AMA/Specialty RVS Update Committee
Meeting Minutes
February 3 – 5, 2005

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 4, 2005 at 8:00am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD*
Michael D. Bishop, MD
James Blankenship, MD
James P. Borgstede, MD
Neil H. Brooks, MD
Ronald Burd, MD*
Norman A. Cohen, MD
James Denneny, MD*
John Derr, Jr., MD
Mary Foto, OT
John O. Gage, MD
William F. Gee, MD
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
George Kwass, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Scott Manaker, MD
John E. Mayer, Jr., MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Sandra Reed, MD*
Chester W. Schmidt, Jr., MD
Daniel Mark Siegel, MD
J. Baldwin Smith, III, 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 made the following announcements:

- Doctor Rich welcomed the CMS Staff attending the meeting, which 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, PT, CMS Health Insurance Specialist

- Doctor Rich welcomed Lee Stillwell, Senior Vice President of Advocacy, and Kathy Kuntzman, the Vice President of Health Policy at the AMA.

- Doctor Rich welcomed the following staff from the General Accounting Office (GAO) who were in attendance Feb 2-3, 2005:
    - Nancy Edwards
    - Beth Feldpush
    - Marc Feuerberg
    - Nora Hoban

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting are:

  James Anthony, MD
  Joel Brill, MD
  Manuel Cerqueira, MD
  Neal Cohen, MD
  Thomas Felger, MD
  Gregory Kwasny, MD
  Peter McCreight, MD
  Bill Moran, MD
  Tye Ouzounian, MD
  James Regan, MD
  Anthony Senagore, MD

- The following individuals were observers at the February 2005 meeting:

Deb	Abel	American Academy of Audiology
David	Beyer, MD	American Society for Therapeutic Radiology and Oncology
Kathryn	Buettner	Northern Illinois University
Michael	Chaglasian, OD	American Optometric Association
Brett	Coldiron	American Academy of Dermatology
John	Conte	Society of Thoracic Surgeons
Jeffrey	DeManes, MD	American Society for Therapeutic Radiology and Oncology
Aidnag	Diaz, MD	Northern Illinois University
Kim	French	American College of Chest Physicians
Patricia	Golden	American Society of Hematology
Gerald	Hanson, MD	College of American Pathologists
Samuel	Hassenbusch, MD	American Academy of Pain Medicine
Wayne	Holland	American Speech, Language, and Hearing Association

Kirk	Kanter	Society of Thoracic Surgeons
Jenna	Kappel	American Society for Therapeutic Radiology and Oncology
Wayne	Koch, MD	American Academy of Otolaryngology - Head and Neck Surgery
Robert	Kossmann, MD	Renal Physicians Association
Judy	Mitchell, RN	American College of Physicians
Doc	Muhlbaier	Society of Thoracic Surgeons
Elizabeth	Mullikin	American Academy of Neurology
Irvin	Muszynski	
Daniel	O'Keefe, MD	American Academy of Ophthalmology
Robert	Park, MD	American Academy of Ophthalmology
Diane	Pedulla	American Psychological Association
Antonio	Puente, PhD	American Psychological Association
Ellen	Riker	American Academy of Sleep Medicine
Henry	Rosenberg, MD	American Society of Anesthesiologists
Jason	Scull	Infectious Diseases Society of America
Christopher	Senkowski, MD	American College of Surgeons
Patricia	Serpico	American Association of Oral and Maxiollfacial Surgery
Richard	Smith	Society of Thoracic Surgeons
Frank	Spinosa	American Podiatric Medical Association
Robert	Weinstein, MD	American Society of Hematology
Eric	Whitacre, MD	American Society of Breast Surgeons
Andrew	Whitman	

- Doctor Rich welcomed the Korean Medical Association (KMA) and presented them with gifts. The KMA observers include:

Name	Title (Position)	Organization
Mr. Hyo-keel Park*	Vice President, M.D.	Korean Medical Association
Mr. Chang-rok Shin	Director of Health Insurance M.D.	Korean Medical Association
Mr. Sang-keun Park	Director of Health Insurance M.D.	Korean Hospital Association
Ms. Sook-ja Lee	General Manager	Korean Hospital Association
Ms. Jong-Nam Joh*	Director of Health Insurance M.D.	Korean Society of Obstetrics and Gynecology
Mr. Young-Jae Kim*	Director of Health Insurance M.D.	Korean Association of Family Medicine
Mr. Seoung-Wan Chae	Director of Health Insurance M.D.	Korean Society of Pathologists
Mr. Joo-Seung Kim	Director of Health Insurance M.D.	Korean Neurosurgical Society
Mr. Myung-Soo Choo	Director of Health Insurance M.D.	Korean Urological Association

Mr. JAE-HO Ban	Member of Health Insurance M.D.	Korean Society of Otolaryngology
Ms. Seon-Kui Lee	Researcher	Asian Institute for Bioethics and Health Law, Yeonsei University
Ms. Young-joo Cha	Director of Health Insurance M.D.	Korean Society for Laboratory Medicine
Mr. Soon-Hyun Kim	Director of Health Insurance M.D.	Korean Opthamological Society
Mr. Young-hoon Ryu*	Director of Health Insurance M.D.	Korean Society of Nuclear Medicine

**Also attended September 2004 RUC Meeting*

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1
Michael Bishop, MD (Chair)
Robert Barr, MD
John Derr, Jr., MD
Mary Foto, OTR*
David Hitzeman, DO
Barbara Levy, MD
John Mayer, Jr., MD
Charles Mick, MD
Gregory Przybylski, MD*
Susan Strate, MD
Maurits J. Wiersema, MD

Facilitation Committee #2
John Gage, MD (Chair)
James Blankenship, MD
Eddy Fraifeld, MD
Peter Hollmann, MD
Scott Manaker, MD, PhD*
Bill Moran, MD*
Chester W. Schmidt, Jr., MD
Dennis Stone, MD
Trexler Topping, MD
Richard Tuck, MD
Richard Whitten, MD
Robert Zwolak, MD

Facilitation Committee #3
Neil Brooks, MD (Chair)
James Borgstede, MD*
Norman Cohen, MD

William Gee, MD
Anthony Hamm, DC
Charles F. Koopman, Jr., MD
J. Leonard Lichtenfeld, MD
Keith Naunheim, MD
Bernard Pfeifer, MD
Daniel Mark Seigel, MD*
J. Baldwin Smith, III, MD
John Zitelli, MD

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

- Doctor Rich discussed the following:
  - Financial disclosure forms must be on file prior to presentation
  - April 2005 RUC meeting - presentations deferred from the February 2005 RUC meeting will not be given preferential treatment on the schedule. Doctor Rich advises staff and consultants to be present for the entire April meeting in Chicago
- Doctor Rich made comments regarding pay for performance in his PowerPoint presentation, which is attached to these minutes.

III. Approval of Minutes for the September 30- October 2, 2005, RUC meeting

The minutes were reviewed by the RUC and all changes were accepted as editorial.

IV. CPT Editorial Panel Update

Doctor Peter Hollmann briefed the RUC on the following issues:

- The annual CPT meeting, November 4-6, 2004, Bal Harbour, Florida included sessions on:
  - Drafting vignettes
  - Care plan oversight as a method of addressing all pre- and post-service work involved in complex care coordination. Care management was considered as a potential solution and will be submitted to the CPT Editorial panel in February 2005.

- The conscious sedation workgroup met at the November 2004 meeting and will be presenting at the February 2005 meeting.

- The CPT Editorial Panel indicated that it is trying to continuously improve the interaction between the RUC and the CPT Editorial Panel to

ensure that societies properly prepare surveys and have them ready for the RUC meeting immediately following the CPT Editorial Panel. He also discussed what actions may be taken if societies are not adequately prepared for the RUC after they have been given a CPT code.

- Sherry Smith announced: The CPT Editorial Panel now offers one RUC representative the opportunity to attend each Panel meeting, all expenses paid, to observe and participate in the Panel process. Doctor Zwolak will be attending the February 2005 meeting, Doctor Gage will attend the June 2005 meeting and Doctor Bishop will be attending the October 2005 meeting.

V. CMS Update

Doctor Ken Simon stated that:

- CMS has been working on implementing many of the elements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The main focus this year will be on the issue of quality and pay for performance. CMS will be making an effort to change the paradigm from having payment based entirely on resources to identify ways to provide payment for excellence and care.

- Other areas of refinement are the issue of ASP +6% as it relates to drug payments. There will be opportunities for public comment for competitive bidding for drugs, a part of the MMA legislation that will materialize later this year.

Doctor Simon responded to several questions from the RUC members, including:

- A RUC member questioned if pay-for-performance will be a real method to improve quality. Doctor Simon responded that the payment side of the agency is statutorily limited to a resourced-based payment system currently. There are restraints and pay-for-performance still needs to be thoroughly identified. This issue will be further examined in the near future.

- A RUC member queried CMS about ASP methodology and the competitive bidding process for drugs. Doctor Simon responded that CMS is working on issues related to the competitive bidding process and methods to ensure level playing fields as it pertains to the majority of the drugs. This area is dynamic because ASP data comes in quarterly and new things surface as the agency acquires more information under ASP and the pricing for numerous drugs.

VI. CMD Update

Doctor William Mangold, Contractor Medical Director (CMD) for Arizona and Nevada, indicated that the CMDs have not put together a formal public comment for the Five-Year Review process, but will be providing input on codes identified.

