospital on the day prior to the procedure. The workgroup felt that the RUC has been very flexible in reviewing the pre-service work of new and revised codes. Several workgroup members stated that although the RUC survey definitions limit the time period to a day before the procedure, the RUC has recognized that the work that occurs between the decision for surgery and the procedure is valid physician work to be included in the procedure. The practical effect therefore in term of RUC review of codes has been to assume that all pre-service work occurs on the day before the procedure.

The workgroup tried to identify any scenarios where physicians would be disadvantaged by changing the pre-service time definition such as not being allowed to bill for separate E/M visits prior to the procedure. Doctor Gage explained that if the test results indicated that the surgery should be cancelled, then the patient would be seen and a separate E/M visit would be billed, and there would be no conflict. Alternatively, if a patient would need to been seen for a separate condition prior to the surgery, then the physician should be able to code for an E/M visit using a modifier. Also, if a patient is seen the day before a procedure, then that E/M visit would be the decision for surgery and should be separately coded. The workgroup realized that this issue would need to be closely reviewed by CMS, but felt it was appropriate to make the request to CMS so that CMS can begin to analyze the request.

The workgroup discussed requesting CMS to provide data that would identify E/M codes billed by the same physician for the same patient prior to a procedure. Ideally the workgroup would want to know if physicians were billing for separate E/M visits between the decision for surgery and the day before the procedure. Since the decision for surgery can not be determined from claims data the only alternative would be to identify if there are E/M visits that occur within a certain time period prior to a procedure. Even this data would probably require some type of further analysis such a chart review to determine when the decision for surgery occurs. Therefore, the workgroup did not formally request data, but would be willing to work with CMS further is specific data needs are identified.

The workgroup agreed to make the following recommendation to the RUC:

**The RUC requests CMS to change the pre-service definition for 000, 010, and 090 day global periods to the following:**
**The pre-service period includes physician services provided following the visit at which the decision for surgery is finalized until the time of the operative procedure**.

Pre-Service Time Variability
The workgroup agreed that it would be worthwhile to look at the pre-service times that have been assigned by the RUC to determine the extent that the times vary. The workgroup suggested that the data be grouped according to global period to determine if it would be worthwhile to begin exploring the possibility of obtaining more standardization in pre-service times. The workgroup would examine this data the next time it meets.

**AMA/Specialty Society RVS Update Committee**
**Administrative Subcommittee Report**
**January 29, 2004**

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Michael Bishop, John Derr, David Hitzeman, Peter A. Hollmann, John E. Mayer, J. Baldwin Smith, III, Richard W. Whitten and Robert Fifer, PhD

I. Review and Final Approval of Rotating Seat and Election Rules for the Administrative Subcommittee

The RUC tabled approval of the Rotating Seat and Election Rules pending AMA Legal Department review of this document to determine if it was consistent with Preferential Voting as described in Sturgis Fourth Edition and referred this issue back to the Administrative Subcommittee. AMA staff advised the Subcommittee that these documents are in agreement. The Subcommittee gave final approval of these rules. **These documents are attached to this report for approval by the RUC.**

II. Other Issues

The progress of the request made by Medicare Carrier Medical Directors to provide them with the RUC database CD was discussed by the Subcommittee. Discussion included which portions of the database are currently public information; internal AMA discussions regarding AMA copyright policy and possible future discussions with Carrier Medical Directors to explore the best mechanism of sharing this information. This issue will be discussed formally by the Administrative Subcommittee at the April Meeting.

**AMA/Specialty Society RVS Update Process**
**Rotating Seat Policies and Election Rules**

Societies Eligible for Nomination

- Only those specialty societies which have appointed a physician Advisor to the RUC should be eligible. Any specialty society seated in the AMA House of Delegates may choose to appoint an advisor.

- The solicitation for nominations for the three rotating seats should be sent to the Executive Director of each specialty society represented on the RUC Advisory Committee, including those represented on the RUC. Those specialty societies in the AMA House of Delegates that have chosen not to appoint a physician representative to the RUC Advisory Committee will not receive an invitation.

- 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.

- A specialty cannot run for both an Internal Medicine rotating seat and an "any other seat".

Individual/Coalition Seats on the RUC

A specialty society may only be listed once on the ballot, either individually or as a part of a coalition. The RUC Staff will review the nominations and work with the nominated specialty societies to revise the ballot as necessary to avoid duplicate nominations and resolve other problems that may arise.

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, internal medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.

- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.

- The "other rotating seat" on the RUC shall not be open to internal medicine subspecialties.

Candidate Eligibility

The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.

*Approved by the RUC – January 2004*

Election Process

- All eligible specialty societies should be notified that they should attend the RUC meeting to make their presentation.

- Candidates will be allowed to present a two page biographical sketch or abbreviated CV. In addition to the biographical sketch, candidates will have two minutes, or less (at the discretion of the RUC Chair depending on the number of candidates) to present their qualifications before the entire RUC.

- There must be a quorum to hold the election and **a majority is considered 50 percent plus one vote** of the total number of valid ballots cast. The RUC utilizes rank voting, as follows:

    - In the case of **four or more candidates**, there could be up to three ballots. The first ballot will list all contending candidates. Voters will rank the candidates by assigning points to their choices as follows:

        | | |
        |---|---|
        | First choice | = 3 points |
        | Second choice | = 2 points |
        | Third choice | = 1 points |

        No points will be assigned for unranked candidates. A candidate with a majority vote (i.e. greater than 50 percent of the RUC members indicate the candidate as the first choice) will be awarded the seat. In the case of no majority vote, the three candidates garnering the highest number of points will be placed on a second ballot. Voters will then use the process described above to rank the candidates. The candidate with a majority vote will be awarded the seat. In the case of no majority vote, the two candidates garnering the highest points will be placed on a third ballot. From that ballot, the candidate with the majority vote will be elected to the seat.

    - In the case of **three candidates**, there will be two ballots. The first ballot will use the ranking process described above and the second ballot will identify the two candidates with the most points from the first ballot.

    - In the case of **two candidates**, the candidate with the majority vote will be elected to the seat.

    - An election will be unnecessary in the case that there is an **unchallenged seat** and the seat will be awarded to the unchallenged candidate by voice vote.

Voter Eligibility
All current members of the RUC with voting seats are eligible to vote.

Ballot Validity
Names will be placed on the ballot to ensure that AMA staff can return any invalid ballot (e.g. an incomplete ballot) to the voter. Only AMA staff should have access to these ballots and they should otherwise confidential.

**AMA.Specialty Society RVS Update Committee**
**Five-Year Review Workgroup Report**
**January 29, 2004**

The following Five-Year Review Workgroup members met via conference call in December 2003 and then face-to-face on January 29, 2004 to review the scope, compelling evidence standards, appeals process, screening criteria, and timeline for the next Five-Year Review : Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, James Maloney, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Scope of Review

AMA staff summarized the results of an e-mail survey to specialty societies, regarding the scope of next Five-Year Review. Thirty –two specialty societies had responded to date. Of those responding, none indicated an intention to request an alternative methodological approach. The following were the responses regarding the expected number of codes to be submitted via comment:

| | |
|---|---|
| We do not expect to submit any codes | 6 specialty societies |
| We expect to submit very few codes (1-10) | 16 specialty societies |
| We expect to submit several codes (11-50) | 5 specialties societies |
| We expect to submit a large number of codes (greater than 50) | 2 specialty societies |
| Completely Unknown at this time | 3 specialty societies |

Compelling Evidence Standards

The RUC's current definitions regarding compelling evidence were formulated at the initiation of the RUC process and have were modified prior to a previous Five-Year Review process. These definitions are contained in the *Instructions to Specialties Developing Work Relative Value Recommendations* on page 7.

The workgroup discussed these definitions of compelling evidence and made several observations, including:

- The review and acceptance of compelling evidence arguments should be applied uniformly in the Five-Year Review process.
- The list of compelling evidence parameters should be finalized prior to submission of the Five-Year Review Proposal to CMS.
- Documentation that there has been a significant change in the patient population should serve as compelling evidence.
- Documentation that there has been a change in the site-of-service should be included as compelling evidence
- Documentation that there has been a significant change in hospital length of stay may serve as compelling evidence
- Documentation that technology has diffused to other providers that were not originally included in the survey may be used as compelling evidence.

The workgroup discussed several aspects of the Five Year Review procedures and made several recommendations:

- **The RUC should request that CMS include the RUC standards of compelling evidence standards in its notice of proposed rule making announcement.**
- **The RUC should request that CMS specify the format of comment letters to include documentation of compelling evidence and other items recommended in the RUC's proposal to CMS.**
- CMS should review and screen comment letters to make sure that they meet minimal standards regarding compelling evidence prior to submission to the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted
- **The Workgroup agreed that the existing work relative value for the code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.**
- The draft definitions of compelling evidence should be shared with specialty societies, CMS, and carrier medical directors (CMDs) for comment prior to finalization.

**Attached is a draft list of compelling evidence standards that will be circulated for review and potentially modified prior to the April RUC meeting.**

Appeals Process

The RUC has a formal appeals (re-consideration) process included in the RUC's Rules and Procedures document (pages 4 and 5).

In addition, the Five-Year Review processes utilized in the past allows for a specialty to extract a Workgroup recommendation from the consent calendar for presentation to the RUC. These processes are outlined in the Five-Year Plan and Five-Year Procedures documents from the previous review

**The workgroup discussed the Appeals processes and agreed that they currently provide appropriate flexibility for the specialty societies. However, the Workgroup recommends that the RUC formalize several issues prior to the initiation of the next Five-Year Review, including:**

- **All specialties will have equal opportunity to collect and present data to the Workgroup meetings in August 2005. Specialties will not be provided with additional opportunity to collect new data following these meetings.**

- **Workgroup members recommend a change in the voting rules for the consent calendar process. The current procedure states "The item initially on the table for each code will be the workgroup's recommendation." The Workgroup recommends that this be re-stated to read "If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value to be voted upon."**

- **The Workgroup also recommends a change in assignments to Facilitation Committees. The procedures currently state, "If a facilitation committee is needed for an issue, the issue will be referred to a workgroup other than the one to which it was originally assigned. This facilitation committee may be augmented with other specialty or HCPAC members as appropriate." In accordance with comments following the previous Five-Year Review that it was disruptive to require a specialty to re-present their entire argument to a new group individuals, the Workgroup recommends that the procedures be changed to read, "If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the society, the workgroup, or the RUC chair.**

Additionally, a Workgroup member strongly recommended that the Five-Year Review Workgroups meet prior to the initiation of the full RUC meeting in September to review any codes that have been pulled from the consent calendar. This occurred in the previous Five-Year Review at a luncheon meeting, as stated in the procedures document, "A lunch meeting will be arranged for each workgroup on Thursday, October 5. At that time, the groups will meet in executive session to discuss the codes to be extracted, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and October meetings."

<u>Screening Criteria</u>

Upon receipt of the comment letters and list of codes for review by CMS, the AMA staff conduct a Level of Interest (LOI) process, distributing this material to all specialty societies and HCPAC organizations on the RUC Advisory Committee, and assessing their interest in developing recommendations. After the completion of the LOI process, AMA staff organize these lists for review by the RUC at the April meeting.

In the first, Five-Year Review process, the RUC agreed to prioritize codes for review and convened their Five-Year Review Workgroup to screen the codes that had been submitted. The result of the discussions at this meeting was to implement the following screening criteria:

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

Codes that met the above criteria were excluded from further review.

In the second, Five-Year Review process, the RUC refined these criteria to be as follows:

1. Overall recommended change in work RVU is within +/- 10% or less <u>AND</u> frequency is less than 10,000 annual Medicare claims per 1998 data.

2. No request for involvement (ie, no interest expressed by any specialty during the LOI process).
3. Service has been reviewed by the RUC, and accepted by HCFA, since the previous five-year review (*CPT 1996* and forward).

The Workgroup has reviewed this information and determined that codes should not be excluded from the Five-Year Review if an adequate rationale has been provided in the comment letter (ie, an argument from the RUC's list of compelling evidence**). The Workgroup, therefore, does not recommend an automated screening process be used in the third Five-Year Review. However, the Workgroup would like to convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.**

Finalize Timeline of Five-Year Review

**The Workgroup approved the attached timeline and recommends that the RUC finalize this document for inclusion in the Proposal on the Five-Year Review currently under development.**

Identification of Potentially Identified Mis-Valued Codes

The Workgroup discussed the identification of potentially mis-valued codes and determined that the RUC should focus on developing the compelling evidence standards. These standards could then be utilized by an entity that chooses to identify potentially undervalued and overvalued services.

# Compelling Evidence Standards - DRAFT

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the revised codes. This evidence must be provided in the comment letter to CMS and to the RUC in writing along with the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been significant changes in physician work due to one or more of the following:
  - technique
  - technology
  - patient population
  - site-of-service
  - length of hospital stay

- An anomalous relationship between the code being valued and multiple key reference services. For example, if code A describes a service that requires significantly more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services should be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:
  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;
  - a seriously flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values;
  - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data;

## Timetable for the Five-Year Review

| | |
|---|---|
| April 2004 | Submission of RUC Proposal on Five-Year Review to CMS |
| December 30, 2004 | Comment period closes on public solicitation of codes to be reviewed. *Assumes publication date of CMS Final Rule of November 1, 2004* |
| February 1, 2005 | CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation. |
| February 3-6, 2005 | Research Subcommittee to review any changes to the existing RUC survey instrument. |
| February 15, 2005 | AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1. |
| April 1, 2005 | Responses to the LOI due to the AMA. |
| April 28 – May 1, 2005 | Initial screen of all codes at the April RUC meeting.<br><br>Research Subcommittee to review any alternative methodologies introduced. |
| May 9, 2005 | Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying. |
| August 2, 2005 | Recommendations due to the AMA from specialty societies. |
| August 25-28, 2005 | Five-year review workgroups meet and review recommendations. |
| September 14, 2005 | Workgroup recommendations and consent calendars sent to the RUC. |
| September 29 – October 2, 2005 | RUC meeting to review workgroup recommendations and consent calendars |
| October 31, 2005 | RUC recommendations submitted to CMS. |
| November 2005- February 2006 | CMS Review |
| March 2006 | Notice of Proposed Rulemaking (NPRM) on Five-Year Review |
| November 2006 | Final Rule on Five-Year Review |
| January 1, 2007 | Implementation of new work relative value units. |

*Approved by the RUC – January 2004*

**AMA/Specialty Society RVS Update Committee**
**Multi-Specialty Points of Comparison (MPC) Workgroup Report**
**January 2004**

The following members of the Multi-Specialty Points of Comparison (MPC) Workgroup met on January 20, 2004 via conference call and on January 29, 3004 to review various issues related to the Multi-Specialty Points of Comparison (MPC). Doctors James Blankenship (Chair), John Derr, William Gee, Marc Lenet, John Mayer, Chester Schmidt, Susan Strate, and Maurits Wiersema.

Review of Specialty Society Comments Regarding IWPUT on MPC

In follow-up to actions by the Research Subcommittee at the September 2003 meeting, AMA staff sent an e-mail to all RUC participants with the updated 2004 MPC lists. These lists included an IWPUT calculation for each Category A (RUC survey time available) code with a global period of 90 days. The specialty societies were asked to review the codes on the list with IWPUT calculated and indicate whether or not the specialty would like IWPUT listed on the MPC for their codes. The responses to this e-mail are attached to this report. Two societies requested that IWPUT *not* be listed with their 90 day global codes, one society requested that IWPUT be listed with some but not all of their codes, and six societies approved listing IWPUTs.

The Workgroup discussed these responses on their call and again at the face-to-face meeting and did not reach a consensus on the following issues:

- Is it appropriate to list the IWPUT for some 090 day global codes, but not others? Within a specialty, is it appropriate to list IWPUT for some 90 day global codes but not others? Or should it be an all or none decision? The Workgroup noted the Research Subcommittee's intention that specialties be afforded the maximum flexibility in selecting whether or not their codes should have an IWPUT listed on the MPC. **The RUC reviewed the September 2003 Research Subcommittee Report and concluded that the specialty society requests to delete IWPUT information from specific CPT codes is consistent with the actions of the RUC in September.**

- **The MPC understands and reaffirms previous RUC policy that IWPUT should only be included on the MPC that is internal to the RUC. Any distribution of the MPC to CMS or others should not include IWPUT information.**

Five-Year Review Considerations for MPC

The Workgroup discussed the MPC in relation to the next Five-Year Review of the RBRVS. **The Workgroup recommends that all specialties review the MPC before the September 2004 RUC meeting.** The MPC Workgroup will meet in September 2004 to consider requests to add or delete codes from the MPC. The MPC that is finalized at the September 2004 meeting will be the list utilized by the RUC during the third Five-Year Review of the RBRVS to be initiated in November 2004.

In September 2003 the RUC decided that any new codes added to the MPC should be RUC-surveyed (Type A) codes. The Workgroup notes the RUC's trend toward using RUC-surveyed codes as reliable benchmarks for new codes. **The Workgroup recommends that specialties be encouraged to replace MPC codes that have not been reviewed by the RUC (Type B or C)**

**with codes that have been RUC surveyed (Type A), where possible.** At present the MPC list contains approximately 188 A codes (67%), 32 B codes (11%), and 61 C codes (22%).

In September 2003 RUC members expressed concern that external requests may be made to review all codes on the MPC in the next Five-Year Review. The MPC Workgroup discussed this and reaffirms the RUC position that specialty societies be provided an opportunity to pull their codes from the MPC if such a request is made.

Additional Data Elements to be Added to MPC

In September, the Research Subcommittee requested that the MPC Workgroup consider additional data elements that may be useful to add to the MPC list. The Workgroup considered several data points, including RUC meeting date, length of stay, intensity measure results from the RUC surveys, and others. **The Workgroup recommends adding the date at which each code was RUC-reviewed to the information on each code in the MPC list.**

At present the MPC list is ordered by ascending CPT code order and by ascending physician work RVU order. **The Workgroup recommends that the MPC should be ordered and presented in two ways: 1) by CPT Code order; and 2) by global period, then work value in ascending order.** The workgroup agreed that when evaluating a new code, it is most helpful to first find codes with the same global period and then look amongst those codes for codes with similar work values.

**The Workgroup also recommends that the MPC in database form be included in the Agenda CD for each RUC meeting.**

Review of Potential Uses for the MPC

**The MPC Workgroup discussed ways to better incorporate the MPC into the RUC work valuation process and recommends the following:**

- **The RUC should request that specialty societies include, in their Summary of Recommendations for new codes, comparisons of RVU recommendations for new codes against codes with the same global periods from the MPC list. Reference codes from the MPC list should be chosen that have RVUs higher and lower than the requested RVUs for the code under review.** This would require a revision in the Summary of Recommendation form by the Research Subcommittee.

- **The RUC should request that each Facilitation Committee Report include at least one comparison to a code on the MPC.** This would strengthen the rationale of the work relative value recommendation for the new code.

## *E-Mail Sent January 8, 2004*

"Attached are the most recent versions of the RUC's Multi-Specialty Points of Comparison (MPC) documents, in CPT code and work value order. These lists incorporate the new 2004 CPT codes and the work relative values, as well as the utilization data for 2002.

The Research Subcommittee requested that this list be circulated an additional time to all specialties so that you may notify AMA staff if you do not wish the IWPUT to be listed next to your 090 day global code. Per action at the September RUC meeting (report attached), only category A codes (RUC approved time) with 90 day globals will include IWPUT. Accordingly, please review the attached lists. Please respond to Sherry_Smith@ama-assn.org no later than Monday, January 19 to state whether or not you would like the IWPUT information removed from your code on the MPC list. The MPC Workgroup will meet via conference call on January 20 and we would like to provide this information to them at that time.

Although, any specialty on the RUC Advisory Committee or HCPAC is welcome to respond, according to our review of the utilization data, we would expect a response from the following specialties:

| **Specialty Society** | **Response** |
|---|---|
| American Academy of Dermatology Association | No Response |
| American Academy of Ophthalmology | **May NOT be included** |
| American Academy of Orthopaedic Surgeons | May be included |
| American Academy of Otolaryngology – Head & Neck Surgery | No Response |
| American Association of Neurological Surgeons | No Response |
| American College of Cardiology | **Remove code 33235 completely from MPC** |
| American College of Obstetricians and Gynecologists | No Response |
| American College of Radiology | May be included |
| American College of Surgeons | No Response |
| American Podiatric Medical Association | May be included |
| American Society of Cataract and Refractive Surgeons | No comment |
| American Society of Colon and Rectal Surgeons | May be included |
| American Society of Plastic Surgeons | May be included |
| American Society for Therapeutic Radiation Oncology | **May NOT be included** |
| American Society for Surgery of the Hand | May be included |
| American Urological Association | **Remove IWPUT from 53850 and 50590** |
| Society of Thoracic Surgeons | No Response |
| Society of Vascular Surgeons | No Response |

# Overview of Practice Expense Scaling Factors

Warning: These slides have not been reviewed by CMS for Accuracy

Scaling is Major Step in Determining PE RVUs

The Goal of scaling is to make the Sum of all of a specialties practice expenses equal what the SMS survey determined that we actually spend

SMS Survey data is the current "Gold Standard" for Practice Expense

# Definition: Unscaled Input Cost Pool

= Sum across all procedures of direct inputs (CPEP or PEAC) X frequencies X cost, for each of three categories, for each specialty

This value in $ is what the CPEP/PEAC methods says it costs the specialty to practice

This represents a bottom up approach to PE, meaning that expenses for each procedure are calculated then added across all codes.

# Definition: SMS-Based Cost Pool

= Total Dollars spent by a Specialty on Practice costs for clinical labor, medical supplies and medical equipment

Calculated by total costs from SMS survey in each direct cost category

This is what CMS uses as the best estimate of what we really spend

# How Does Unscaled Input Cost Pool Relate to SMS-based Cost Pool?

In the best of worlds these should be exactly equivalent because they are two different methods to calculate the very same thing

# Why Do We need Two Different Methods?

The Unscaled Input Cost Method is the only method to distribute PE RVUs to individual codes since direct inputs are determined for each code

The SMS-based Cost Pool is the most accurate method, according to CMS to obtain Total Overall Annual Expense

# Why Is There a Problem?

For Almost All Specialties the Cost-based Pool is NOT Equal to the SMS-based pool

An important step in PE methodology is to adjust PE RVUs based on Unscaled Input costs to meet SMS Overall Cost.

# Clinical Labor Example

Based on SMS survey, Gen Surg spends $436 million per year on clinical labor.

Based on Unscaled Input Costs (CPEP/PEAC) General Surgery spends $736 million per year on clinical labor. Unscaled Inputs must be adjusted to match SMS

Clin Labor scaling factor = 436/736 = 0.59

# Comparison of Clinical Scaling Factors

Inf Dis Clinical Scaling Factor is 1.65

Psychiatry Clinical Scaling Factor is 0.33

New ID service with 60 minutes of
RN service = $30.60 x 1.65 = $50.49
$50.49/$37.34 = 1.35 RVUs

New Psychiatry w 60 minuntes of
RN service is $30.60 x 0.33 = $10.10
$10.10/$37.34 = 0.27 RVUs

# Medical Supply Example

According to SMS Cardiology spends $770 million per year on supplies

According to CPEP/PEAC Cardiology spends only $263 million per year on supplies

Cardiology supply Scaling factor
= $770/$263 = 2.93

# Medical Supply Example Cont'd

For Cardiology CPT code the CPEP/PEAC supplies will be multiplied by 2.93 as an integral step in calculation of the PE RVUs for this code.

# What is Impact of Supply Scaling Factor?

New Cardiology CPT code does not involve massive physician work but does use an expensive new disposable catheter.

RUC approves RVW 4.0 RVUs

RUC approves disposable catheter that costs $1,000

# What is Impact of Supply Scaling Factor

Disposable catheter costs $1,000

In reality catheter costs $1,000/$37.34
= 26.8 RVUs

With Cardiology Supply Scaling factor of 2.93, the Scaling Factor adjustment step multiplies $1,000 by 2.93 = $2,930

$2,930/$37.34 = 78.5 RVUs

# What Is Impact of Supply Scaling Factor?

New Cardiology Service Without Scaling

Work RVU = 4.0 RVUs
PE RVU = 26.8 RVUs
Total RVU = 30.8 RVUs

New Cardiology Service With Scaling

Work RVU = 4.0 RVUs
PE RVU = 78.5 RVUs
Total RVU = 82.5 RVUs

# What is Impact of Supply Scaling Factor?

Catheter is Direct Input paid to physician only in "Out of Facility" setting.

MFS payment for new service performed in facility is RVW of 4.0, plus small PE RVUs – does not include catheter

MFS payment for new service performed in office is RVW 4.0 *Plus* 82.5 PE RVUs

# Why Is There a Difference between Unscaled Input Cost and SMS Cost?

Initially felt that CPEP data was inaccurate and in many cases inflated.

Now that PEAC is almost done, more accurate, the SMS data becomes suspect.

If scaling factor is >> 1.0, SMS pool estimate is much more than CPEP/PEAC Inputs.  How can that be?

Bad SMS Survey data?

Systematic inclusion in SMS that is not in CPEP/PEAC data?  Clinical labor or Supplies that are separately billable were included in SMS – not excluded

# Important Details

These examples are VERY simplified

Budget neutralization steps excluded

Blending if multiple specialties provide service has not been addressed in this presentation

CMS has NOT reviewed these slides for accuracy

# Where does RUC go from here?

Is this important for RUC to address?

How do we attack the problem?