VII. Washington Update

Lee Stillwell, Senior Vice President of Advocacy for the American Medical Association, addressed the following issues:

- *Medical Liability Reform:* Senior White House staff meeting in mid-December indicated that Medical Liability Reform is a high priority of the president. An action plan was unveiled at the AMA State Legislation meeting. Each state is working on reform. However, the focus of reform is at the national level.
    - *AMA Action Plan:* planning conference calls with state and national medical specialty societies to organize town hall meetings for physicians to interact with congressmen and senators.
    - *The House of Representatives and Senate Bills:* The House has passed a MICRA-style bill nine times in the last decade. The Senate is where the hurdle is when trying to pass a non-economic damages capitation. Sixty Senate votes are needed for the motion to proceed to the Conference Committee and only 51 votes are needed to pass the bill (without amendments).
    - *AMA Principles*
        - Protect strong state laws
        - Final product must achieve goal of stabilizing/ultimately reducing premiums
- *Political Obstacles*
    - Budget, deficit reduction
    - Provider groups hope to push action on Omnibus Medicare bill into next year
    - Social Security
- *Sustainable Growth Rate (SGR)*
    - Step 1: Remove prescription drugs from the formula
    - Step 2: Implement MedPac recommendation
    - Elements of the SGR Campaign
        - Focus groups to hone messaging
        - Physician surveys to measure access problems
        - Patient Action Network – patients supporting physicians
        - Ads

        - AMA House Calls – board members participating in press conferences
        - Beyond the beltway meetings – talk to local congressmen and senators
        - Periodic conference calls – coordination
    - Together We Are Stronger – SGR workgroups, meetings and research to coordinate a consistent message
- *Other Important Issues*
    - Coverage for the Uninsured
    - Patient Safety – last year was passed in both the House and Senate, but it did not pass in the Conference Committee
    - Medicaid Reform – task force
    - Quality Improvement (linked to SGR)
    - Electronic Medical Records (linked to SGR)
    - Pay for Performance (linked to SGR)
    - Funding for Medical Research and Public Health Programs
    - Specialty Hospitals
    - Regulatory Relief
    - Anti-trust Relief

The full PowerPoint presentation is attached to these minutes.

Questions

- A RUC member posed the question, would linking patient safety legislation with tort reform provide enough for the swing democrats to vote in favor of such a bill? Several RUC members commented on the importance of medicine tying-in patient safety with tort reform discussions. Lee Stillwell responded that the AMA tried to link patient safety with tort reform the last time around but it did not work. The reality is that the patient safety bill must pass separately.
- A RUC member questioned if CMS/AMA will be conducting an SMS survey. The RUC recommended that the AMA reconsider conducting this survey. Mr. Stillwell responded that it is a budgetary problem and a problem finding a way to effectively perform the survey. AMA would consider performing it again if there was a legitimate plan to perform what CMS needs and if the funds were available. Carolyn Mullen, CMS, announced that CMS is still hoping to produce the funds to conduct the SMS survey, but would also hope that the AMA would partner with CMS and its contractor in conducting the surveys.

VIII. Directors Report

Sherry Smith made the following announcements:

- The 2005 RUC database is available. Recipients must sign the license agreement. The non-facility total payment rate is incorrect. An updated version will be available at the April 2005 RUC meeting.

IX. Relative Value Recommendations for CPT 2005

Gastric Restrictive Procedure (Tab 4)
Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

The RVU work recommendation for code 43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)* has been postponed until the April 2005 RUC meeting. The specialty requested more time to adequately prepare the survey and present this code. **The RUC does not make a recommendation at this time.**

X. Relative Value Recommendations for CPT 2006

TMJ Manipulation Under Anesthesia (Tab 5)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American Dental Association

The two following codes 21XXX1 *Manipulation, therapeutic, temporomandibular joint (TMJ); requiring conscious sedation* and 21XXX2 *requiring general anesthesia* have been referred back to CPT for clarification. **The RUC does not make any recommendations at this time.**

Radiologic Venous Catheter Evaluation (Tab 6)
Bibb Allen, Jr., MD, American College of Radiology (ACR)
Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR)
Facilitation Committee # 3

In 2004, the CPT Editorial Panel significantly changed the family of codes describing central venous access procedures. However, the radiological evaluation of an existing venous access device was not addressed. New code, 3659X *Contrast injection(s) for radiologic evaluation of existing venous access device, including fluoroscopy, image documentation and report* will be added to delineate the radiological evaluation and maintenance of existing venous access within the CPT.

The RUC discussed the possibility of code 3659X being billed with de-clotting procedures such as 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (Work RVU = 3.59) or 36596 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen* Work RVU = 0.75). RUC members commented that a parenthetical should be placed in CPT for the code not to be billed with these codes.

The RUC reviewed and compared the work of this code to reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (000 day global, Work RVU= 0.76) and to code 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)* (000 day global, Work RVU = 0.76) . The RUC believed that the physician work was closely aligned with both codes 50394 and 49424, considering there was more time spent in the pre and post time periods. The RUC also believed that the 25th percentile survey results were consistent with the physician work involved, and therefore **recommends a relative work value of 0.74 for code 3659X.**

Practice Expense

The RUC made some modifications to the specialty's original practice expense recommendation. Specifically, the clinical labor activity time was reduced on the following lines:

- Review Charts, line 25
- Provide pre-service education/obtain consent, line 28
- Assist physician in performing the procedure, line 34

In addition, the RUC increased the quantity of the exam table paper by one foot. The modified practice expense inputs recommended by the RUC are attached.

Physician Liability Crosswalk

The RUC recommends that an appropriate crosswalk code for the physician liability is its reference code 50394 *Injection procedure for pyelography (as nephrostrogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter.*

Vertebral Augmentation - Kyphoplasty (Tab 7)
American Association of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pain Medicine
American College of Radiology
American Society of Anesthesiologists
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology
American Society of Neuroradiology

The following three codes 2252X1, 2252X2 and 2252X3 have been referred back to CPT for clarification **The RUC does not make any recommendations at this time.**

High Energy Extracorporeal Shock Wave Therapy (Tab 8)
Tye Ouzounian American Academy of Orthopaedic Surgeons (AAOS)
Lloyd S. Smith, DPM, American Podiatric Medical Association (APMA)
Frank Spinosa, American Podiatric Medical Association (APMA)
Facilitation Committee #1

The CPT Editorial Panel created a new code to differentiate between high energy and low energy Extra Corporeal Shock Wave Therapy in the treatment of plantar fascitis. CPT also revised a category III code that describes other extracorporeal shock wave procedures. The RUC evaluated the procedure performed in the facility setting since the CPT RUC representative confirmed that during the CPT presentation, the Panel approved the code based on the presenters' statements that it is only performed in the facility setting because the procedure requires general anesthesia due to the high level of pain involved. However, during the RUC presentation, a presenter stated that the procedure is also performed in the non-facility setting. The RUC did not take formal action on the non-facility practice expense for CPT code 2825X, but will forward the specialty recommendation for CMS' independent evaluation.

During the RUC review, the presenters agreed to reduce the pre-service time and eliminate one post-service office visit from the survey results as the presenters felt that the results overstated the total time. By reducing these inputs a revised recommended value of 3.85 was presented for RUC consideration. The RUC agreed that code 25001 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* (work RVU, 3.37, 090 day global) should be used as an additional reference service because the physician time for 25001 (pre time = 30, intra = 30, immediate post=30, ½ day discharge, 2 x 99212, and 1x99213) is very similar to the new code. The RUC concluded that the new code should be valued slightly below this reference procedure. Also, the RUC made a number of changes to the physician time:

- **Pre-Evaluation time = 15 minutes**
- **Pre-Positioning time= 5 minutes**
- **Pre-Wait (related to ultrasound)= 10 minutes**
- **Intra-Service Time = 25 minutes**
- **Immediate Post time = 18 minutes**
- **Half Day Discharge = 18 minutes**
- **Three post operative visits at a level of 99212 (most typically at 1 week, 4 weeks, and 8 weeks following the procedure)**

Based on these changes and in comparison to code 25001, the RUC concluded that a work RVU of 3.30, which is slightly below the value of the reference service 25001 would place the code in proper rank order. **The RUC recommends a work RVU of 3.30 for code 2825X.**

Practice Expense

Facility Setting

The RUC altered the post-operative visit clinical labor time, medical supplies, and equipment to reflect the reduction in physician post operative visits. The RUC agreed with the specialty proposed 24 minutes of pre-service time. Attached are the revised practice expense recommendations for this site of service.

Non-Facility Setting

The RUC did not take formal action on the non-facility practice expense for CPT code 2825X, but will forward the specialty recommendation for CMS' independent evaluation.

Professional Liability

The RUC recommends that the Professional Liability Insurance (PLI) RVU be cross-walked to code 28430 *Closed treatment of talus fracture, without manipulation* since it is a non invasive procedure.

Inferior Turbinate Procedures (Tab 9)

James Denneny, MD, American Academy of Otolaryngology-Health and Neck Surgery (AAO-HNS)

The CPT Editorial Panel revised codes 30130 *Excision inferior turbinate, partial or complete, any method* (Work RVU=3.37), 30140 *Submucous resection inferior turbinate, partial or complete, any method* (Work RVU=3.42), 30801 *Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method, (separate procedure); superficial* (Work RVU=1.09), and 30930 *Fracture nasal inferior turbinate(s), therapeutic* (Work RVU=1.26) to clarify the appropriate use as private payors were not processing claims appropriately for inferior turbinates. The specialty society presented that these changes are editorial, which identifies that these procedures only include the inferior turbinate (not the superior or middle turbinate). The

RUC did not feel that these codes need to be surveyed again. **The RUC recommends that the revisions are editorial. The RUC recommends to maintain the current values of 30131, 30140, 30801, 30802 and 30930.**

Laryngeal Function Studies (Tab 10)
James Denneny, MD, American Academy of Otolaryngology-Health and Neck Surgery (AAO-HNS)

The CPT Editorial Panel revised code 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* to reflect more specifically its current clinical usage and to remove ambiguity by specifying types of testing. Further, with the adoption of code series 92612-92617 [describing flexible fiberoptic evaluation of swallowing and sensory testing with or without physician interpretation/report] there has been concern that 92520 would be utilized inappropriately to report these services.