Look at Very Low or Very High Scaling factors?

Limit impact of high/low scaling factors?

**AMA/Specialty Society RVS Update Committee**
**Practice Expense Subcommittee Report**
**January 29, 2004**

The Practice Expense Subcommittee met during the February 2004 RUC meeting to discuss the allocation of physician time components, two practice expense methodologies used by CMS, and the removal of survey data in the RUC database. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Przbylski, Siegel, Strate, and Wiersema.

## Physician Time Allocations

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes, which have only total physician time within CMS's database. The PEAC has assigned post operative practice expense inputs according to existing codes through RUC and CMS physician time components. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide all the necessary time components for each of the identified codes. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

The Subcommittee and the RUC have expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs and should have no bearing on physician work. With this in mind, the RUC has directed AMA staff to clearly identify these codes within the RUC database to indicate to RUC members that the physician time from this exercise is not to be considered when making work recommendations.

For this meeting, AMA staff obtained physician time allocations for 4 CPT codes. Two have been surveyed and two have been allocated to existing "PR" (CMS cross-walked) time. Subcommittee members first reviewed two surveyed codes presented by the American Burn Association, American Society of Plastic Surgeons, and American Podiatric Medical Association. The Subcommittee believed that the total time being presented, 173 minutes for CPT 15342 and 77 minutes for CPT 15343, did not equate to the physician work value, of 1.0 and 0.25 respectively. A comment was made by a CMS observer that the global period should be reconsidered. The two codes had previously been G codes and the work value had been cross-walked to new CPT codes in 1999. Subcommittee members rejected the time components recommended by the specialty societies and recommended the following to the RUC for approval:

> **The RUC recommends that the specialty society should request that CMS make a recommendation concerning the global period, the society consider performing a full RUC survey for codes 15342 and 15343. This review includes physician time and work recommendations. In addition, the two codes will be taken off the March 2004 PEAC agenda.**

The Subcommittee then reviewed two other codes presented by the society of American Academy of Otolaryngology – Head and Neck Surgery. The Subcommittee agreed with the specialty's time allocation. This time allocation is shown below.

| CPT | Descriptor | glob | "PR" Time | "PR" total time split | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | pre time | intra time | Im-SD | Hosp Visits (992-) | | | | Office Visits (992-) | | | | |
| | | | | | | | 33 | 32 | 31 | 38 | 15 | 14 | 13 | 12 | 11 |
| 64885 | Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length | 090 | **384** | 60 | 151 | 30 | | | 2 | 1.0 | | | 3 | | |
| 64886 | Nerve graft (includes obtaining graft), head or neck; more than 4 cm length | 090 | **440** | 60 | 177 | 30 | | 1 | 2 | 1.0 | | | 3 | | |

**CMS's Scaling Factors between CPEP data and SMS Survey Data:**

CMS has requested the RUC to begin a general discussion of the scaling factors CMS uses to equate the CPEP derived cost pools with the Socioeconomic Monitoring System derived pools, to identify where anomalies might exist and what future actions to take. Doctor Zwolak made a presentation on the derivation of the CMS scaling factors in the top down practice expense methodology. If the SMS data and the CPEP data were identical, for any particular specialty group, the scaling factor would be 1.00. If the scaling factor is shown to be less than 1.00, the CPEP data would be indicating higher specialty costs than the SMS survey data indicates. If the scaling factor is shown to be greater than 1.00, the CPEP data would be indicating lower costs than the SMS survey data indicates.

CMS representatives explained that, over time, the clinical labor portion of the scaling factors have come closer to equality due to the PEAC's efforts to refine direct inputs. CMS suggested that specialty societies and the RUC continue to seek the true cost of medical services, either through supplemental surveys, and other methods through the RUC process.

Subcommittee members discussed the practice expense direct input methodology in detail and expressed concern regarding these scaling factors and the implications to the practice expense methodology. The Subcommittee recommends the following to the RUC:

> **The RUC express a note of grave concern regarding aberrations in some PE RVUs brought about by the current PE methodology.**
>
> **The RUC should continue to explore and suggest improvements in CMS's practice expense methodology, in order to minimize anomalies in CMS's scaling factors.**

**Removal of Rejected RUC Survey Data from the RUC Database**

The American Society for Surgery of the Hand (ASSH) and the American Academy of Orthopaedic Surgery (AAOS), requested that the RUC remove the rejected RUC survey data of code 64718 from the RUC database and any AMA/CPT product containing this information. The RUC had included the data from this code in the RUC database despite the rejection of survey data during the initial 5-year review. ASSH and AAOS considered the data in the database to be misleading and inaccurate, since it was rejected by the RUC. AMA staff searched the RUC database for any code where 64718 had been used in a RUC rationale for a new or revised code and found none. Subcommittee members agreed with the specialty society's recommendation to remove the data, and made the following recommendation.

> **The AAOS survey vignette, service descriptions, and RUC survey data for CPT code 64718 should be removed from the RUC database.**

AMA staff will communicate this change to other AMA publications since it was rejected by the RUC.

*Approved by the RUC – January 2004*

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**AMA/Specialty RVS Update Committee**
**Practice Expense Advisory Committee**

**August 20-23, 2003**

Bill Moran, MD (Chair)
James Anthony, MD
Katherine Bradley, PhD, RN
Joel Brill, MD
Ann Cea, MD
Manuel D. Cerqueira, MD
Neal Cohen, MD
Richard A. Dickey, MD
Thomas A. Felger, MD
Blair Filler, MD
Mary Foto, OTR
Gregory Kwasny, MD
Alex G. Little, MD
Peter McCreight, MD
Scott Manaker, MD
James Metcalf, MD
Tye Ouzounian, MD
Julia Pillsbury, DO
Dighton Packard, MD
James Regan, MD
Anthony Senagore, MD
Charles Shoemaker, MD
Craig Strattford, MD
Daniel Mark Siegel, MD, MS
Robert Stomel, DO
Lester Wold, MD
Peter Weber, MD

**Call to Order**
Doctor Moran called the group to order and welcomed the three new PEAC members, Charles Shoemaker, MD to the other rotating seat, and Joel Brill, MD and Richard Dickey, MD to the Internal Medicine rotating seats.

**CMS Update**
Ken Simon MD has been promoted to Medical Officer at CMS and will be the new RUC liaison. CMS has been busy publishing three new proposed rules, one for the physician fee schedule, one for the prospective outpatient system, and an additional one for the average wholesale price for the AWP proposed rule, and they welcome comments. Carolyn Mullen, wanted to add that CMS believes that the PEAC has done a magnificent job, and that 83% of Medicare expenditure has been refined by the PEAC. Ms. Mullen stressed that with the amount of work being generated from the PEAC and the RUC, they have had to hire additional staff, all of whom have never been to any of the meetings. It is therefore important for specialty societies to review the proposed rule carefully for errors in the RVUs, and the practice expense inputs. Societies should contact CMS directly for any questions they may have.

Ms. Mullen also reminded specialty staff that all the recommendations are entered into a database by people who have never been to a meeting, and therefore they need to be laid out in a clear and concise manner. For example if a recommendation has different staff types, the total clinical labor time in each time period for each staff type needs to be clearly broken out. In addition, AMA staff has supplied specialties with the proposed rule CPEP data on their agenda CDs so that they may review the recommendations.

In addition, Ms. Mullen mentioned that with the implementation of the 90 day global standard package, CMS has found that for some codes, this standard may not apply. Additional or different items may be wiped out by the implementation of the standard, and it is important for the specialty to step forward and identify what items should remain or be added for a particular code or family of codes. The PEAC would then review these additional items, and if approved, recommend them to CMS, to fully refine the inputs.

**Percutaneous Endovascular Workgroup Discussion**

The RUC and the Percutaneous Endovascular Workgroup discussed the issue of procedures that have historically been performed in the facility setting, but are now also being performed in the non-facility setting. The PEAC and the workgroup have believed that these changes in the sites of service may be reimbursed through the movement of Part A funds to Part B funds, or by some other mechanism. Members of the PEAC and the workgroup had met with RUC members at the April 2003 RUC meeting and with the CMS Administrator. Doctor Cerqueira, the Chair of the workgroup, explained that the CMS administrator told the RUC that the only way to shift funds from Part A to Part B is through legislative action. It was also explained that the SGR target rate may have to change to accommodate these changes in the sites of service.

The workgroup had met in August 2003 via conference call and concluded that they needed direction from the PEAC as a whole as to whether it was appropriate to price the percutaneous endovascular codes, or any code not currently priced in the office, in the office setting. Workgroup members had concerns of not only the potential shifts in Part B funds between specialties, but also concerns of patient safety and the quality of care.

PEAC members believed that with new technologies, the sites of service may change dramatically over the next few years, and the RUC may want to review the fact that there may not be a definitive site of service for many codes in the future. In addition, in a letter to the PEAC, RUC chairman Bill Rich had suggested that the PEAC "refine the non-facility inputs for the group of percutaneous endovascular procedures, if it is the desire of the specialty societies to do so" and that the "specialty societies present inputs that reflect the predominate current practice for this setting, and not be based on isolated examples."

CMS medical officer, Ken Simon, MD explained that CMS's Administrator is reviewing the issue of changing sites of service, however there is not a sense of enthusiasm of having CMS consider having labor and resource intensive procedures shifted to the office setting when the money for these procedures isn't following. In addition, PEAC members believe that by pricing procedures in the office setting that have historically been facility procedures, it will automatically alter practice patterns and may have a significant impact on the remaining physician's who provide services under Part B. Doctor Senegore, explained that the issue is large and complex, and that it is important for the RUC to be involved.

PEAC members also believed that economically and for the patient, a shift in the site of service may be appropriate for specific procedures. Doctor McCreight pointed out that ACR and SIR believe that it is appropriate to perform these percutaneous endovascular procedures out of facility setting, specifically in an physician's office.

AMA staff pointed out that the SGR can grow to account for changes in law and regulation, and by having these services be priced in the office setting, it could be interpreted as a change in law and regulation. Therefore, to the extent that procedures are moving into the office setting where all

payments are subject to the SGR, there will be increased SGR spending without a corresponding increase in the SGR target.

The PEAC decided that **the PEAC formulate in-office direct practice expense inputs for these percutaneous endovascular codes and refer them to a study group for an economic analysis, and review. All other codes currently listed as "NA" in the office setting will also be studied by the workgroup. The PEAC will then make its report to the RUC at a later date.**

To begin the process, Doctor Moran said that he will mention the discussion and decisions made here at the PEAC, during the September 2003 RUC Practice Expense Subcommittee meeting. It was suggested that information could be solicited from the RUC and CMS concerning the current expenditures and volume of these services, to begin understanding what the impact would be of shifting the sites of service of these specific procedures. PEAC members would rely on CMS for much of the data and economic analyses needed to truly understand the impacts of these changes in sites of service. It was also suggested and stressed that the workgroup be comprised of RUC and PEAC members, and that the results of the workgroup would be reviewed by the whole PEAC prior to any final recommendations being forwarded to the RUC or CMS.

**EndoCath and Selective Catheter Families Deferred till January 2004**

The Society for Interventional Radiology (SIR) brought two families of codes forward for revision of their direct practice expense inputs without the associated supervision and interpretation codes. The PEAC believed it would be more appropriate to review these two families with their associated supervision and interpretation codes and deferred their refinement until January 2004. The following codes were deferred till the January 2004 PEAC meeting: 36011 through 36015, 36215 through 36218, 36245 through 36248, 36481, 35470 through 35476, and 37203.

**Code 32002 Deferred till January 2004**

CPT Code 32002 was deferred till the January 2004 meeting when input from the Pulmonary Medicine would be available.

**Clinical Staff Time Adjustment for 2004 Fee Schedule**

In 1997, CPT created new codes to differentiate between open and percutaneous abscess drainage. Unlike the open procedure counterparts, all of the percutaneous codes were assigned a global period of 000 days. It appears that CMS cross walked the direct inputs from the open codes to the percutaneous codes, which seemed inappropriate to AMA staff, considering the differences in the global periods, and the PEAC's standards. Each of the following percutaneous codes are priced in the facility setting only and are predominately performed in the inpatient setting. The PEAC accepted the AMA staff recommendation for the following codes be recommended to have zero clinical labor staff time in the facility setting.

| Code | Short Descriptor |
|---|---|
| 32201 | Drain, percutaneous, lung lesion |
| 44901 | Drain app abscess, percutaneous |
| 48511 | Drain pancreatic pseudocyst |
| 49021 | Drain peritoneal abscess |
| 49041 | Drain, precut, abdominal abscess |
| 49061 | Drain, precut, retroperitoneal abscess |
| 50021 | Renal abscess, precut drain |
| 58823 | Drain pelvic abscess, percutaneous |

In addition, the PEAC agreed with AMA staff that code 67875 *Temporary closure of eyelids by suture (eg, Frost suture)* was an anomaly in that the CPEP data indicates post operative direct inputs for this 000 day global code. Ahead of CMS's implementation of the March 2003 PEAC recommendations, AMA staff and the PEAC agreed that this code's refined practice expense recommendations be put in place for the 2004 Medicare fee schedule.