The specialty society reviewed the survey results for 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* and proposed a work RVU of 0.75 which is lower than the surveyed low outlier (0.80). The response rate was high, however the sample size was small. Therefore a specialty society expert panel convened and recommended a lower value than the survey respondents because the panel felt that the survey respondents overvalued their work. Reference codes 92613 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only* (Work RVU=0.71) and 92617 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by or video recording; physician interpretation and report only* (Work RVU=0.79) were used because they reflected a comparable amount of work and intensity. In addition, the intra-service time for code 92520 (10 minutes) is comparable to the intra-service times for the reference service codes, 92613 (intra-service time = 10 minutes) and 92617 (intra-service time = 15 minutes). **The RUC recommends a work RVU of 0.75 for code 92520.**

The specialty society clarified that this procedure typically can not be performed in many outpatient centers because of the elaborate laboratory set-up that is used. Code 92520 will typically be billed incident-to a physician.

Practice Expense
The RUC reviewed the revised recommended practice expense inputs in detail and agreed to reduce the clinical labor time in the pre-service time period and the intra-service time period. **The revised practice expense inputs are attached and recommended by the RUC.**

Pre-service time = 10 minutes
Intra-service time = 11 minutes
Post-service time = 10 minutes

Coronary Artery Anomaly Unroofing (Tab 11)
Society of Thoracic Surgeons

Code 3350X *Repair of anomalous (eg intramural) aortic origin of coronary artery by unroofing or translocation* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey data were flawed and unusable and that the overall survey responses were inadequate. The specialty society will re-survey and present at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Ventricular Restoration (Tab 12)
Society of Thoracic Surgeons

Code 3354X *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Cavopulomary Shunting (Tab 13)
Society of Thoracic Surgeons

Code 3376X *Anastomosis, cavopulmonary, second superior vena cava (List separately into addition to primary procedure)* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Repair of Pulmonary Artery Arborization Anomaly (Tab 14)
Society of Thoracic Surgeons

Codes 3392X1 *Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass* and 3392X2 *with cardiopulmonary bypass* have been postponed until the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Partial Gastrectomy (Tab 15)
Charles D. Mabry, MD, American College of Surgeons (ACS)

The CPT Editorial Panel deleted CPT codes 43638 *Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;* and 43639 *Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloplasty or pyloromyomotomy* which are outmoded procedures. The Panel originally created a cross-reference that these deleted codes should now be reported with CPT codes 43122 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty* and 43123 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es).* 43122 and 43123 have work relative values greater than the deleted codes 43638 and 43639 which would lead to a work neutrality issue. At the February 2005 meeting, the Editorial Panel removed the cross-reference as obsolete services should not be referred to other CPT codes when the codes are deleted. *Staff Note: the CPT Editorial Panel did remove these cross references.*

Laparoscopic Gastric Restrictive Procedure, with Gastric Band (Tab 16)
Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

The laparoscopic gastric restrictive procedures, with gastric band, codes 4XXX1 – 4XXX8 have been postponed until the April 2005 RUC meeting. The specialty society did not have adequate time to develop, run, interpret and process the data for all 8 codes in time to present at the RUC meeting for the February deadline. **The RUC does not make any recommendations at this time.**

Laparoscopic Enterostomy Closure (Tab 17)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created a new code 442X1 *Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)* to report the laparoscopic approach of an enterostomy closure. The RUC reviewed the survey data of over 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. During its review, the RUC made the following observation about performing laparoscopic procedures, that once the techniques for performing laparoscopic surgery have been mastered for any existing procedure, the

learning curve for performing a new procedure laparoscopically is not as dramatic as the learning curve for performing the laparoscopic techniques themselves. The RUC observed that although the societies' reference service code, CPT code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU=25.32) has a greater total time than the new code, 524 minutes and 488 minutes, respectively, the reference code requires less technical skill and less intra-operative intensity/complexity when compared to the new code. Therefore, the specialty societies recommended the survey median RVU of 26.50. The RUC agreed with the specialty societies' recommendation and agreed that this value for the new code is appropriately placed between 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04) and 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure* (RVW=29.96) as 442X1 requires greater exposure and represents a more complex re-operation than 44204 and 44206 includes more intra-operative work and the post-operative work is more intense/complex than the surveyed code. **The RUC recommends a work RVU of 26.50 for CPT code 442X1**.

Practice Expense

The RUC recommends the standard inputs for this 090 day global period code that is performed only in the facility setting.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance Crosswalk for 442X1 is 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure).* The PLI for 44206 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44206 is very similar to the new code.

Laparoscopic Splenic Flexture (Tab 18)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created a new code 442X2 *Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)* to report the laparoscopic approach of a splenic flexure. The RUC reviewed the survey data of over 35 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that reference code 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (work RVU=2.23) had less intra-service time than the surveyed code, 30 minutes and 45 minutes respectively.

In addition, the RUC observed that the surveyed code requires more technical skill and has a higher intra-operative intensity than the reference code. Therefore the specialty societies recommended the survey median RVU of 3.50. The RUC agreed with the specialty societies' recommendation and in addition felt that this value for the new code is appropriate as it is less that 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis* (RVW=4.44), which has an intra-operative time of 60 minutes (15 minutes more than the surveyed code). **The RUC recommends a work RVU of 3.50 for CPT code 442X2**.

Practice Expense

The RUC agreed with the specialty societies' recommendation of no additional practice expense inputs for this code, as all of the practice expense inputs are accounted for in the base code.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance (PLI) Crosswalk for 442X2 is 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* (Work RVU=4.44). The PLI for 44203 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work is very similar to the new code.

Laparoscopic Stomas (Tab 19)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes 442X3 *Laparoscopy, surgical; ileostomy or jejunostomy, non-tube* and 442X4 *Laparoscopy, surgical; colostomy or skin level cecostomy* to report the laparoscopic approach of an ileostomy or jejunostomy and the laparoscopic approach of a colostomy or skin level cecostomy.

442X3

The RUC reviewed the survey data of almost 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that the reference code describing the open procedure, 44310 *Ileostomy or jejunostomy, non-tube* (Work RVU=15.93) has a similar total time as the surveyed code, 367 minutes and 361 minutes, respectively. It was also noted by the RUC that the reference code and the surveyed code had similar intensity and complexity. Therefore, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 15.93. **The RUC recommends a work RVU of 15.93 for CPT code 442X3.**

442X4

The RUC reviewed the survey results of almost 80 colon/rectal surgeons and gastrointestinal endoscopic surgeons. Upon reviewing the specialty societies' recommendations, the RUC determined that a 99214 office visit should be removed and a 99213 office visit should be added as this allocation of office visits more accurately reflected the treatment of a typical patient. With this modification, the RUC observed that although the reference code describing the open procedure 44320 *Colostomy or skin level cecostomy;* (Work RVU=17.61) has a greater total time than the surveyed code, 465 minutes and 384 minutes, respectively, there is additional skill and intra-operative intensity required to perform this procedure as compared to the reference code. Therefore, the RUC recommended that the work RVU for the new code be cross-walked to the work RVU of the existing code. A work RVU of 17.61 for 442X4 will appropriately identify the additional intra-operative work associated with 442X4 as compared to 442X3, 90 and 75 minutes respectively. **The RUC recommends a work RVU of 17.61 for CPT code 442X4.**

Practice Expense

The RUC recommends the standard inputs for these 090 day global period codes that is performed only in the facility setting with a modification to reflect the change of an office visit from a 99214 to a 99213 in the 442X4 code. In addition, the RUC recommends that 7 minutes be included for both 442X3 and 442X4 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance (PLI) crosswalk for 442X3 and 442X4 is 44205 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy* (Work RVU=22.20). The PLI for 44205 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44205 is very similar to 442X3 and 442X4.

Laparoscopic Protectomy (Tab 20)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes 454X1 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* and 454X2 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* to report the laparoscopic approach of a complete protectomy and a proctectomy that is combined with an abdominoperineal pull-through procedure.

454X1

The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic suregeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 210 minutes and 180 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity that the reference code. Therefore the RUC agreed with the specialty societies' recommendation of the survey median RVU of 30.50. **The RUC recommends a work RVU of 30.50 for CPT code 454X1**.

454X2

The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic suregeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 240 minutes and 210 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity that the reference code. Therefore the specialty society recommended the survey median RVU of 34.00. The RUC agreed with the specialty societies recommendation of the survey median RVU of 34.00 and felt that the survey median RVW of 34.00 is appropriately greater than 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (work RVU=31.95) and less than 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (work RVU=34.95). **The RUC recommends a work RVU of 34.00 for CPT Code 454X2.**

Practice Expense

The RUC recommends the standard inputs for these 090 day global period codes that are performed only in the facility setting. In addition, the RUC recommends that 7 minutes be included for both 454X1 and 454X2 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance Crosswalk for 454X1 is 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (Work RVU=31.95) and for 454X2 is 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (Work RVU=34.95). The PLI for these existing codes incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for these existing codes is very similar to the new codes.

Laparoscopic Proctopexy (Tab 21)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes to describe the laparoscopic approach for proctopexy so that they are differentiated from the open procedures that can not be used to report the laparoscopic procedures. The RUC compared codes 454X3 *Laparoscopy, surgical; proctopexy (for prolapse) and code* 454X4 *Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection* to their open procedure counterparts, code 45540 *Proctopexy for prolapse; abdominal approach* (work RVU = 16.25) and code 45550 *Proctopexy combined with sigmoid resection, abdominal approach* (work RVU= 22.97). The RUC agreed with the presenters that the new codes had significantly higher risk and were technically more difficult than the open procedures and to establish proper rank order, the new procedures needed to be valued higher than the open procedures. Additionally, if there was not sufficient RVU difference between the new codes and the open codes there would be a rank order anomaly among the family of laparoscopic codes.