**Spine Injection Codes Using Low Osmolar Contrast**

The North American Spine Society (NASS) alerted the PEAC that in January the PEAC will be reviewing a group of codes where contrast material needs to be utilized. NASS informed the group that the standard of care for spine injection procedures has gone to a newer contrast material, and when CMS first started reimbursing physicians for these procedures, there was a very specific ruling that it could only paid by CMS when certain criteria are met. What has happened is with the evolution of the standard of care for specific spine procedures, the low Osmoler contrast material is now universally being used, rather than the old dyes that were utilized. NASS requested support from the PEAC in their effort to have CMS revise their reimbursement policy statement for the use of the new contrast material, reflecting the new standard of care.

Medical officer, Ken Simon, MD from CMS stated that CMS is aware of the issue and is currently reviewing its policy statement to reflect the contemporary use of the agent. **The PEAC supports NASS's efforts to have CMS clarify its policy statement for the use of low Osmolar contrast media facilitated by January, so that the decision could be utilized by the PEAC during its January 2004 meeting**

**Refinement of Codes 21078 through 21089**

The American Association of Oral and Maxillofacial Surgeons (AAOMS), and the American Dental Association (ADA) had asked the PEAC to remove codes 21078 through 21089 from the PEAC's agenda, as CMS was currently in the process of providing specific direct inputs for the codes. CMS officials stated that they would be talking with the American College of Prosthodontists (ACP) directly to create specific practice expense inputs, and would like the entire PEAC to review the specific inputs once they are compiled by CMS, to ensure the PEAC and CMS were in agreement. The PEAC accepted CMS's proposal to review the specific inputs for the family of codes once they've been compiled by CMS. For now, in the 2004 Medicare proposed rule, CMS is proposing to eliminate the special practice expense pool for these procedure codes, and use otolaryngology as the crosswalk for oral surgeons and maxillofacial surgeons as a more appropriate approximation of the specialties practice expense per hour.

**Codes where No Recommendations were Received**

The following codes were on the August 2003 agenda whereas Society for Interventional Radiology had expressed interest in their refinement, and no recommendations were received:

20225 Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)
27095 Injection procedure for hip arthrography; with anesthesia
75945 Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel
75946 Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)

The PEAC decided that codes 20225 and 27095 should be reviewed by Radiology, and codes 75945 and 75946 should be reviewed by Cardiology at the January 2004 meeting.

**PEAC Transition Issues**

AMA staff identified a list codes that had been partially refined by the PEAC and a list of unrefined codes for PEAC review. The partially refined codes were placed on the March 2004 agenda so that they may be fully refined. AMA staff also identified codes that have not gone through the PEAC process.

A PEAC transition workgroup has been organized as the PEAC will sunset after its March 2004 meeting. The transition workgroup will consist of doctors Bill Moran (Chair), Joel Brill, Jim Borgsted, Mary Foto, Greg Kwasny, Barabara Levy, Dan Siegel, Greg Przybylski, and Richard Whitten. To help this group, Doctor Moran asked PEAC members to submit recommendations to the group as to what should occur, and how should the RUC handle the new code practice expenses in the future. There has been concern throughout the RUC, that the practice expense inputs of new codes have not gone through the same level of scrutiny as the codes that have been reviewed by the PEAC. Understandably this is a sensitive issue, and Doctor Moran is asking PEAC members for their feedback as to how the RUC may proceed with its review of practice expense inputs.

**Clarification of Instrument Packs**
Doctor Moran clarified when a procedure qualified for a medium instrument pack. A medium pack is allowed when $1,500 or more of instruments is typically used for the procedure. It was clarified that a $1,000 pack does not qualify as a medium pack, but would qualify as a basic pack. In addition, the specialty should provide a specific list of the contents, prices, and sources of each instrument in any pack contained in the practice expense inputs for a code.

**Sedation or Anesthetic Preparation Time**
Recognizing that there is clinical labor involved in the preparation of sedation or anesthetic agents administered by the physician, the PEAC agreed that the PEAC set a 2 minute standard for such activities with the standard clinical staff blend.

**Removal of Phone Call Time in the Post-Op Period**
CMS asked the PEAC to discuss the appropriateness of including a phone call in the post operative period for 10 and 90 day global codes. Ms. Mullen stated that such phone calls are questionable and would need to specifically be approved as an exception to the PEAC standard packages. Therefore Ms. Mullen suggested that these phone calls should be removed from all PEAC recommendations. The PEAC agreed that any phone calls in the post op in office period for 10 and 90 day codes should be removed, as the post op e/m codes already contain time for phone calls and adding any additional calls would be duplicative. The PEAC agreed to the change and AMA staff will make a change to the standard spreadsheet to clarify the use of phone calls.

**Film Processor Time**
During its discussion of the radiology codes, the PEAC set a standard of 2 minutes for an initial film to be processed, and 1 minute for each additional film.

**March 2004 PEAC Party**
The PEAC decided that tentatively, the PEAC would have its farewell party on Thursday, March 25, 2004

## *Codes Refined by the PEAC*
## *August 2003*

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|---|---|---|---|---|---|
| 10120 | 010 | Remove foreign body | 10140 | 010 | Drainage of hematoma/fluid |
| 10160 | 010 | Puncture drainage of lesion | 11740 | 000 | Drain blood from under nail |
| 11755 | 000 | Biopsy, nail unit | 11760 | 010 | Repair of nail bed |
| 11762 | 010 | Reconstruction of nail bed | 11765 | 010 | Excision of nail fold, toe |
| 11971 | 090 | Remove tissue expander(s) | 15050 | 090 | Skin pinch graft |
| 15220 | 090 | Skin full graft | 15240 | 090 | Skin full graft |
| 15350 | 090 | Skin homograft | 15400 | 090 | Skin heterograft |
| 15570 | 090 | Form skin pedicle flap | 15572 | 090 | Form skin pedicle flap |
| 15574 | 090 | Form skin pedicle flap | 15576 | 090 | Form skin pedicle flap |
| 15600 | 090 | Skin graft | 15610 | 090 | Skin graft |
| 15620 | 090 | Skin graft | 15630 | 090 | Skin graft |
| 15650 | 090 | Transfer skin pedicle flap | 15760 | 090 | Composite skin graft |
| 15810 | 090 | Salabrasion | 15811 | 090 | Salabrasion |
| 15837 | 090 | Excise excessive skin tissue | 15839 | 090 | Excise excessive skin tissue |
| 15860 | 000 | Test for blood flow in graft | 19350 | 090 | Breast reconstruction |
| 19355 | 090 | Correct inverted nipple(s) | 20680 | 090 | Removal of support implant |
| 20694 | 090 | Remove bone fixation device | 20900 | 090 | Removal of bone for graft |
| 20910 | 090 | Remove cartilage for graft | 20922 | 090 | Removal of fascia for graft |
| 20972 | 090 | Bone/skin graft, metatarsal | 21077 | 090 | Prepare face/oral prosthesis |
| 21079 | 090 | Prepare face/oral prosthesis | 21080 | 090 | Prepare face/oral prosthesis |
| 21081 | 090 | Prepare face/oral prosthesis | 21082 | 090 | Prepare face/oral prosthesis |
| 21083 | 090 | Prepare face/oral prosthesis | 21084 | 090 | Prepare face/oral prosthesis |
| 21086 | 090 | Prepare face/oral prosthesis | 21087 | 090 | Prepare face/oral prosthesis |
| 21088 | 090 | Prepare face/oral prosthesis | 21100 | 090 | Maxillofacial fixation |
| 21110 | 090 | Interdental fixation | 21125 | 090 | Augmentation, lower jaw bone |
| 21127 | 090 | Augmentation, lower jaw bone | 21208 | 090 | Augmentation of facial bones |
| 21209 | 090 | Reduction of facial bones | 21210 | 090 | Face bone graft |
| 21215 | 090 | Lower jaw bone graft | 21235 | 090 | Ear cartilage graft |
| 21245 | 090 | Reconstruction of jaw | 21246 | 090 | Reconstruction of jaw |
| 21248 | 090 | Reconstruction of jaw | 21249 | 090 | Reconstruction of jaw |
| 21270 | 090 | Augmentation, cheek bone | 21337 | 090 | Treat nasal septal fracture |
| 21345 | 090 | Treat nose/jaw fracture | 21345 | 090 | Treat nose/jaw fracture |
| 21346 | 090 | Treat nose/jaw fracture | 21360 | 090 | Treat cheek bone fracture |
| 21400 | 090 | Treat eye socket fracture | 21401 | 090 | Treat eye socket fracture |
| 21431 | 090 | Treat craniofacial fracture | 21440 | 090 | Treat dental ridge fracture |
| 21445 | 090 | Treat dental ridge fracture | 21450 | 090 | Treat lower jaw fracture |
| 21451 | 090 | Treat lower jaw fracture | 21452 | 090 | Treat lower jaw fracture |
| 21453 | 090 | Treat lower jaw fracture | 21461 | 090 | Treat lower jaw fracture |
| 21462 | 090 | Treat lower jaw fracture | 21485 | 090 | Reset dislocated jaw |
| 21497 | 090 | Interdental wiring | 21800 | 090 | Treatment of rib fracture |
| 21820 | 090 | Treat sternum fracture | 21925 | 090 | Biopsy soft tissue of back |
| 21930 | 090 | Remove lesion, back or flank | 23000 | 090 | Removal of calcium deposits |
| 23066 | 090 | Biopsy shoulder tissues | 23500 | 090 | Treat clavicle fracture |
| 23505 | 090 | Treat clavicle fracture | 23520 | 090 | Treat clavicle dislocation |
| 23525 | 090 | Treat clavicle dislocation | 23540 | 090 | Treat clavicle dislocation |

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|---|---|---|---|---|---|
| 23545 | 090 | Treat clavicle dislocation | 23570 | 090 | Treat shoulder blade fx |
| 23575 | 090 | Treat shoulder blade fx | 23600 | 090 | Treat humerus fracture |
| 23605 | 090 | Treat humerus fracture | 23620 | 090 | Treat humerus fracture |
| 23625 | 090 | Treat humerus fracture | 23650 | 090 | Treat shoulder dislocation |
| 23665 | 090 | Treat dislocation/fracture | 23675 | 090 | Treat dislocation/fracture |
| 23921 | 090 | Amputation follow-up surgery | 24066 | 090 | Biopsy arm/elbow soft tissue |
| 24075 | 090 | Remove arm/elbow lesion | 24201 | 090 | Removal of arm foreign body |
| 24500 | 090 | Treat humerus fracture | 24505 | 090 | Treat humerus fracture |
| 24530 | 090 | Treat humerus fracture | 24535 | 090 | Treat humerus fracture |
| 24560 | 090 | Treat humerus fracture | 24565 | 090 | Treat humerus fracture |
| 24576 | 090 | Treat humerus fracture | 24577 | 090 | Treat humerus fracture |
| 24600 | 090 | Treat elbow dislocation | 24650 | 090 | Treat radius fracture |
| 24655 | 090 | Treat radius fracture | 24670 | 090 | Treat ulnar fracture |
| 24675 | 090 | Treat ulnar fracture | 25500 | 090 | Treat fracture of radius |
| 25505 | 090 | Treat fracture of radius | 25520 | 090 | Treat fracture of radius |
| 25530 | 090 | Treat fracture of ulna | 25535 | 090 | Treat fracture of ulna |
| 25560 | 090 | Treat fracture radius & ulna | 25565 | 090 | Treat fracture radius & ulna |
| 25600 | 090 | Treat fracture radius/ulna | 25605 | 090 | Treat fracture radius/ulna |
| 25622 | 090 | Treat wrist bone fracture | 25624 | 090 | Treat wrist bone fracture |
| 25630 | 090 | Treat wrist bone fracture | 25635 | 090 | Treat wrist bone fracture |
| 25650 | 090 | Treat wrist bone fracture | 25675 | 090 | Treat wrist dislocation |
| 26600 | 090 | Treat metacarpal fracture | 26605 | 090 | Treat metacarpal fracture |
| 26641 | 090 | Treat thumb dislocation | 26645 | 090 | Treat thumb fracture |
| 26670 | 090 | Treat hand dislocation | 26675 | 090 | Treat hand dislocation |
| 26700 | 090 | Treat knuckle dislocation | 26705 | 090 | Treat knuckle dislocation |
| 26720 | 090 | Treat finger fracture, each | 26725 | 090 | Treat finger fracture, each |
| 26740 | 090 | Treat finger fracture, each | 26742 | 090 | Treat finger fracture, each |
| 26750 | 090 | Treat finger fracture, each | 26755 | 090 | Treat finger fracture, each |
| 26770 | 090 | Treat finger dislocation | 26775 | 090 | Treat finger dislocation |
| 26991 | 090 | Drainage of pelvis bursa | 27047 | 090 | Remove hip/pelvis lesion |
| 27193 | 090 | Treat pelvic ring fracture | 27194 | 090 | Treat pelvic ring fracture |
| 27200 | 090 | Treat tail bone fracture | 27220 | 090 | Treat hip socket fracture |
| 27230 | 090 | Treat thigh fracture | 27246 | 090 | Treat thigh fracture |
| 27301 | 090 | Drain thigh/knee lesion | 27327 | 090 | Removal of thigh lesion |
| 27372 | 090 | Removal of foreign body | 27500 | 090 | Treatment of thigh fracture |
| 27501 | 090 | Treatment of thigh fracture | 27508 | 090 | Treatment of thigh fracture |
| 27516 | 090 | Treat thigh fx growth plate | 27517 | 090 | Treat thigh fx growth plate |
| 27520 | 090 | Treat kneecap fracture | 27530 | 090 | Treat knee fracture |
| 27532 | 090 | Treat knee fracture | 27538 | 090 | Treat knee fracture(s) |
| 27550 | 090 | Treat knee dislocation | 27560 | 090 | Treat kneecap dislocation |
| 27603 | 090 | Drain lower leg lesion | 27604 | 090 | Drain lower leg bursa |
| 27614 | 090 | Biopsy lower leg soft tissue | 27618 | 090 | Remove lower leg lesion |
| 27619 | 090 | Remove lower leg lesion | 27630 | 090 | Removal of tendon lesion |
| 27656 | 090 | Repair leg fascia defect | 27658 | 090 | Repair of leg tendon, each |
| 27659 | 090 | Repair of leg tendon, each | 27664 | 090 | Repair of leg tendon, each |
| 27665 | 090 | Repair of leg tendon, each | 27685 | 090 | Revision of lower leg tendon |
| 27686 | 090 | Revise lower leg tendons | 27730 | 090 | Repair of tibia epiphysis |
| 27732 | 090 | Repair of fibula epiphysis | 27740 | 090 | Repair of leg epiphyses |
| 27742 | 090 | Repair of leg epiphyses | 27750 | 090 | Treatment of tibia fracture |