In addition to examining the survey results, the RUC also examined the IWPUT calculations as an additional rationale and felt that using the 25th percentile RVU of 18.06 for code 454X3 produced an IWPUT of 0.097 and the RUC was comfortable that this value placed the code in proper rank order. Also, the 25th percentile value places 454X3 appropriately greater than 44200 (*Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure*) (work RVU, 14.42) and is less than 44205 (*Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy*) (work RVU, 22.05)

The RUC used an additional reference code 44204 *Laparoscopy, surgical; colectomy, partial with anastomosis* (work RVU=25.04 and IWPUT of 0.097) to compare to 454X4. The total time for code 44204 is 439 minutes compared to 446 minutes for 454X4. However, the intra service time for 44204 is 30 minutes longer. The committee felt that the intensity of code 454X4 is greater than this reference code but the total RVU should be the same. At an RVU of 25.04, the IWPUT for 454X4 is .110. The committee felt that this reflected the higher intensity while the total RVU of 25.04 kept the code in proper rank order especially compared to 44204. This value also is similar to the 25th percentile as determined by the RUC survey.

The RUC recommends a work RVU of 18.06 for code 454X3.
The RUC recommends a work RVU of 25.04 for code 454X4.

Practice Expense
The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Ileoanal Pouch Fistula Repair (Tab 22)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

CPT created two new codes to accurately describe circumferential transanal pouch advancement to repair a pouch-vaginal or pouch-perineal fistula or long exit conduit of S-pouch. The RUC reviewed code 4670X1 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* and felt that the recommended median RVU of 18.00 resulted in an IWPUT of .119 that was too high for this procedure. Therefore, it was agreed to use a work relative value between the 25th % and the median value that would produce an IWPUT that would place the code in proper rank order such as with code 454X3 *Laparoscopy, surgical; proctopexy (for prolapse)* (recommended RVU = 18.06). Using a work relative value of 16.00 results in an IWPUT of .097 that is the same as code 454X3. The RUC determined that this intensity value and work relative value was appropriate and placed the code in proper rank order especially with code 454X3, which the RUC felt had the same intra-service intensity as 4670X1. **The RUC recommends a work RVU of 16.00 for code 4670X1.**

The presenters explained that code 4670X2 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach* involved some of the most difficult cases that colon and rectal surgeons see and the procedure involves significant risk. The RUC examined the new code in comparison to the reference procedure, code 45119 *Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy* (work RVU, 30.79). Total times of these two codes were similar with code 4670X2 having 30 additional minutes of intra-service time. Also, the intensity measures of the surveyed code were higher in each category when compared to the reference service. Therefore, the RUC agreed that the median survey RVU of 34.00 would place the code in proper rank order and reflect the additional complexity and technical skill needed in comparison with the reference service. Also, the presenters explained that the higher RVU is warranted because the procedure is always performed in a reoperative field in a patient that already has a pouch with inherent sphincter pouch disfunction and chronic inflammation. More than reoperative surgery, this deep pelvic operation

is techincally difficult because of the tenuous blood supply to the pouch and risk of ureter damage that requires slow, detailed dissections in a confined space. Failure of this operation would result in a permanent stoma. **The RUC recommends a work RVU of 34.00 for code 4670X2.**

Practice Expense
The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Anal Sphincter Chemodenervation (Tab 23)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

CPT created code 465X1 *Chemodenervation of internal anal sphincter* to describe a new medical modality that involves injecting Botulinum toxin for the medical management of anal fissures. The RUC reviewed the specialty society's survey data and was comfortable with the median RVU, however the RUC noted that the median value was based on the inclusion of a full discharge day management service. Since this is an outpatient procedure, the RUC concluded that the physician work associated with half of a visit would be more typical and therefore reduced the recommended value by 0.64 RVUs , which is half a discharge day management service. Therefore the RUC concluded that a work RVU of 2.86 was appropriate especially compared to reference service 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU= 2.20), which does not include a post service office visit or any discharge day management. **The RUC recommends a work RVU of 2.86 for code 465X1.**

Practice Expense
The RUC approved practice expense inputs for the facility and non-facility setting. Intra-service assist time was set equal to the physician time and in the non-facility setting a local anesthetic is typically used, which is reflected in the supplies.

Hyperhidrosis Chemodenervation (Tab 24)
American Academy of Dermatology
American Academy of Neurology

Daniel Mark Siegel, MD, excused himself from the table due to a disclosed conflict of interest.

Codes 6468X1-6468X4 have been postponed until the April 2005 RUC meeting. The surveying specialties felt that too few survey responses were

received and have postponed presenting recommendations until April 2005 when sufficient data can be collected.

The RUC agreed with the specialty societies to use a global period of 000-days for purposes of conducting their survey. The RUC does not make any recommendations at this time.

Belpharoptosis Repair, Harvest of Fascia (Tab 25)
Gregory Kwasny, MD, American Academy of Ophthalmology (AAO)
Jeffrey Paul Edelstein, MD, American Academy of Ophthalmology (AAO)
Facilitation Committee # 2

The CPT Editorial Panel revised two existing codes, 67901 *Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)* and 67902 *frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* to differentiate between repair of blepharoptosis frontalis muscle technique with autologous fascial sling requiring harvesting and blepharoptosis frontalis muscle technique with suture or banked graft.

At the November 2004 CPT Editorial Panel, the specialty society requested that both codes be resurveyed since there was a clarification on how the fascia is being obtained and these services had never been reviewed before. Previously 67901 would be reported for either banked fasica or other methods of obtaining grafts. This coding change directs all banked fascia to be reported with 67901 and all autologous fascia be reported the 67902. Typically, the RUC would have expected a work neutrality adjustment. However, the specialty society feels that both codes are currently undervalued. Specialty societies must present compelling evidence in such a review and this was not presented in February 2005. The specialty society will request that this issue either be addressed the Five-Year review or they will re-present in April 2005 with compelling evidence available. **At this time the RUC offers no recommendation on these two codes.**

Neutron Therapy (Tab 26)
David Beyer, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)
Jeffrey DeManes, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)

The CPT Editorial Panel created two new codes and revised one code to allow for more specificity in CPT for radiation treatment delivery, and to recognize high energy neutron therapy that is greater than 45MeV. The new codes now reflect the actual resources used in delivering neutron therapy and enable tracking and monitoring of this modality. Neutron therapy facilities require a

high capital investment, and therefore only three neutron therapy facilities exist in the United States for this non-physician service. These facilities continue to draw patients from all over the United States, and many countries throughout the world.

The RUC then carefully reviewed the practice expense inputs for the two new codes. The RUC had minor changes regarding the clinical staff type and medical supplies in the non-facility setting. **The RUC recommends a total of 46 minutes of clinical labor time for code 774XX1 and 76 minutes for 774XX2. The RUC recommends no facility practice expense inputs for the codes, only non-facility practice expense inputs are recommended. The full revised practice expense recommendations from the RUC are attached.**

Caffeine Halothane Contracture Test (Tab 27)
James D. Grant, MD, American Society of Anesthesiologists (ASA)
Brenda Lewis, DO, American Society of Anesthesiologists (ASA)
Henry Rosenberg, MD, American Society of Anesthesiologists (ASA)
Joseph Tobin, MD, American Society of Anesthesiologists (ASA)

The CPT Editorial Panel created a new code under its Pathology and Laboratory procedures section, to identify individuals who are susceptible to malignant hyperthermia. Exposure to some common anesthetic agents can cause patients to develop an extremely high metabolic rate resulting in symptoms such as muscular rigidity and hyperthermia in excess of 110 degrees. Susceptibility to malignant hyperthermia is inherited, and the Caffeine Halothane Contracture Test is performed on patients who have a family history or past medical history that indicates susceptibility to this condition.

The RUC reviewed the physician work associated with the new code 89XXX *Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report.* The RUC and the specialty society believed that the survey responses included technical clinical time (60 minutes of pre-service time, 90 minutes of intra-service time and 60 minutes post service for a total of 210 minutes). The RUC and the specialty society agreed that the physician work reflected a much lower total time of 45 minutes (5 minutes pre-service and 40 minutes of post-service time). The RUC and the specialty society believed the revised physician time should be used in a building block approach resulting in a physician work relative value of 1.40.

The RUC also assimilated the work intensity of 89XXX to code 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (Work RVU = 1.33) and RUC approved code 88361 *Morphometric analyis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual using computer assisted technology* (Work RVU = 1.18). In addition, the work intensity of new code 89XXX was

understood to be similar to that of an E/M service for 45 minutes (.031 * 45 minutes = 1.40 RVUs). Considering the building block approach, and the comparison of codes with similar physician work intensity, **the RUC recommends a relative value of 1.40 for code 89XXX.**

The RUC recommends the following physician time for code 89xxx:

- **Total Pre-Service Time = 5 minutes**
- **Total Intra-Service Time = 0 minutes**
- **Immediate Post Service time = 40 minutes**

Practice Expense:
The RUC examined the direct practice expense inputs for code 89XXX with the understanding that the test requires significant clinical labor time to perform. This service is performed so rarely that a technologist may be required to dedicate as many as 5 hours per patient when the service is performed. The RUC recommends the attached non-facility direct practice expense inputs, and zero facility direct inputs for code 89XXX.

<u>Antroduodental Manometry (Tab 28)</u>
Joel Brill, MD, American Gastroenterological Association (AGA)

The CPT Editorial Panel created a new code 910XX *Duodenal motility (manometric) study* to assess small intestinal motility. It was believed that neither esophageal nor gastric motility studies provide information about duodenal and jejunal motility, and the new code allows for the reporting of this specific procedure.

The RUC discussed the work relative values in relation with the specialty selected key reference services: 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;*(000 global, Work RVU=1.25) and 91020 *Gastric motility study* (000 global, Work RVU=1.44).

The RUC agreed that this new code fits into the same family as its key reference services and believed that code 91020 was very similar in physician work, time, and effort. **The RUC recommends a relative value of 1.44 work RVUs for new code 910XX.**

The RUC reviewed the physician time components from the specialty survey and discussed them in relation to recently RUC reviewed codes: (91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation (*Work RVU=0.97) 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (Work RVU= 1.59), and 91037 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;*(Work RVU=0.97), and believed this new code

should have similar time components as the rest of its family. The codes intra-service work per unit of time was agreed to be approximately equivalent to .025. With this knowledge**, the RUC recommends the following physician time components for code 910XX**:

- **Pre-Service Evaluation time = 15 minutes**
- **Intra-Service Time = 30 minutes**
- **Immediate post operative time = 16 minutes**

Practice Expense

The RUC made some modifications to the clinical labor time to reflect changes in physician time, and reallocated existing time to appropriate clinical activity components. In addition, the specialty believed that the disposable catheter in line 73 of the medical supplies should be deleted as it would not typically be used. **The modified practice expense inputs are attached to this report and recommended by the RUC.**

Physician Liability Crosswalk

The facilitation committee believed that an appropriate crosswalk code for the physician liability is its reference code 91020 , and recommends this crosswalk to the RUC.

Continuous Glucose Monitoring Interpretation (Tab 29)
Sethu K. Reddy, MD, American Association of Clinical Endocrinologists (AACE)

The CPT Editorial Panel created a new CPT code 9525X *Ambulatory continuous glucose monitoring of for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report* as a substitute for reporting an Evaluation and Management code for this service. The RUC reviewed survey data from 37 endocrinologists and agreed that the 25th percentile of the survey work value (0.85) appeared to be appropriate. The RUC also agreed that this service would require approximately 30 minutes of physician time, including interpretation of over 900 glucose values, overlayed with a patient log of several variables (caloric intake, physical activity, symptoms of hypo- or hyper-glycernia, and other symptoms as they occur). **The RUC recommends a work relative value of 0.85 for CPT code 9525X.**

Practice Expense Inputs

All practice expense inputs associated with this service are included in CPT code 95250. Therefore, there are no direct practice expense input recommendations for CPT code 9525X.

Education and Training for Patient Self Management (Tab 30)
Sethu K. Reddy, MD, American Association of Clinical Endocrinologists (AACE)
Jane White, PhD, American Dietetic Association (ADiA)

The CPT Editorial Panel created new codes to describe educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional. There is no physician work associated with these services. The RUC considered recommendations for direct practice expense inputs only. The RUC reviewed inputs for CPT code 97XX1 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient* only. The RUC recommended that the coding for group education be referred back to CPT for further consideration.

The revised practice expense inputs are attached to this recommendation.

Inpatient Follow-Up and Confirmatory Consultations (Tab 31)

The RUC briefly discussed the work neutrality implications of deleting the inpatient follow-up and confirmatory consultation CPT codes in CPT with cross-references to report other existing CPT codes. The RUC understands that CMS will have the work neutrality impact analysis complete by the April RUC meeting. The RUC will discuss this issue at that time.

XI. Practice Expense Review Committee Report (Tab A)

Doctor Moran reported that the Practice Expense Review Committee (PERC) reviewed over 150 codes during its meeting, including several additional codes that were added to the agenda by specialty society special request. This meeting concluded the PERC's work on refining the inputs of existing codes. The PERC will now concentrate on reviewing the practice expense inputs of new and revised codes before each RUC meeting. Doctor Moran reminded specialties to take the PERC's advisement under serious consideration when presenting at the RUC. Doctor Rich added that the review of practice expense inputs is time consuming for the RUC and he expects specialty practice expense recommendations to be in good shape when presented to RUC. He stated that if the practice expense recommendations are not in good shape at the RUC, the RUC will not perform a line by line review and the code would be sent to facilitation for work and practice expense.

XII. RUC HCPAC Review Board Report (Tab B)

Mary Foto, OTR, HCPAC Co-Chair, presented the HCPAC report to the RUC. Ms. Foto announced that a new HCPAC member and alternate member have joined the HCPAC. The American Nurses Association's (ANA) new HCPAC member is Katherine Bradley, PhD, RN and the American Occupational Therapy Association's (AOTA) new HCPAC alternate is Terry A. Moon, OTR/L.

Ms Foto explained that the HCPAC approved the revised HCPAC MPC List.

Ms. Foto indicated that the American Psychological Association's (APA) updated the HCPAC on its efforts to seek the Research Subcommittee input and approval of the proposed education information, survey edits and reference services list of the neurobehavioral status exam and psychological testing codes which will be presented to the HCPAC in April 2005.

The American Speech-Language-Hearing Association (ASHA), informed the HCPAC on codes which they have submitted to CMS for the upcoming Five-Year Review. ASHA is requesting that services performed by speech-language pathologists and audiologists be assigned a physician work value similar to the physical and occupational therapists.

The American Dietetic Association (ADiA), updated the HCPAC on issues surrounding the medical nutrition therapy codes due to a change in the services provided. ADA is currently trying to discern the best method to address these issues, which could potentially include (1) modifying existing codes to adequately reflect the services performed and (2) determining the benefits of their payment remaining in the non-physician work pool, changing their payment to traditional practice expense inputs or changing their payment to include physician work.

The HCPAC also heard discussions from various allied health professionals pertaining to changing their payment methodology, including requests made by ASHA and the issues surrounding the medical nutrition therapy codes. The HCPAC has decided to further study this issue and determine possible solutions.

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

XIII. Practice Expense Subcommittee Report (Tab C)

Doctor Zwolak reported that the practice expense subcommittee met for an hour and reviewed several topics and had one motion to bring to the RUC.

This Subcommittee spent most of the time discussing the evolution of PE inputs, payments and the issue of a five-year review of PE inputs. There are three specific areas regarding the practice expense methodology on which the Subcommittee focused. First, the fact that the PEAC and PERC have done a tremendous job at refining the practice expense inputs for all the codes whereas the result is a significant improvement over the original CPEP data. The question came up whether there should be a review of these inputs, and Doctor Moran pointed out that in the first year or two of the PEAC, there was more variance in the inputs and less standardization. The Subcommittee discussed whether there was a role for the RUC to review these inputs. The Subcommittee placed this discussion on hold until CMS completes a review of the inputs looking for standardization and outliers.

The second item discussed was the PE pool creation and the SMS inputs that derive these pools. The SMS data is now over six years old, and the question arises as to whether the data should be renewed and reviewed. Subcommittee members agreed again that the data should be updated and it was understood that CMS is now actively considering a renewed survey process through one of its contractors. The RUC is waiting for CMS to make its move in this area.

The final item discussed regarding the SMS data was the direct expense of some very expensive disposable medical supplies, and the impact of the scaling factors on those supplies. The Subcommittee believed in an effort to try to minimize the distortions that result from the scaling factors, J should codes be created for high priced disposable supplies. The Subcommittee was also concerned that these disposables are priced at one point and placed into CMS's supply list for years to come, when these prices may change within 6 months of being put on the list. After much discussion, the RUC made the following amended recommendation:

CMS be requested to set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

RUC Member Evaluation of Practice Expense Inputs

Doctor Moran presented a slide show for RUC members entitled: "How to Evaluate a Practice Expense Recommendation, Tips for RUC Members". Doctor Moran's presentation was very well received by the group, and PowerPoint slides are available to all by contacting AMA staff.

GAO and MedPAC Reports

The subcommittee briefly discussed the reports and their relevance to future practice expense direct input review, but made no recommendations

XIV. Five-Year Review Workgroup Report (Tab D)

Doctor Meghan Gerety, Chair of the Five-Year Review Workgroup, presented the Workgroup report to the RUC. Doctor Gerety informed the RUC that at this time, it is estimated specialty societies have submitted comments on more than 400 individual CPT codes. In addition, CMS is planning to submit codes that are potentially mis-valued. It is expected that the final list of codes will be submitted to the AMA by mid-February.

Doctor Gerety explained that CPT codes are likely to be included in the Five-Year Review that were not submitted by the specialties. A question arose regarding what action the RUC would take if a specialty chose to not express an interest in participating in reviewing a service identified by CMS. Although, several members noted that it is unlikely that a specialty would choose this course of action, it was recognized that the current action keys do not include an appropriate RUC action for such a scenario. **The Workgroup recommends that an eighth action key be added as follows:**

8 = No Level of Interest submitted, no RUC recommendation submitted.

The RUC proposal on the Five-Year Review and the CMS discussion in the November 15 *Final Rule* both indicate that the this third Five-Year Review should be based on potential mis-valuation of physician work. This decision was made after consideration that all CPT codes have recently been reviewed under the PEAC process. However, modification to the number and level of post-operative office visits and modifications to physician intra-service time for services performed in the office will result in changes to the clinical staff time. AMA staff will be supplying specialty societies with current information on the ratio of intra-service clinical staff to physician time and office visit information to all specialty societies involved in the Five-Year Review process. **The Five-Year Review Workgroup proposes that a short addendum be included in the Specialty Summary of Recommendation form to capture these changes to allow for easy CMS application of these modifications.**

The Five-Year Review Workgroup Report was approved and is appended to these minutes.

XV. Professional Liability Insurance Workgroup Report (Tab E)

Doctor Gregory Przybylski, Chair of the Professional Liability Insurance (PLI) Workgroup, presented the Workgroup report to the RUC. Doctor Stephen Kamenetzky had presented the Workgroup with a progress update on

his ability to obtain PLI data from the Physician Insurer Association of America (PIAA) for use in the CMS PLI methodology. The RUC is supportive of these efforts and offered to **send a letter to PIAA requesting its provision of PLI premium data to CMS. The letter should state that PIAA should only send the data to CMS if the agency is able to ensure confidentiality.**

Doctor Przybylski presented the PLI Workgroup recommendations to modify the crosswalk assumptions utilized by CMS. **The RUC recommends the following modifications to the risk factor assignments:**

- **As the PLI Workgroup understands that the following professions would not incur PLI premium rates greater than $6,152 per year, it appears appropriate to assign the current lowest risk factor of 1.00 for both non-surgical and surgical codes. This recommendation is considered an interim step. The PLI Workgroup believes that the PLI premium rates for the following may be substantially less than $6,152 and requests that CMS collect premium data for these professions.**

  Clinical Psychologist
  Licensed Clinical Social Worker
  Occupational Therapist
  Psychologist
  Optician
  Optometry
  Chiropractic
  Physical Therapist

- **The PLI Workgroup expresses concern about a number of specialties/professions that were assigned to an average "all physician" risk factor (3.04 non-surgical / 3.71 surgical). The Workgroup recommends that the following groups should have been treated as the other 34 Medicare specialties that were excluded from the analysis:**

  Certified Clinical Nurse Specialist
  Clinical Laboratory
  Multi-Specialty Clinic or Group Practice
  Nurse Practitioner
  Physician Assistant
  Physiological Laboratory (Independent)

- **The PLI Workgroup recommends that CRNAs should be crosswalked to Anesthesiology (2.84), rather than to the "all physicians" category.**

- **The PLI Workgroup also noted that the rank order premium data appeared problematic for colorectal surgery and gynecologist/oncologist and recommends that these two specialties be crosswalked as follows:**

  Gynecologist/oncologist (current 5.63) should be crosswalked to surgical oncology (6.13 – based on crosswalk to general surgery).