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|---|---|---|---|---|---|
| 27752 | 090 | Treatment of tibia fracture | 27760 | 090 | Treatment of ankle fracture |
| 27762 | 090 | Treatment of ankle fracture | 27780 | 090 | Treatment of fibula fracture |
| 27781 | 090 | Treatment of fibula fracture | 27786 | 090 | Treatment of ankle fracture |
| 27788 | 090 | Treatment of ankle fracture | 27808 | 090 | Treatment of ankle fracture |
| 27810 | 090 | Treatment of ankle fracture | 27816 | 090 | Treatment of ankle fracture |
| 27818 | 090 | Treatment of ankle fracture | 27824 | 090 | Treat lower leg fracture |
| 27825 | 090 | Treat lower leg fracture | 27830 | 090 | Treat lower leg dislocation |
| 28001 | 010 | Drainage of bursa of foot | 28002 | 010 | Treatment of foot infection |
| 28003 | 090 | Treatment of foot infection | 28008 | 090 | Incision of foot fascia |
| 28010 | 090 | Incision of toe tendon | 28011 | 090 | Incision of toe tendons |
| 28020 | 090 | Exploration of foot joint | 28022 | 090 | Exploration of foot joint |
| 28024 | 090 | Exploration of toe joint | 28035 | 090 | Decompression of tibia nerve |
| 28043 | 090 | Excision of foot lesion | 28045 | 090 | Excision of foot lesion |
| 28046 | 090 | Resection of tumor, foot | 28050 | 090 | Biopsy of foot joint lining |
| 28052 | 090 | Biopsy of foot joint lining | 28054 | 090 | Biopsy of toe joint lining |
| 28060 | 090 | Partial removal, foot fascia | 28062 | 090 | Removal of foot fascia |
| 28070 | 090 | Removal of foot joint lining | 28072 | 090 | Removal of foot joint lining |
| 28080 | 090 | Removal of foot lesion | 28086 | 090 | Excise foot tendon sheath |
| 28088 | 090 | Excise foot tendon sheath | 28090 | 090 | Removal of foot lesion |
| 28092 | 090 | Removal of toe lesions | 28100 | 090 | Removal of ankle/heel lesion |
| 28103 | 090 | Remove/graft foot lesion | 28104 | 090 | Removal of foot lesion |
| 28107 | 090 | Remove/graft foot lesion | 28108 | 090 | Removal of toe lesions |
| 28110 | 090 | Part removal of metatarsal | 28111 | 090 | Part removal of metatarsal |
| 28112 | 090 | Part removal of metatarsal | 28113 | 090 | Part removal of metatarsal |
| 28114 | 090 | Removal of metatarsal heads | 28116 | 090 | Revision of foot |
| 28118 | 090 | Removal of heel bone | 28119 | 090 | Removal of heel spur |
| 28120 | 090 | Part removal of ankle/heel | 28122 | 090 | Partial removal of foot bone |
| 28124 | 090 | Partial removal of toe | 28126 | 090 | Partial removal of toe |
| 28140 | 090 | Removal of metatarsal | 28150 | 090 | Removal of toe |
| 28153 | 090 | Partial removal of toe | 28160 | 090 | Partial removal of toe |
| 28173 | 090 | Extensive foot surgery | 28175 | 090 | Extensive foot surgery |
| 28190 | 010 | Removal of foot foreign body | 28192 | 090 | Removal of foot foreign body |
| 28193 | 090 | Removal of foot foreign body | 28200 | 090 | Repair of foot tendon |
| 28202 | 090 | Repair/graft of foot tendon | 28208 | 090 | Repair of foot tendon |
| 28210 | 090 | Repair/graft of foot tendon | 28220 | 090 | Release of foot tendon |
| 28222 | 090 | Release of foot tendons | 28225 | 090 | Release of foot tendon |
| 28226 | 090 | Release of foot tendons | 28230 | 090 | Incision of foot tendon(s) |
| 28232 | 090 | Incision of toe tendon | 28234 | 090 | Incision of foot tendon |
| 28238 | 090 | Revision of foot tendon | 28240 | 090 | Release of big toe |
| 28250 | 090 | Revision of foot fascia | 28260 | 090 | Release of midfoot joint |
| 28261 | 090 | Revision of foot tendon | 28262 | 090 | Revision of foot and ankle |
| 28264 | 090 | Release of midfoot joint | 28270 | 090 | Release of foot contracture |
| 28272 | 090 | Release of toe joint, each | 28280 | 090 | Fusion of toes |
| 28285 | 090 | Repair of hammertoe | 28286 | 090 | Repair of hammertoe |
| 28288 | 090 | Partial removal of foot bone | 28289 | 090 | Repair hallux rigidus |
| 28290 | 090 | Correction of bunion | 28292 | 090 | Correction of bunion |
| 28294 | 090 | Correction of bunion | 28296 | 090 | Correction of bunion |
| 28297 | 090 | Correction of bunion | 28298 | 090 | Correction of bunion |
| 28299 | 090 | Correction of bunion | 28300 | 090 | Incision of heel bone |

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|---|---|---|---|---|---|
| 28302 | 090 | Incision of ankle bone | 28304 | 090 | Incision of midfoot bones |
| 28305 | 090 | Incise/graft midfoot bones | 28305 | 090 | Incise/graft midfoot bones |
| 28306 | 090 | Incision of metatarsal | 28307 | 090 | Incision of metatarsal |
| 28308 | 090 | Incision of metatarsal | 28310 | 090 | Revision of big toe |
| 28312 | 090 | Revision of toe | 28313 | 090 | Repair deformity of toe |
| 28315 | 090 | Removal of sesamoid bone | 28322 | 090 | Repair of metatarsals |
| 28340 | 090 | Resect enlarged toe tissue | 28341 | 090 | Resect enlarged toe |
| 28344 | 090 | Repair extra toe(s) | 28345 | 090 | Repair webbed toe(s) |
| 28400 | 090 | Treatment of heel fracture | 28405 | 090 | Treatment of heel fracture |
| 28430 | 090 | Treatment of ankle fracture | 28435 | 090 | Treatment of ankle fracture |
| 28450 | 090 | Treat midfoot fracture, each | 28455 | 090 | Treat midfoot fracture, each |
| 28470 | 090 | Treat metatarsal fracture | 28475 | 090 | Treat metatarsal fracture |
| 28490 | 090 | Treat big toe fracture | 28495 | 090 | Treat big toe fracture |
| 28496 | 090 | Treat big toe fracture | 28505 | 090 | Treat big toe fracture |
| 28510 | 090 | Treatment of toe fracture | 28515 | 090 | Treatment of toe fracture |
| 28525 | 090 | Treat toe fracture | 28530 | 090 | Treat sesamoid bone fracture |
| 28531 | 090 | Treat sesamoid bone fracture | 28540 | 090 | Treat foot dislocation |
| 28545 | 090 | Treat foot dislocation | 28546 | 090 | Treat foot dislocation |
| 28555 | 090 | Repair foot dislocation | 28570 | 090 | Treat foot dislocation |
| 28575 | 090 | Treat foot dislocation | 28576 | 090 | Treat foot dislocation |
| 28585 | 090 | Repair foot dislocation | 28600 | 090 | Treat foot dislocation |
| 28605 | 090 | Treat foot dislocation | 28606 | 090 | Treat foot dislocation |
| 28645 | 090 | Repair toe dislocation | 28675 | 090 | Repair of toe dislocation |
| 28740 | 090 | Fusion of foot bones | 28750 | 090 | Fusion of big toe joint |
| 28755 | 090 | Fusion of big toe joint | 28760 | 090 | Fusion of big toe joint |
| 28820 | 090 | Amputation of toe | 28825 | 090 | Partial amputation of toe |
| 29893 | 090 | Scope, plantar fasciotomy | 30580 | 090 | Repair upper jaw fistula |
| 30600 | 090 | Repair mouth/nose fistula | 40500 | 090 | Partial excision of lip |
| 40510 | 090 | Partial excision of lip | 40520 | 090 | Partial excision of lip |
| 40530 | 090 | Partial removal of lip | 40650 | 090 | Repair lip |
| 40652 | 090 | Repair lip | 40654 | 090 | Repair lip |
| 40840 | 090 | Reconstruction of mouth | 40842 | 090 | Reconstruction of mouth |
| 40843 | 090 | Reconstruction of mouth | 40844 | 090 | Reconstruction of mouth |
| 40845 | 090 | Reconstruction of mouth | 41005 | 010 | Drainage of mouth lesion |
| 41006 | 090 | Drainage of mouth lesion | 41007 | 090 | Drainage of mouth lesion |
| 41008 | 090 | Drainage of mouth lesion | 41009 | 090 | Drainage of mouth lesion |
| 41015 | 090 | Drainage of mouth lesion | 41016 | 090 | Drainage of mouth lesion |
| 41017 | 090 | Drainage of mouth lesion | 41018 | 090 | Drainage of mouth lesion |
| 41823 | 090 | Excision of gum lesion | 41827 | 090 | Excision of gum lesion |
| 41872 | 090 | Repair gum | 41874 | 090 | Repair tooth socket |
| 42107 | 090 | Excision lesion, mouth roof | 42140 | 090 | Excision of uvula |
| 42260 | 090 | Repair nose to lip fistula | 42325 | 090 | Create salivary cyst drain |
| 42326 | 090 | Create salivary cyst drain | 42335 | 090 | Removal of salivary stone |
| 42340 | 090 | Removal of salivary stone | 42408 | 090 | Excision of salivary cyst |
| 42409 | 090 | Drainage of salivary cyst | 42600 | 090 | Closure of salivary fistula |
| 42665 | 090 | Ligation of salivary duct | 50010 | 090 | Exploration of kidney |
| 50020 | 090 | Renal abscess, open drain | 50040 | 090 | Drainage of kidney |
| 50045 | 090 | Exploration of kidney | 50060 | 090 | Removal of kidney stone |
| 50065 | 090 | Incision of kidney | 50070 | 090 | Incision of kidney |

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| 50075 | 090 | Removal of kidney stone | 50080 | 090 | Removal of kidney stone |
| 50081 | 090 | Removal of kidney stone | 50100 | 090 | Revise kidney blood vessels |
| 50120 | 090 | Exploration of kidney | 50125 | 090 | Explore and drain kidney |
| 50130 | 090 | Removal of kidney stone | 50135 | 090 | Exploration of kidney |
| 50200 | 000 | Biopsy of kidney | 50205 | 090 | Biopsy of kidney |
| 50220 | 090 | Remove kidney, open | 50225 | 090 | Removal kidney open, complex |
| 50230 | 090 | Removal kidney open, radical | 50234 | 090 | Removal of kidney & ureter |
| 50236 | 090 | Removal of kidney & ureter | 50240 | 090 | Partial removal of kidney |
| 50280 | 090 | Removal of kidney lesion | 50290 | 090 | Removal of kidney lesion |
| 50300 | XXX | Removal of donor kidney | 50320 | 090 | Removal of donor kidney |
| 50340 | 090 | Removal of kidney | 50360 | 090 | Transplantation of kidney |
| 50365 | 090 | Transplantation of kidney | 50370 | 090 | Remove transplanted kidney |
| 50380 | 090 | Reimplantation of kidney | 50400 | 090 | Revision of kidney/ureter |
| 50405 | 090 | Revision of kidney/ureter | 50500 | 090 | Repair of kidney wound |
| 50520 | 090 | Close kidney-skin fistula | 50525 | 090 | Repair renal-abdomen fistula |
| 50526 | 090 | Repair renal-abdomen fistula | 50540 | 090 | Revision of horseshoe kidney |
| 50541 | 090 | Laparo ablate renal cyst | 50542 | 090 | Laparo ablate renal mass |
| 50544 | 090 | Laparoscopy, pyeloplasty | 50545 | 090 | Laparo radical nephrectomy |
| 50546 | 090 | Laparoscopic nephrectomy | 50547 | 090 | Laparo removal donor kidney |
| 50548 | 090 | Laparo remove k/ureter | 50551 | 000 | Kidney endoscopy |
| 50553 | 000 | Kidney endoscopy | 50555 | 000 | Kidney endoscopy & biopsy |
| 50557 | 000 | Kidney endoscopy & treatment | 50559 | 000 | Renal endoscopy/radiotracer |
| 50561 | 000 | Kidney endoscopy & treatment | 50562 | 090 | Renal scope w/tumor resect |
| 50570 | 000 | Kidney endoscopy | 50572 | 000 | Kidney endoscopy |
| 50574 | 000 | Kidney endoscopy & biopsy | 50575 | 000 | Kidney endoscopy |
| 50576 | 000 | Kidney endoscopy & treatment | 50578 | 000 | Renal endoscopy/radiotracer |
| 50580 | 000 | Kidney endoscopy & treatment | 50590 | 090 | Fragmenting of kidney stone |
| 50600 | 090 | Exploration of ureter | 50605 | 090 | Insert ureteral support |
| 50610 | 090 | Removal of ureter stone | 50620 | 090 | Removal of ureter stone |
| 50630 | 090 | Removal of ureter stone | 50650 | 090 | Removal of ureter |
| 50660 | 090 | Removal of ureter | 50686 | 000 | Measure ureter pressure |
| 50700 | 090 | Revision of ureter | 50715 | 090 | Release of ureter |
| 50722 | 090 | Release of ureter | 50725 | 090 | Release/revise ureter |
| 50727 | 090 | Revise ureter | 50728 | 090 | Revise ureter |
| 50740 | 090 | Fusion of ureter & kidney | 50750 | 090 | Fusion of ureter & kidney |
| 50760 | 090 | Fusion of ureters | 50770 | 090 | Splicing of ureters |
| 50780 | 090 | Reimplant ureter in bladder | 50782 | 090 | Reimplant ureter in bladder |
| 50783 | 090 | Reimplant ureter in bladder | 50785 | 090 | Reimplant ureter in bladder |
| 50800 | 090 | Implant ureter in bowel | 50810 | 090 | Fusion of ureter & bowel |
| 50815 | 090 | Urine shunt to intestine | 50820 | 090 | Construct bowel bladder |
| 50825 | 090 | Construct bowel bladder | 50830 | 090 | Revise urine flow |
| 50840 | 090 | Replace ureter by bowel | 50845 | 090 | Appendico-vesicostomy |
| 50860 | 090 | Transplant ureter to skin | 50900 | 090 | Repair of ureter |
| 50920 | 090 | Closure ureter/skin fistula | 50930 | 090 | Closure ureter/bowel fistula |
| 50940 | 090 | Release of ureter | 50945 | 090 | Laparoscopy ureterolithotomy |
| 50947 | 090 | Laparo new ureter/bladder | 50948 | 090 | Laparo new ureter/bladder |
| 50949 | YYY | Laparoscope proc, ureter | 50951 | 000 | Endoscopy of ureter |
| 50953 | 000 | Endoscopy of ureter | 50955 | 000 | Ureter endoscopy & biopsy |
| 50957 | 000 | Ureter endoscopy & treatment | 50959 | 000 | Ureter endoscopy & tracer |

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| 50961 | 000 | Ureter endoscopy & treatment | 50970 | 000 | Ureter endoscopy |
| 50972 | 000 | Ureter endoscopy & catheter | 50974 | 000 | Ureter endoscopy & biopsy |
| 50976 | 000 | Ureter endoscopy & treatment | 50978 | 000 | Ureter endoscopy & tracer |
| 50980 | 000 | Ureter endoscopy & treatment | 53850 | 090 | Prostatic microwave thermotx |
| 53852 | 090 | Prostatic rf thermotx | 53853 | 090 | Prostatic water thermother |
| 57520 | 090 | Conization of cervix | 57522 | 090 | Conization of cervix |
| 58800 | 090 | Drainage of ovarian cyst(s) | 59030 | 000 | Fetal scalp blood sample |
| 59140 | 090 | Treat ectopic pregnancy | 59820 | 090 | Care of miscarriage |
| 59821 | 090 | Treatment of miscarriage | 70030 | XXX | X-ray eye for foreign body |
| 70134 | XXX | X-ray exam of middle ear | 70140 | XXX | X-ray exam of facial bones |
| 70150 | XXX | X-ray exam of facial bones | 70160 | XXX | X-ray exam of nasal bones |
| 70190 | XXX | X-ray exam of eye sockets | 70200 | XXX | X-ray exam of eye sockets |
| 70210 | XXX | X-ray exam of sinuses | 70220 | XXX | X-ray exam of sinuses |
| 70240 | XXX | X-ray exam, pituitary saddle | 70250 | XXX | X-ray exam of skull |
| 70260 | XXX | X-ray exam of skull | 70360 | XXX | X-ray exam of neck |
| 70380 | XXX | X-ray exam of salivary gland | 70450 | XXX | Ct head/brain w/o dye |
| 70460 | XXX | Ct head/brain w/dye | 70470 | XXX | Ct head/brain w/o&w dye |
| 70480 | XXX | Ct orbit/ear/fossa w/o dye | 70481 | XXX | Ct orbit/ear/fossa w/dye |
| 70482 | XXX | Ct orbit/ear/fossa w/o&w dye | 70486 | XXX | Ct maxillofacial w/o dye |
| 70487 | XXX | Ct maxillofacial w/dye | 70488 | XXX | Ct maxillofacial w/o&w dye |
| 70490 | XXX | Ct soft tissue neck w/o dye | 70491 | XXX | Ct soft tissue neck w/dye |
| 70492 | XXX | Ct sft tsue nck w/o & w/dye | 70542 | XXX | Mri orbit/face/neck w/dye |
| 70543 | XXX | Mri orbt/fac/nck w/o&w dye | 70552 | XXX | Mri brain w/dye |
| 70553 | XXX | Mri brain w/o&w dye | 71010 | XXX | Chest x-ray |
| 71015 | XXX | Chest x-ray | 71020 | XXX | Chest x-ray |
| 71021 | XXX | Chest x-ray | 71022 | XXX | Chest x-ray |
| 71030 | XXX | Chest x-ray | 71035 | XXX | Chest x-ray |
| 71100 | XXX | X-ray exam of ribs | 71101 | XXX | X-ray exam of ribs/chest |
| 71110 | XXX | X-ray exam of ribs | 71111 | XXX | X-ray exam of ribs/ chest |
| 71120 | XXX | X-ray exam of breastbone | 71130 | XXX | X-ray exam of breastbone |
| 71250 | XXX | Ct thorax w/o dye | 71260 | XXX | Ct thorax w/dye |
| 71270 | XXX | Ct thorax w/o&w dye | 71551 | XXX | Mri chest w/dye |
| 71552 | XXX | Mri chest w/o&w/dye | 71555 | XXX | Mri angio chest w or w/o dye |
| 72010 | XXX | X-ray exam of spine | 72020 | XXX | X-ray exam of spine |
| 72040 | XXX | X-ray exam of neck spine | 72050 | XXX | X-ray exam of neck spine |
| 72052 | XXX | X-ray exam of neck spine | 72070 | XXX | X-ray exam of thoracic spine |
| 72072 | XXX | X-ray exam of thoracic spine | 72074 | XXX | X-ray exam of thoracic spine |
| 72080 | XXX | X-ray exam of trunk spine | 72090 | XXX | X-ray exam of trunk spine |
| 72100 | XXX | X-ray exam of lower spine | 72110 | XXX | X-ray exam of lower spine |
| 72114 | XXX | X-ray exam of lower spine | 72120 | XXX | X-ray exam of lower spine |
| 72125 | XXX | Ct neck spine w/o dye | 72126 | XXX | Ct neck spine w/dye |
| 72127 | XXX | Ct neck spine w/o&w/dye | 72128 | XXX | Ct chest spine w/o dye |
| 72129 | XXX | Ct chest spine w/dye | 72130 | XXX | Ct chest spine w/o&w/dye |
| 72131 | XXX | Ct lumbar spine w/o dye | 72132 | XXX | Ct lumbar spine w/dye |
| 72133 | XXX | Ct lumbar spine w/o&w/dye | 72142 | XXX | Mri neck spine w/dye |
| 72147 | XXX | Mri chest spine w/dye | 72149 | XXX | Mri lumbar spine w/dye |
| 72156 | XXX | Mri neck spine w/o&w/dye | 72157 | XXX | Mri chest spine w/o&w/dye |
| 72158 | XXX | Mri lumbar spine w/o&w/dye | 72159 | XXX | Mr angio spine w/o&w/dye |
| 72170 | XXX | X-ray exam of pelvis | 72190 | XXX | X-ray exam of pelvis |

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|---|---|---|---|---|---|
| 72192 | XXX | Ct pelvis w/o dye | 72193 | XXX | Ct pelvis w/dye |
| 72194 | XXX | Ct pelvis w/o&w/dye | 72196 | XXX | Mri pelvis w/dye |
| 72197 | XXX | Mri pelvis w/o & w/dye | 72198 | XXX | Mr angio pelvis w/o&w/dye |
| 72200 | XXX | X-ray exam sacroiliac joints | 72202 | XXX | X-ray exam sacroiliac joints |
| 72220 | XXX | X-ray exam of tailbone | 73000 | XXX | X-ray exam of collar bone |
| 73010 | XXX | X-ray exam of shoulder blade | 73020 | XXX | X-ray exam of shoulder |
| 73030 | XXX | X-ray exam of shoulder | 73050 | XXX | X-ray exam of shoulders |
| 73060 | XXX | X-ray exam of humerus | 73070 | XXX | X-ray exam of elbow |
| 73080 | XXX | X-ray exam of elbow | 73090 | XXX | X-ray exam of forearm |
| 73092 | XXX | X-ray exam of arm, infant | 73100 | XXX | X-ray exam of wrist |
| 73110 | XXX | X-ray exam of wrist | 73120 | XXX | X-ray exam of hand |
| 73130 | XXX | X-ray exam of hand | 73140 | XXX | X-ray exam of finger(s) |
| 73200 | XXX | Ct upper extremity w/o dye | 73201 | XXX | Ct upper extremity w/dye |
| 73202 | XXX | Ct uppr extremity w/o&w/dye | 73219 | XXX | Mri upper extremity w/dye |
| 73220 | XXX | Mri uppr extremity w/o&w/dye | 73222 | XXX | Mri joint upr extrem w/dye |
| 73223 | XXX | Mri joint upr extr w/o&w/dye | 73225 | XXX | Mr angio upr extr w/o&w/dye |
| 73500 | XXX | X-ray exam of hip | 73510 | XXX | X-ray exam of hip |
| 73540 | XXX | X-ray exam of pelvis & hips | 73560 | XXX | X-ray exam of knee, 1 or 2 |
| 73562 | XXX | X-ray exam of knee, 3 | 73564 | XXX | X-ray exam, knee, 4 or more |
| 73565 | XXX | X-ray exam of knees | 73590 | XXX | X-ray exam of lower leg |
| 73600 | XXX | X-ray exam of ankle | 73610 | XXX | X-ray exam of ankle |
| 73620 | XXX | X-ray exam of foot | 73630 | XXX | X-ray exam of foot |
| 73650 | XXX | X-ray exam of heel | 73660 | XXX | X-ray exam of toe(s) |
| 73700 | XXX | Ct lower extremity w/o dye | 73701 | XXX | Ct lower extremity w/dye |
| 73702 | XXX | Ct lwr extremity w/o&w/dye | 73719 | XXX | Mri lower extremity w/dye |
| 73720 | XXX | Mri lwr extremity w/o&w/dye | 73722 | XXX | Mri joint of lwr extr w/dye |
| 73723 | XXX | Mri joint lwr extr w/o&w/dye | 73725 | XXX | Mr ang lwr ext w or w/o dye |
| 74000 | XXX | X-ray exam of abdomen | 74010 | XXX | X-ray exam of abdomen |
| 74020 | XXX | X-ray exam of abdomen | 74022 | XXX | X-ray exam series, abdomen |
| 74150 | XXX | Ct abdomen w/o dye | 74160 | XXX | Ct abdomen w/dye |
| 74170 | XXX | Ct abdomen w/o&w/dye | 74182 | XXX | Mri abdomen w/dye |
| 74183 | XXX | Mri abdomen w/o&w/dye | 74185 | XXX | Mri angio, abdom w or w/o dy |
| 75553 | XXX | Heart mri for morph w/dye | 75989 | XXX | Abscess drainage under x-ray |
| 76010 | XXX | X-ray, nose to rectum | 76020 | XXX | X-rays for bone age |
| 76040 | XXX | X-rays, bone evaluation | 76062 | XXX | X-rays, bone survey |
| 76065 | XXX | X-rays, bone evaluation | 76066 | XXX | Joint survey, single view |
| 76090 | XXX | Mammogram, one breast* | 76091 | XXX | Mammogram, both breasts |
| 76092 | XXX | Mammogram, screening* | 76093 | XXX | Magnetic image, breast |
| 76094 | XXX | Magnetic image, both breasts* | 76098 | XXX | X-ray exam, breast specimen |
| 76360 | XXX | CAT scan for needle biopsy | 76380 | XXX | CAT scan follow-up study |
| 76390 | XXX | Mr spectroscopy | 76604 | XXX | Us exam, chest, b-scan |
| 76645 | XXX | Us exam, breast(s) | 76705 | XXX | Echo exam of abdomen |
| 76775 | XXX | Us eam abdo back wall, lim | 76886 | XXX | Us exam infant hips, static |
| 76941 | XXX | Echo guide for transfusion | 76946 | XXX | Echo guide for amniocentesis |
| 76948 | XXX | Echo guide, ova aspiration | | | |