  Colorectal surgery (4.08) should be crosswalked to general surgery (6.13).

- **The RUC recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

The RUC recommends that the RUC HCPAC review and discuss the above recommendations. The PLI Workgroup would also be willing to review any data provided by a professional group to refute the understanding that its annual PLI premium data is less than $6,100.

A RUC member expressed concern that the impact of these changes is unknown and requested that CMS publish this impact prior to any implementation. The RUC agreed and **recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

Doctor Przybylski explained that the American College of Cardiology (ACC) has requested that the RUC correct a clerical mistake created when the PLI Workgroup updated exceptions to the surgical risk factor assignment. The PLI Workgroup agrees that it appears that a clerical mistake was made as the society never intended that these services be removed from the exception list. **The RUC recommends that CMS add back the following codes to the surgical risk factor list for cardiac catheterization (2.53):**

92980-92984
92985-92998
93617-93641

The RUC also recommends that 92975 be added to the cardiac catheterization (surgical risk factor) list based on the PLI Workgroup review of the cardiology codes.

The PLI Workgroup and the RUC discussed the dominant specialty approach and **recommends reaffirmation of the RUC recommendation that CMS utilize the dominant specialty in determining which specialty risk factor**

to apply to each CPT code. The Workgroup noted that it was flexible regarding the percentage threshold in determining the definition of dominant specialty. CMS staff indicated an interest in discussing this issue via conference call with interested members of the PLI Workgroup. AMA staff will arrange this call in the near future. In addition, CMS indicated that it was performing an analysis of removing specialties from the utilization data if the specialty performs a small percentage of the service (eg, less than 5% of total utilization). CMS will share this analysis with the PLI Workgroup.

The RUC also agreed to engage in a review of aberrant data in low utilization services. AMA staff will list all CPT codes with Medicare utilization data of less than 100 claims. This list will include the current utilization by specialty and then an "expected specialty" indication based on staff review of placement in CPT, who reviewed at RUC/PEAC, etc. This list will be forwarded to all RUC Advisors for review and comment prior to the April 2005 RUC meeting.

XVI. Research Subcommittee Report (Tab F)

Doctor James Borgstede, Chair of the Research Subcommittee, presented the Subcommittee Report to the RUC. The Research Subcommittee discussed a proposal from ASGS for a new survey methodology using magnitude estimation of intra-service work and using a building block methodology for pre and post-service work. This survey would be used in the upcoming Five-Year Review. **The subcommittee recommends approving the methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work but the survey should not contain intra-service times and IWPUT calculations.**

The subcommittee then discussed changes to the RUC survey for the Five-Year Review. In prior five-year reviews the RUC added a question to the RUC survey to assist RUC members in evaluating how physician work has changed over the previous five years. The results were reported in the RUC Summary of recommendation form. The following question was added at the end of the survey during the last five-year review and the Research Subcommittee agreed to include the following question to the RUC survey for use in the upcoming Five-Year Review.

Additional Question: The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.

Has the work of performing this service changed in the past 5 years?
Yes No

If Yes, please circle the response to questions a-c:

a. This service represents new technology that has become more familiar (i.e., less work).
I agree
I do not agree

b. Patients requiring this service are now:
more complex (more work)
less complex (less work)
no change

c. The usual site-of-service has changed:
from outpatient to inpatient
from inpatient to outpatient
no change

The Research Subcommittee reaffirmed its prior approval of the following Reference Service List guidelines to be added to the RUC survey instructions document.

Existing Guidelines:

- **Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.**
- **Services on the list should be those which are well understood and commonly provided by physicians in the specialty.**
- **Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)**

New Guidelines

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**
- **Include several high volume codes typically performed by the specialty.**

The Research Subcommittee reviewed proposed changes to the RUC survey for the psychological and neuropsychological testing codes. The changes include changing references to "physician" to "professional" and including generic pre, intra, and post service time period definitions. **The subcommittee recommends approving the changes to the APA survey.**

The Research Subcommittee has been assigned the task of examining the family of ultrasound codes to determine if rank order anomalies exist among the codes. The Subcommittee will attempt to use IWPUT calculations as a first step in identifying potential anomies.

The full report of the Research Subcommittee was approved by the RUC and is attached to these minutes.

XVII. Administrative Subcommittee Report (Tab G)

Doctor Chester Schmidt presented the Administrative Subcommittee report to the RUC. The Administrative Subcommittee met to discuss several issues including: 1.) CPT/RUC Meeting Dates, 2.) Re-review of RUC Recommendations- New Technology, 3.) Release of RUC Database to Specialty Society Representatives for Functions Not Pertaining to the RUC Process and 4.) Clarification of RUC Membership Criterion.

In its discussion of the CPT/RUC meeting dates, AMA Staff announced that at the April/May 2004 CPT Editorial Panel meeting, the Panel Members approved a motion changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. The Administrative Subcommittee was informed by AMA staff that CPT has finalized its annual calendar. The Administrative Subcommittee reviewed the timeline between all CPT and RUC Meetings and determined that there was sufficient time for specialty societies to develop RUC recommendations. **The Administrative Subcommittee recommended and the RUC approved all of the RUC meeting dates for the 2007 CPT RUC cycle.**

At the April 2004 RUC Meeting, a RUC member indicated that there is no formal process to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. This issue was referred to the Administrative Subcommittee for discussion. **After careful consideration of this issue, the Administrative Subcommittee recommended and the RUC approved that these codes should be identified, and the following process for formalized review should be implemented:**

The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure

has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.

At the September RUC meeting the Administrative Subcommittee recommended to the RUC that the RUC Database be released to the Specialty Societies for use outside of the CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims). The RUC extracted this item and tabled its discussion pending review by the AMA legal department.

AMA Staff met with Andrea Cooper-Finkle, JD, Senior Division Counsel for the AMA to obtain a legal review of this issue. Ms. Cooper-Finkle delivered a presentation to the Administrative Subcommittee to describe the findings of the AMA. Ms. Cooper-Finkle began by describing some history pertaining to this request. She stated that a request to release the RUC database to the public was first made several years ago. The AMA Legal Counsel at that time sought an opinion from the Justice Department which was referred to the Federal Trade Commission (FTC) opinion for legal review of this issue. The FTC in its opinion stated that releasing the RUC database to the public would not violate anti-trust laws and could also potentially have pro-competitive benefits. However, the response also may be interpreted that limiting distribution of the RUC database to selective recipients for use outside the CPT/RUC process may violate anti-trust laws. Therefore it is the opinion of the AMA Legal Counsel that the RUC database not be distributed to specialty society representatives for functions not pertaining to the RUC process as it may lead to a violation of the anti-trust laws.

After much discussion pertaining to the legal issues surrounding the release of the database, the Administrative Subcommittee recommended and the RUC approved the following motion:

The RUC database will not be distributed to the specialty society representatives for functions not pertaining to the RUC process.

The Administrative Subcommittee then discussed releasing the RUC database to the public. The members of the Administrative Subcommittee discussed the FTC's opinion that the release of the database could potentially have pro-competitive benefits. The Administrative Subcommittee understands the FTC's opinion and agrees that both providers and payors should have equal access to this information. Other issues discussed by the Administrative

Subcommittee included: 1.) the logistical distribution of the RUC database, 2.) the creation of new licenses to use the RUC database and 3.) the creation of new potential AMA products that would be affordable to individual proprietors to avoid an asymmetrical distribution of this data. The Administrative Subcommittee recommended and the RUC approved the following motion:

AMA staff will explore options for the public release of the RUC database with input from AMA Senior Management and AMA Legal Counsel with the objective of a symmetrical distribution amongst all potential recipients.

In April 2004, The RUC received a request from the American College of Physicians (ACP), to provide clarification regarding the first criterion for a permanent seat on the RUC, as stated in the "Criteria for Participation" section of the RUC Structure and Functions document. The Criteria for Participation as approved at the April 2002 RUC Meeting reads as follows:

1.) The specialty is an ABMS Specialty
2.) The specialty comprises 1 percent of physicians in practice
3.) The specialty comprises 1 percent of physician Medicare expenditures
4.) Medicare revenue is at least 10 percent of mean practice revenue for the specialty
5.) The specialty us not meaningfully represented by an umbrella organization, as determined by the RUC

In September 2004, this issue was discussed by the Administrative Subcommittee and Doctor Leahy of the ACP gave a brief presentation regarding this request and clarified that not only was his society seeking clarification but also was requesting that this criterion be assessed to determine its suitability as a criterion for a permanent seat on the RUC. The Administrative Subcommittee decided that further assessment of the first criterion for RUC membership, related to ABMS specialties, was needed.

Since September 2004, AMA staff has received 6 additional letters:

1.) A joint letter from the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), the American Society for Hematology (ASH) and the American Society for Clinical Endocinology (ASCO) requesting three permanent seats on the RUC for pulmonary medicine, gastroenterology and hematology-oncology.