*RUC modifications made to PEAC recommendations at the February 2004 RUC meeting.

**AMA/Specialty Society RVS Update Committee**
**PEAC Transition Workgroup Report**
**January 29, 2004**

The PEAC Transition workgroup met to develop recommendations regarding PEAC participation in the RUC review of direct inputs of new and revised codes. The following members participated: Willard Moran, MD, Chair; Joel Brill, MD; James P. Borgstede, MD; Mary Foto, OTR; Barbara Levy, MD; Daniel Mark Siegel, MD; and Richard Whitten, MD.

Doctor Moran opened the meeting by discussing the following ideal goals the workgroup should consider:

1. The review of PE and physician work should occur at the same RUC meeting.
2. The same level of PE expertise review should be applied to the new codes was applied to all of the existing codes.
3. Minimize costs to specialty societies.
4. Decrease workload on RUC and increase efficiency.
5. Allow PEAC to periodically examine outlier codes and reexamine expensive disposable supplies or equipment costs periodically, as well as develop or refine PE standards.

The Workgroup agreed that the PEAC expertise that has been developed over the last few years should not be lost. Although the workgroup was presented with two potential options for involving the PEAC in RUC review, a third option was discussed. This new option would involve convening a subset of PEAC members by conference call to identify those codes on a RUC agenda that would need further review such as those with non-standard inputs. Any concerns identified during the conference call would be communicated by AMA staff to the affected specialty society and then the specialty would be given the opportunity to make changes to the presentation or seek a pre-facilitation committee. The pre-facilitation committees would be comprised of a combination of PEAC and RUC members. The PEAC members would then become members of RUC facilitation committees and attend the RUC meeting to assist with any other codes that may be sent to facilitation.

It was pointed out that there is a very short time frame between a CPT meeting and the following RUC meeting. The short time between the February CPT meeting and the April RUC meeting was discussed in particular. In order for a pre-facilitation committee comprised of PEAC members to meet by phone prior to a RUC meeting would possibly require moving up the due date or require a very fast turn around between the time of the conference call and preparation of revised specialty society PE inputs. Since RUC members receive their agenda material two weeks before a RUC meeting, the conference call and revisions would need to occur in that short time frame. The workgroup agreed that once the due dates are established, specialty societies will need to provide their recommendations by the set deadline for this proposal to be a success.

Doctor Moran explained that during the PEAC meeting earlier in the week, PEAC members stated they were willing to assist the RUC and attend at least one RUC meeting

a year. The PEAC also felt that it would be necessary for the PEAC to meet once a year to refine or develop additional standards.

The workgroup discussed the possibility of the PEAC meeting as a whole each year and some felt that a meeting each year is needed to look at major PE issues such as the changing site of service and changes in the use of expensive supplies. The workgroup agreed that there should be a periodic review of standards and the mechanism of how to do this should be determined later in the year by the RUC. It was noted that RUC members also felt it was important to periodically review all standards and processes, and would find it important to participate in such a review of practice expense issues. CMS representatives stated that they would like a mechanism to quickly review PE for services performed in a new setting such as procedures moving into the office setting.

The workgroup makes the following recommendation to the RUC:

**A subset of PEAC members would meet via conference call before each RUC meeting to identify codes that may have practice expense issues that need to be addressed. AMA staff would convey the PEAC concerns to the appropriate specialty societies and ask specialties to respond by revising the practice expense inputs or to resolve the issue through a prefacilitation committee comprised of PEAC and RUC members. Several PEAC members will then be assigned to each RUC facilitation committee. They would be members of the committee specifically to review the practice expense issues for codes sent to either pre-facilitation or facilitation.**

**AMA/Specialty Society RV S Update Committee**
**Professional Liability Insurance Workgroup**
**January 29, 2004**

The following members of the Professional Liability Insurance (PLI) Workgroup met on January 29, 2004 to discuss data utilized by CMS in establishing both PLI geographic practice cost indices and relative values: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Stephen A. Kamenetzky, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith

CMS Update

The PLI Workgroup spoke with Mr. Rick Ensor, Centers for Medicare and Medicaid Services (CMS), via teleconference. Mr. Ensor indicated that CMS has initiated work on the five-year PLI relative value refinement to be implemented on January 1, 2005. CMS is utilizing the services of BearingPoint. A July 24, 2003 Written Technical Proposal will be shared with the RUC and distributed to RUC participants in February 2004. Providing the methodology to the RUC was felt to be crucial to the Workgroup's ability to evaluate how the PLI RVUs are developed in order to allow for additional recommendations to be made. In the RUC's comment letter on the 2003 *Proposed Rule* the RUC requested that in developing the new PLI relative values, CMS consider the use of the dominant specialty rather than a weighted average of all specialties that perform the service. Mr. Ensor indicated that CMS had instructed their contractor to examine this approach.

Mr. Ensor also indicated that he will provide the RUC with the CMS requirements for any PLI premium data collection activities. He explained that CMS had utilized, for the first time, predictions for 2003 premium data. However, CMS did not feel comfortable utilizing these predictions only and preferred the approach of blending the 2001-2003 data. Mr. Ensor did clarify that the cost of tail coverage was incorporated into the determination of PLI actual premium data. Mr. Ensor reiterated the Agency's interest in considering other data sources to better reflect current PLI costs.

Review of Summary Professional Liability Insurance Data Utilized in 2004 PLI GPCIs

CMS did share data utilized in establishing the 2004 PLI GPCIs with the RUC. AMA staff collated these files into one database and has shared this information with all RUC participants. AMA staff also provided summary information on this data. Several questions were raised regarding this data:

- The twenty specialties included in the data did not include anesthesiology and obstetrics and gynecology. Mr. Ensor indicated that he would explore the rationale for this and provide further information to the RUC.

- Doctor Stephen Kamenetzky discussed the limitations in the state PLI premium data and suggested that other data collections would provide more reliable and more recent data.

- There was a lengthy discussion concerning the disparity between the data provided and the actual PLI costs currently incurred by physicians. Although Mr. Ensor assured the Workgroup that the data was actual raw data, the process of averaging the data which is highly variable state by state and even regions within a state do not provide an appropriate reflection of costs incurred by practitioners in high-risk states.

- It was pointed out that statute limits the GPCI to account for less then half of the actual difference among geographical regions. This was felt to again unfairly compress the actual range of costs, thereby penalizing physicians in "high-risk" states. For example, data based on state averages had lower medians than the aggregate median of all data points.

Discuss Process for Reviewing Risk Classifications for Individual CPT Codes

CMS utilizes risk factors based on the surgical versus non-surgical risk factor categories. In general, CMS assumes that all CPT codes in the 10000-69999 series are surgical and all other codes are in the non-surgical category. However, CMS does allow certain "special cases" in the assignment of risk factors. The PLI Workgroup recommends the following:

**AMA staff will circulate the PLI contractor report, including the current methodology for assigning risk factors to each CPT code, to all RUC participants. RUC participants will have the opportunity to review this information and provide comment to the PLI Workgroup for consideration at a future meeting.**

A question arose regarding the assignment of risk categories for anesthesia services and more generally, the approach that CMS employs to evaluate the anesthesia relative values for these services. Mr. Ensor indicated that he would send additional information regarding this methodology to the AMA.

Other Issues

The PLI Workgroup continued its discussion regarding how PLI premium data provided by individual physicians can be utilized. Specifically, Workgroup members remain interested in pursuing a methodology for paying physicians for their share of the individual physician's professional liability insurance premium in a more direct manner than on a per service basis.

**AMA/Specialty Society RVS Update Committee**
**Research Subcommittee Report**
**January 29, 2004**

The following members of the Research Subcommittee participated: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Megan Gerety, David Keepnews, PhD, Barbara Levy, J. Leonard Lichtenfeld, Bernard Pfeifer, Alan Plummer, Trexler Topping, and Richard Tuck.

Practice Expense Effects on Code Development

The RUC previously identified this issue because there was a concern that a substantial number of new codes might need to be developed in the future to differentiate among medical devices that can be used for the same procedure. These would be codes where the procedure described would be the same with the same physician work but the practice expense differed according to the device used. The Subcommittee agreed that either expensive disposable supply items or expensive equipment could drive the development of codes leading to several codes describing the same procedure.

Currently, expensive disposable supplies are not separately reimbursable and are included as direct expenses in the methodology used to create practice expense relative values. The Subcommittee was in favor of establishing a system that would allow CMS to separately price these items and allow physicians to code for these items through a J code type system. The goal would be to have CMS price the items and negotiate a competitive price directly with the manufactures so that physicians would not be affected by the cost of the items. The CMS representatives were receptive to explore the development of such a system, but stressed that any items that would qualify for separate pricing would need to meet specific criteria such as a certain cost threshold as well as needing to be a supply that is typically used.

Currently there does not appear to be a significant number of high cost disposable items contained in the PE methodology. However, it is predicted that as more services move into the office setting, the list of items will grow. According to the CMS contractor responsible for repricing supplies, the CMS supply list contains only 28 items over $100 and these are assigned to 59 codes representing a total office based claim volume of 64,263. The Subcommittee agreed to discuss this issue further at its next meeting but would like to examine a list of those supplies equal to or greater than $50 and also to receive further input from CMS regarding potential criteria that could be established to determine if an item would be eligible for a separate HCPCS code. An explanation by CMS on the HCPCs process might also be needed. Additionally, the Subcommittee would like to receive input from specialty societies and would like AMA staff to solicit specialty societies on their views of establishing a separate HCPCs codes for expensive supplies. The specialty society input would be reviewed at the next meeting.

Conscious Sedation

The Research Subcommittee agreed that the RUC should add a question to the RUC survey instrument and the summary of recommendation form. This will allow the RUC to identify those codes that typically use conscious sedation as an inherent part of the procedure**. The Subcommittee recommends the RUC add the following question to the RUC survey:**

**BACKGROUND FOR QUESTION 6**

Conscious sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal or intranasal routes. For purposes of the following question, sedation and analgesia delivered by an anesthesiologist or other anesthesia provider is not considered conscious sedation.

**QUESTION 6: Do you or does someone under your direct supervision typically administer conscious sedation for these procedures?**

New/Revised Code Yes ❒ No ❒ Reference Code Yes ❒ No ❒

Addition of PLI Information to the Summary of Recommendation Form

During the last RUC meeting, the PLI Workgroup concluded that the RUC should take a more active role in the establishment of PLI relative value units and provide additional information to CMS to assist in the development of PLI RVUs for new and revised codes. Currently CMS staff assign PLI RVUs with limited physician input. New and revised codes are temporarily assigned a PLI relative value based on CMS staff analysis of an appropriate crosswalk. This analysis usually includes a review of the frequency estimations on the RUC's *Summary of Recommendation* form and often the key reference service used to determine physician work. CMS staff also determines if the CPT code should be assigned a specific risk factor.