2.) A letter from the American Board of Internal Medicine supporting the original ACP recommendation that general certificates and sub-specialty certificates that are approved by the American Board of Medical Specialties meet the first criterion for a permanent seat on the RUC, the specialty is an ABMS specialty
3.) A letter from ACP supporting the organizations representing the internal medicine subspecialties of gastroenterology, pulmonary medicine and hematology/oncology in their request for each subspecialty to receive a permanent seat on the RUC
4.) A letter form ASH and ASCO requesting a permanent seat on the RUC for hematology/oncology
5.) A letter from ACCP and ATS requesting a permanent seat on the RUC for pulmonary medicine and
6.) A letter from ACG, AGA and ASGE requesting a permanent seat on the RUC for gastroenterology

The Administrative Subcommittee, after much discussion amongst its members and members of the aforementioned societies, determined that before the requests made by the specialties could be assessed, the charge of the Subcommittee must be addressed, namely the clarification of the term ABMS specialty. The Administrative Subcommittee determined after reviewing documents from June 1991 pertaining to the proposed composition of the RUC that this criterion upon its creation refers to the 24 approved ABMS specialty boards. Therefore the Administrative Subcommittee recommended and the RUC approved the following motion:

The first criterion for a permanent seat on the RUC, as currently stated in the "Criteria for Participation" section of the RUC Structure and Functions document, the specialty is an ABMS specialty, refers to the 24 approved ABMS specialty boards. All other specialties currently represented on the RUC with permanent seats should be grandfathered on the RUC regardless of inclusion or exclusion on this list of 24 ABMS specialties.

After this criterion had been clearly defined, the Administrative Subcommittee discussed the suitability of this criterion. Several members felt that this criterion as defined is an antiquated view of the ABMS certification. Therefore, the Administrative Subcommittee recommended the following motion:

The first criterion for a permanent seat on the RUC, as currently state in the "Criteria for Participation" section of the RUC Structure and Functions document, "The specialty is an ABMS specialty," should be amended to read,

1.) The specialty or subspecialty has an approved general certificate or subspecialty certificate of an ABMS Member Board.

The RUC carefully reviewed this language and after lengthy discussion with input from the societies requesting RUC membership, voted on the subcommittee recommendation.

The motion failed.

The RUC passed a motion to record the vote on this subcommittee recommendation. The RUC did not approve this motion by a two-thirds vote. Twenty-six members voted, thirteen members voted in favor of the motion and thirteen members opposed the motion.

XVIII. Other Issues

Immunization Administration (PE only) (Tab H)
Richard Tuck, MD, American Academy of Pediatrics (AAP)

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) presented the direct practice expense input recommendations for consideration during the February 2005 RUC meeting. In an effort to ensure that the direct practice expense inputs for the immunization administration codes are also consistent with the Drug Administration inputs, AAP, AAFP, and AAP presented revised direct practice expense input recommendations for the RUC's consideration. The RUC agreed with these revised recommendations and will submit them to CMS when the recommendations from the February 2005 PERC recommendations are submitted in March.

Other Issues:

- A RUC member requested that AMA legal staff brief the RUC on the legal liability protection provided to RUC participants. Specifically it was requested that the RUC receive a briefing as well as a written description of the type of legal protection provided to RUC participants in the event of a lawsuit related to participation in the RUC process. Doctor Rich agreed to have AMA staff request that AMA legal staff provide a briefing during the April RUC meeting.

- Doctor Whitten then reminded RUC members that they are not to serve as both RUC members and RUC advisors. This is apparent in the Structure and Functions book, Advisory Committee section B(3) "Specialty Society representatives, to the extent practicable, shall not be the same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee."

- A RUC member requested that the AMA HOD Resolution regarding criteria for individuals who are members of the RUC and CPT Editorial Panel. AMA staff has responded to the HOD by including the following statement in all RUC nomination letters: "The AMA requests that you nominate an individual who is currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely-related activities."

The meeting adjourned on Saturday, October 2, 2004 at 12:00 p.m.

AMA/Specialty RVS Update Committee
Practice Expense Review Committee
February 1-2, 2005

Bill Moran, MD (Chair)	Gregory Kwasny, MD
James Anthony, MD	Peter McCreight, MD
Joel Brill, MD	Tye Ouzounian, MD
Neal Cohen, MD	James B. Regan, MD
Thomas A. Felger, MD	Anthony Senegore, MD

Call to Order
Doctor Moran called the group to order and explained to the members that the committee was under a tight timeframe to finish all of its work during the meeting. Doctor Moran also reminded the group that the PERC will refine all of the remaining unclaimed codes in tab V of the agenda book with or without specialty input from the specialty groups. Tab V of the agenda book contained codes that had no specialty society interest. AMA staff had contacted specialties for the refinement of the codes several times however no inputs are received for any one of the codes. At the conclusion of this meeting, the PEAC/PERC's refinement of existing codes was complete.

CMS Update Ken Simon, MD of CMS provided the following CMS update to the group:

- CMS continues its effort to implement many of the components of the MMA legislation.
- CMS will provide a list of codes they believe should be reviewed at the upcoming 5 year review. This list is expected to be sent to the AMA late in Februrary.
- Pay for performance initiatives are in the works at CMS for physicians that provide outstanding care to Medicare and Medicaid beneficiaries and link it to electronic medical records keeping. The idea is to provide incentives for high quality physician services. Currently, there are some demonstration projects underway, however many details still need to be finalized. Any national change in the payment methodology however, would need Congressional approval.

Specialty Society Requests and Specific Committee Recommendations

The committee discussed and made decisions on the following Specialty Society Special Requests:

1. The American Academy of Pediatrics and the Society of Thoracic Surgeons requested that code 33961 *(prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours)* be added to the PERC agenda with code 33960 *(prolonged extracorporeal circulation for cardiopulmonary insufficiency: initial 24 hours).* The PERC granted the society's request to add code 33961 to the agenda, and both codes were recommended to have no direct practice expense inputs per the specialty's request.

2. The American Academy of Neurology (AAN) requested the PERC add the family of Electroencephalography codes 95812 – 95822 to its agenda to update the direct practice expense inputs. The Centers for Medicare and Medicaid Services encouraged AAN to revisit the codes at this meeting. The PERC granted the society's request and made a revised direct practice expense recommendation for the family of codes.
3. The American Dietetic Association requested the PERC add three medical nutrition therapy (MNT) codes (97802, 97803, and 97804) to its agenda. The PERC reviewed the society's request, provided their recommendations to the society, and referred the issue to the RUC's HCPAC for resolution, because these codes had been previously reviewed by the HCPAC.
4. The American Academy of Pediatrics requested the PERC that code 92551 (*screening test, pure tone, air only)* be reviewed for direct practice expense inputs during this meeting. Code 92551 had not been through the RUC and had zero total relative value units assigned on the Medicare physician fee schedule. The PERC granted the specialty's request, and reviewed and refined the specialty recommendations.
5. The American Society of Gastrointestinal Endoscopy and the American Gastroenterological Association requested codes 89105-89141 be added to the PERC agenda in order to complete the family of codes that were on the agenda under the unclaimed code section. The PERC granted the society's request and reviewed and revised the entire family of codes together.
6. The Joint Council of Allergy, Asthma and Immunology provided direct practice expense inputs to the PERC for codes 95071 and 95075, however were unable to present. The PERC reviewed the Council's recommendations and modified them according to PERC standards and its understanding of the procedures.

Code Specific RUC Practice Expense Recommendation – February 2005
The PERC recommended no practice expense inputs for the following codes in either the non-facility or facility settings:

00104	32960	76975	86585
00124	33960	78182	90997
15852	33961	78350	93561
31730	76940	78351	93562

The PERC also made the recommendations regarding the unclaimed codes that were listed in Tab V of the agenda book:

- Codes 78160, 78162, 78170, 78172, 78182, 78350, 78351, and 78455 were recommended to be NA in the non-facility setting and zero inputs in the facility, and will be recommended for deletion by the Society of Nuclear Medicine and the American College of Radiology in February

2005. *(Staff note: Codes 78160, 78162, 78170, 78172, and 78455 were recommended for deletion in February 2005)*

- 38794 is a 90 day global and the standards would be applied
- The following codes are recommended to have zero inputs in the facility setting and NA in the non-facility setting: 15851, 90997, 93561, 93562, 95060, and 95065
- Codes 95078 will be recommended for deletion by the American Academy of Pediatrics
- Codes 99185 and 99186 will be recommended for deletion by the American Academy of Neurology

Codes Reviewed at the February 2005 PERC Meeting

CPT Code	*Descriptor*	*Specialty*
11975	Insert contraceptive cap	ACOG
11976	Removal of contraceptive cap	ACOG
11977	Removal/reinsert contra cap	ACOG
15342	Cultured skin graft, 25 cm	APMA, ASPS, ABA
15343	Culture skn graft addl 25 cm	APMA, ASPS, ABA
15775	Hair transplant punch grafts	ASPS
15776	Hair transplant punch grafts	ASPS
15851	Removal of sutures	PERC
15852	Dressing change not for burn	ACS
17250	Chemical cautery, tissue	AAD
17304	1 stage mohs, up to 5 spec	AADA
17305	2 stage mohs, up to 5 spec	AADA
17306	3 stage mohs, up to 5 spec	AADA
17307	Mohs addl stage up to 5 spec	AADA
17310	Mohs any stage > 5 spec each	AADA
17360	Skin peel therapy	AADA
19000	Drainage of breast lesion	ACS
19396	Design custom breast implant	ASPS
21300	Treatment of skull fracture	AANS/CNS
21310	Treatment of nose fracture	AAFP
31700	Insertion of airway catheter	ACCP
31730	Intro, windpipe wire/tube	ACCP
31730	Intro, windpipe wire/tube	ACCP
32960	Therapeutic pneumothorax	STS
33960	External circulation assist	AAP, STS
33961	External circulation assist	AAP/STS
36860	External cannula declotting	PERC
36860	External cannula declotting	PERC
38230	Bone marrow collection	ASH
38794	Access thoracic lymph duct	PERC
41250	Repair tongue laceration	AAO-HNS
41251	Repair tongue laceration	AAO-HNS, AAOMS
41252	Repair tongue laceration	AAO-HNS, AAOMS
42100	Biopsy roof of mouth	AAO-HNS
42104	Excision lesion, mouth roof	AAO-HNS, AAOMS
42106	Excision lesion, mouth roof	AAOMS