There is an opportunity for RUC input into this process by providing CMS with both an appropriate crosswalk and the appropriate risk factor determination. These questions would not be added to the RUC survey, but instead would be completed by the specialty after reviewing the survey results. It was clarified that the specialty would only be providing a crosswalk and would not be evaluating the adequacy of the PLI RVU assigned to the reference code. These crosswalks would only be used temporarily until CMS collects enough claims data to calculate a PLI RVU**. The subcommittee recommends adding the following questions to the RUC summary of recommendation form:**

**Does your reference CPT code selected for physician work serve as a reasonable reference for a PLI crosswalk?**
Yes ❒ No ❒

**If no, please select another crosswalk and provide a brief rationale.**

**Indicate what risk factor (e.g., surgical, non-surgical) the new/revised code should be assigned to determine PLI relative value.**

Reference Service Lists
The RUC has historically provided reference service lists to specialty societies in ascending work RVU order so that the survey respondents can examine a range of work values to assist them in recommended a RVU for the new and revised code. A number of RUC members commented that providing the lists in code order makes it easier for respondents to select a reference code. The subcommittee was not aware of any studies on this topic that would indicate if either method would influence a survey. However, the subcommittee did not want the lists to be provided in random order. Therefore, the Subcommittee recommends that:

**The reference service lists should be provided to survey respondents in either ascending CPT code order, or ascending RVU order, or both code and RVU order.**

The Subcommittee also discussed the maintenance of reference service lists and the implications of using either fixed lists or allowing specialties to customize lists depending on the code under review. The Subcommittee members had different interpretations regarding the RUC policy and the ability of specialty societies to change their reference service lists. Some members thought that the lists could not be changed, while others stated that the RUC has always allowed specialties to develop their own reference service lists. It was suggested that the lists would need to be customized based on the code under review, because otherwise a standard list for some specialties would contain several hundred codes. Since the maintenance of lists had not been identified as a problem that has adversely affected RUC surveys, the Subcommittee passed a motion to not discuss the issue any further.

**AMA/Specialty Society RVS Update Committee**
**Site of Service Workgroup Report**
**January 29, 2004**

The Practice Expense Subcommittee met during the February 2004 RUC meeting to discuss the shifting of services from the facility to the non-facility setting. The following Workgroup members participated: Doctors Brooks, (Chair), Anthony, Borgstede, Maloney, Derr, and Moran.

## Background

The Practice Expense Subcommittee agreed in January 2003 that there should be a mechanism to establish non-facility practice expense RVUs as practice patterns change. Subsequently during the March 2003 PEAC meeting the Society for Interventional Radiology (SIR) recommended several percutaneous endovascular codes to be priced in the non-facility setting. These codes have historically only been performed in the hospital setting. In August, 2003, and January 2004 the PEAC created non-facility practice expense direct inputs for these percutaneous endovascular codes, however the PEAC is uncomfortable forwarding its recommendations to the RUC for approval until an economic impact analysis is performed and reviewed. PEAC members believed that these codes can be priced in the office, however, they should not be priced at the expense of other services.

The PEAC was concerned that assigning new office based practice expense relative values could result in an increase in the Sustainable Growth Rate system (SGR) spending without a corresponding increase in the SGR target. A reduction in overall reimbursement could occur if there is an increase in spending that is subject to the SGR target. This means that as procedures that historically have been hospital based now move to the office setting, SGR spending may increase, but the spending target would not. If spending exceeds the target the results can be a decrease in the Medicare conversion factor. The PEAC therefore wanted to closely examine this issue since establishing office based expense inputs for these procedures could set a precedent. The RUC agreed in September 2003 that the RUC should work to resolve this issue and recommended the following approach:

1. The RUC should form a workgroup to address this issue, with involvement of PEAC members.
2. The RUC will ask CMS to conduct an impact analysis on pricing these percutaneous endovascular codes and other services newly priced in the office, that have been proposed to shift major resources from facility to the non-facility setting.
3. For services transitioning from the facility to the non-facility settings, the RUC will advocate that CMS consider a regulatory change in the SGR update formula to increase allowed expenditures.
4. The issue of shifting services from the inpatient setting (ie, hospital visits to office visits) is an issue that needs focus and encourages CMS to continue to consider this issue.

## Workgroup Discussion

Doctor Brooks began the discussion with an explanation of the issues before the group. He explained that a December 2003 request was sent to CMS asking for an analysis predicting non-facility practice expense relative values and payment for the endovascular services if the PEAC inputs were to be accepted. Also, an analysis comparing this predicted payment to OPPS payment and ASC payment was requested. CMS responded to this request verbally questioning the precedent that this may create. Therefore, AMA staff supplied the Workgroup with a list of

the ten codes that had recently been priced in the office and illustrated the analysis for this smaller subset of services.

Workgroup members learned that many of these services were priced in the office setting through the PEAC or RUC process, and that it is the specialties choice to price the services in the non-facility setting. Several of these codes have expensive disposable medical supplies which caused the code to have higher practice expense relative values in the office setting. A member questioned. It was also mentioned that specialties are under significant pressure from device manufacturers to price specific CPT codes in the office setting.

CMS representatives explained the payment methodology for new technology. With the development of the Outpatient Prospective Payment System (OPPS) in the year 2000, CMS provided additional payments for new technology with pass-through payments. The pass-through payments to hospitals off-sets the cost high cost of new devices, and provides a payment for not less than 2 but not more than 3 years. For Ambulatory Surgical Centers (ASC) some devices may qualify for separate payment under the DME post fee schedule. Otherwise, the maximum for an ASC facility payment is $1,339.

Although workgroup members expressed concern over the high non-facility practice expense relative values, CMS representatives mentioned that these values may fall over time. CMS periodically re-prices the various components of its direct inputs. CMS recently has re-priced much of its medical supplies, and will re-price its equipment file for 2005. Workgroup members and CMS representatives believed that over time as lower cost units of medical supplies and equipment become available, and CMS should re-price these items. As the RUC refines practice expense inputs and CMS re-prices these inputs the variation in practice expense relative values between the physician's office and facility setting may narrow. The Workgroup also understands that the Research Subcommittee is also reviewing the supply price issue and may recommend alternatives. The Site of Service Workgroup made the following recommendations to the RUC:

> **The RUC requests the PEAC to forward its recommendations for the endovascular codes (and other codes that have been put on hold pending further analyses), to the RUC for consideration.**

Workgroup members also understood that the SGR target is based on CMS estimates of expenditures for physician services due to changes in prices, fee-for service enrollment, gross domestic product, and laws and regulations. Moving Medicare dollars from one section of Part B funds to another section of Part B funds does not require a statutory or legislative change, as does the movement of Part A funds to Part B funds. Workgroup members believed from the discussion that funds may be added to the physician office Part B pool through a recognition that a newly priced in-office service is a change in the law and regulation component of the SGR allowed expenditures. The Site of Service Workgroup recommends the following to the RUC:

> **The RUC will send a letter to CMS and advocate that the publication of new practice expense of relative values for a service in the non-facility setting is a change in the law and regulation and should be accounted for in the SGR allowed expenditures formula.**

American Medical Association
Physicians dedicated to the health of America

William L. Rich III, MD, FACS
Chairman
AMA/Specialty Society RVS
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March 5, 2004

Dennis G. Smith
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Acting Administrator Smith:

The AMA/Specialty Society RVS Update Committee (RUC) recently reviewed the pre-service definition of codes with global periods of 000, 010, and 090 days. I am forwarding the RUC recommendation on this issue.

During the most recent RUC meeting, a number of specialty societies questioned the accuracy of the CMS pre-service time period definition. Currently, CMS defines the pre-service time period for 000 and 010 global periods as including the pre-service work that occurs on the day of surgery, while the 90 day global period includes pre-service work occurring the day before surgery. The RUC concluded that the current definitions do not capture the physician work that occurs between the decision for surgery and the procedure. For example, the definition for the 90 day global period was based upon situations where a patient was admitted to the hospital the day before surgery. The pre-surgery services were then performed in the hospital while the patient awaited surgery. This scenario of admitting patients on the day before surgery is no longer common and therefore, the pre-service definition no longer reflects current medical practice.

The RUC agreed that there is a substantial amount of physician work that occurs after the decision for surgery, but before the procedure and this work should be reflected in the procedure code. The physician work includes deciding on anesthesia preference and the patient's position or operative approach. The physician must also define and coordinate specific equipment needs such as for a certain type of retractor, or for the laparoscopic approach, coordination with radiology, ultrasound and other intraoperative support services. Prior to surgery, the patient typically needs preoperative clearance and assessment. This involves the physician ordering a number of tests such as a chest X-ray, electrocardiogram, complete blood count, automated serum analysis for a basic set of chemistries (SMAC6), and urine analysis. The physician also must then review the test results.

Since this work may not occur on the day of the procedure or the day before the procedure, the RUC concluded that the pre-service time definitions should be expanded to begin following the decision for surgery visit. This would allow the procedure codes to capture the work that occurs between the final decision for surgery and the surgery itself.

The RUC therefore requests CMS to change the pre-service definition for 000, 010, and 090 day global periods to the following:

The pre-service period includes physician services provided following the visit at which the decision for surgery is finalized until the time of the operative procedure.

Thank you for your consideration of these comments. If you have any questions regarding the RUC's recommendation, please contact Patrick Gallagher of the AMA at patrick_gallagher@ama-assn.org.

Sincerely,

William J. Rich MD FACS

William Rich, MD

cc: Ken Simon, MD
RUC Participants

# American Medical Association

Physicians dedicated to the health of America

**William L. Rich III, MD, FACS**
Chairman
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March 31, 2004

Mark McClellan, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Doctor McClellan:

I would like to take this opportunity to personally congratulate you on your new appointment as Administrator of the Centers for Medicare and Medicaid Services (CMS) and to introduce myself. I am the Chairman of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC). The RUC is a multi-specialty committee that has submitted recommendations to CMS on the Resource-Based Relative Value Scale (RBRVS) since its inception in 1992. The RUC looks forward to a continuing productive relationship with CMS under your administration.

At this time, the RUC would like to alert you to a significant issue that has arisen in the RBRVS during the course of the practice expense refinement. This refinement activity was engaged to improve the reliability of the underlying data utilized to compute practice expense relative values, an important component of the RBRVS physician payment system. We believe that the new assignment of practice expense relative values in the non-facility setting (ie, typically physicians' offices) will have an impact on the expenditures included in the Sustainable Growth Rate (SGR). We recommend recognition of these new costs in the SGR formula as a matter of fairness to all physicians.

As you may know, under the RBRVS, services are typically assigned higher practice expense values when they are performed in an office where the physician is covering all the cost than when they are performed in a hospital or ambulatory surgical center where the facility is responsible and paid for part of the cost. If a service generally is only done in the facility, there will only be one practice expense value; if it can be done in either the facility or the office, there are two different practice expense values--one for the facility setting and one for the non-facility (office) setting. Thus as medical advances allow some procedures that were historically performed only in the hospital outpatient departments and ambulatory surgical centers to now be performed in physician's offices, the RUC has found that in refining the direct practice expense inputs (ie, nursing staff time, medical supplies and equipment) related to specific CPT codes, it has been necessary to also newly price some of these services in the non-facility setting.

Movement to the physician's office makes care more accessible to beneficiaries and typically reduces the cost per service for beneficiaries and the government. The RUC believes it is appropriate to create new non-facility direct practice expense values for these services and has recommended doing so for several CPT codes, primarily for interventional radiology services. To date, CMS has accepted the new values recommended by the RUC and we appreciate this action as we believe that physicians should be fairly compensated for services that are performed in their offices

The RUC is concerned, however, that assigning new non-facility practice expense relative values will result in increases in SGR spending without a corresponding increase in the SGR target, resulting in a reduction in the conversion factor. This means that as procedures move from the hospital outpatient setting to the office setting, SGR spending may increase, but the spending target would not. We believe that CMS may account for these changes in the law and regulation factor of the SGR formula. We would argue that these changes do reflect regulatory changes as these new non-facility practice expense relative values are published in a Proposed and Final regulation each year. **The RUC urges you to consider the proposal and publication of these new non-facility practice expense relative values as a change in regulation and incorporate the resulting costs into the SGR formula.**

The RUC appreciates your consideration of this issue. I would be pleased to meet with you to discuss this issue further. The RUC would also extend an invitation to you to attend a RUC meeting as your predecessor Thomas Scully did in April 2003. Our next meeting will be convened April 22-25, 2004 in Chicago. You may contact Sherry Smith, AMA RUC staff, at (312) 464-5604 or Sherry_Smith@ama-assn.org if you are interested in attending a RUC meeting and/or if you have any questions regarding our request.

Sincerely,

William L. Rich III, MD, FACS

cc: RUC Participants
Ken Simon, MD
Edith Hambrick, MD
Carolyn Mullen