42107	Excision lesion, mouth roof	AAO-HNS, AAOMS
42160	Treatment mouth roof lesion	AAO-HNS
43750	Place gastrostomy tube	ACS, ACR, SIR
43760	Change gastrostomy tube	ASGE, AGA, ACR, SIR
47000	Needle biopsy of liver	ACR
48102	Needle biopsy, pancreas	ACR, SIR
48102	Needle biopsy, pancreas	ACR, SIR
49080	Puncture, peritoneal cavity	ACR, SIR
49081	Removal of abdominal fluid	ACR, SIR
49428	Ligation of shunt	ACS
51000	Drainage of bladder	AUA
51005	Drainage of bladder	AUA
54450	Preputial stretching	AUA
56420	Drainage of gland abscess	ACOG
57150	Treat vagina infection	ACOG
57170	Fitting of diaphragm/cap	ACOG
57180	Treat vaginal bleeding	ACOG
58300	Insert intrauterine device	ACOG
58323	Sperm washing	ACOG
59160	D & c after delivery	ACOG
59300	Episiotomy or vaginal repair	ACOG
60000	Drain thyroid/tongue cyst	ACS
60001	Aspirate/inject thyriod cyst	ACR, SIR
61888	Revise/remove neuroreceiver	AANS/CNS
62194	Replace/irrigate catheter	AANS/CNS
67221	Ocular photodynamic ther	AAO
67225	Eye photodynamic ther add-on	AAO
69300	Revise external ear	AAO-HNS
76120	Cine/video x-rays	ACR
76940	Us guide, tissue ablation	ACR, SIR
76942	Echo guide for biopsy	SIR
76975	GI endoscopic ultrasound	PERC
78160	Plasma iron turnover	PERC
78162	Radioiron absorption exam	PERC
78170	Red cell iron utilization	PERC
78172	Total body iron estimation	PERC
78282	GI protein loss exam	PERC
78350	Bone mineral, single photon	SNM
78351	Bone mineral, dual photon	PERC
78351	Bone mineral, dual photon	PERC
78455	Venous thrombosis study	PERC
79200	Intracavitary nuclear trmt	SNM
79300	Interstitial nuclear therapy	SNM
79440	Nuclear joint therapy	SNM
86585	TB tine test	AAP
88355	Analysis, skeletal muscle	CAP
88356	Analysis, nerve	CAP
89100	Sample intestinal contents	AGA, ASGE
89105	Sample intestinal contents	AGA, ASGE
89130	Sample stomach contents	PERC
89130	Sample stomach contents	PERC
89132	Sample stomach contents	PERC

89132	Sample stomach contents	PERC
89135	Sample stomach contents	PERC
89135	Sample stomach contents	PERC
89136	Sample stomach contents	PERC
89136	Sample stomach contents	PERC
89140	Sample stomach contents	PERC
89140	Sample stomach contents	PERC
89141	Sample stomach contents	PERC
89141	Sample stomach contents	PERC
90871	Electroconvulsive therapy	PERC
90880	Hypnotherapy	APA
90997	Hemoperfusion	PERC
92551	Pure tone hearing test, air	AAP
93561	Cardiac output measurement	PERC
93562	Cardiac output measurement	PERC
94014	Patient recorded spirometry	ACCP
94014	Patient recorded spirometry	ACCP
94015	Patient recorded spirometry	ACCP
94015	Patient recorded spirometry	ACCP
94016	Review patient spirometry	ACCP
94016	Review patient spirometry	ACCP
94200	Lung function test (MBC/MVV)	ACCP
94200	Lung function test (MBC/MVV)	ACCP
94250	Expired gas collection	ACCP
94250	Expired gas collection	ACCP
94350	Lung nitrogen washout curve	ACCP
94350	Lung nitrogen washout curve	ACCP
94370	Breath airway closing volume	ACCP
94370	Breath airway closing volume	ACCP
94400	CO2 breathing response curve	ACCP
94400	CO2 breathing response curve	ACCP
94620	Pulmonary stress test/simple	ACCP
94620	Pulmonary stress test/simple	ACCP
94660	Pos airway pressure, CPAP	ACCP
94660	Pos airway pressure, CPAP	ACCP
94667	Chest wall manipulation	ACCP
94667	Chest wall manipulation	ACCP
94668	Chest wall manipulation	ACCP
94668	Chest wall manipulation	ACCP
94680	Exhaled air analysis, o2	ACCP
94680	Exhaled air analysis, o2	ACCP
94681	Exhaled air analysis, o2/co2	ACCP
94681	Exhaled air analysis, o2/co2	ACCP
94690	Exhaled air analysis	ACCP
94690	Exhaled air analysis	ACCP
94725	Membrane diffusion capacity	ACCP
94725	Membrane diffusion capacity	ACCP
94750	Pulmonary compliance study	ACCP
94750	Pulmonary compliance study	ACCP
95060	Eye allergy tests	PERC
95065	Nose allergy test	PERC
95071	Bronchial allergy tests	JCAAI

95075	Ingestion challenge test	JCAAI
95078	Provocative testing	PERC
95805	Multiple sleep latency test	ACNS, AASM, AAN
95812	Eeg, 41-60 minutes	AAN
95813	Eeg, over 1 hour	AAN
95816	Eeg, awake and drowsy	AAN
95819	Eeg, awake and asleep	AAN
95822	Eeg, coma or sleep only	AAN
95950	Ambulatory eeg monitoring	ACNS, AAN
95950	Ambulatory eeg monitoring	ACNS, AAN
95954	EEG monitoring/giving drugs	ACNS, AAN
95954	EEG monitoring/giving drugs	ACNS, AAN
95956	Eeg monitoring, cable/radio	ACNS, AAN
95956	Eeg monitoring, cable/radio	ACNS, AAN
99185	Regional hypothermia	PERC
99186	Total body hypothermia	PERC

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
February 3, 2005

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Dale Blasier, MD
Jonathan Cooperman, PT
Robert Fifer, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
Marc Lenet, DPM
Antonio Puente, PhD
Christopher Quinn, OD
Doris Tomer, LCSW
Arthur Traugott, MD
Jane White, PhD, RD, FADA

I. Administrative Issues

Mary Foto, OTR, welcomed the American Occupational Therapy Association's (AOTA) new HCPAC alternate Terry A. Moon, OTR/L and announced the American Nurses Association's (ANA) new HCPAC member Katherine Bradley, PhD, RN.

II. CMS Update

Pam West, MPH, PT, provided a CMS update and informed the HCPAC that there is the new HHS Secretary, Michael Leavitt, former Administrator of the EPA and former Utah Governor. Mr. Leavitt will continue to follow current HHS program initiatives. CMS also indicated that they have received comments from specific societies regarding the November 2005 Final Rule concerning future Five-Year Review refinement.

III. HCPAC MPC

The HCPAC reviewed the revised HCPAC MPC list. The HCPAC identified that the list of societies most frequently performing the procedures listed in the HCPAC MPC list are calculated by CMS based on Medicare frequency data and may not necessarily capture all the top specialties actually performing these services. The HCPAC will submit the approved HCPAC MPC list to CMS.

IV. Psychological Testing Update

Antonio Puente, PhD, and James Georgoulakis, PhD, of the American Psychological Association (APA), informed the HCPAC that they will be seeking the Research Subcommittee's input and approval of the proposed education information, survey edits and reference service list for the neurobehavioral status exam and psychological testing codes. These codes were presented and approved at the November 2004 CPT meeting and the work and practice expense will be presented to the HCPAC at its meeting in April 2005.

V. Work as Part of the Reimbursement Formula

Robert Fifer, PhD, of the Speech-Language-Hearing Association (ASHA), informed the HCPAC that ASHA has submitted codes to CMS to be reviewed in the upcoming Five-

Year Review. ASHA is requesting that the services performed by speech-language pathologists and audiologists be assigned a physician work value similar to the physical and occupational therapists. ASHA contends audiologists and speech-language pathologists independently provide the clinical service and interpret the tests performed. Currently, their efforts are captured in the practice expense component of the RBRVS. However, these services describe their work rather than any staff that they do not employ. CMS indicated that if a society believes that specific codes should now contain physician work and they have pursued this request as part of the Five-Year Review process. CMS is considering this request and will forward this request to the RUC if the agency decides that this work effort should be captured under the work component versus the practice expense component. A RUC member and advisor voiced opposition regarding audiologist's interpretations versus a physician's interpretation of test results.

VI. Other Issues

Jane White, PhD, RD, FADA, of the American Dietetic Association (ADA), updated the HCPAC on issues surrounding the medical nutrition therapy codes due to a change in the services provided. ADA is currently trying to discern the best method to address these issues, which could potentially include (1) modifying existing codes to adequately reflect the services performed and (2) determining the benefits of their payment remaining in the non-physician work pool, changing their payment to traditional practice expense inputs or changing their payment to include physician work.

The HCPAC heard discussions from various allied health professionals pertaining to changing their payment methodology, including requests made by ASHA and the issues surrounding the medical nutrition therapy codes. The HCPAC has decided to further study this issue and determine possible solutions.

The RUC HCPAC reviewed the psychotherapy codes which were approved by the PERC. The practice expense for codes 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient* and 90808 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient* will be cross-walked to 90880 *Hypnotherapy*.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report – February 3, 2005

The Practice Expense Subcommittee met during the February 2005 RUC meeting to discuss the future refinement of practice expense inputs, RUC member evaluation of practice expense inputs, and recent GAO and MedPAC reports. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Siegel, Strate, and Weirsema.

Future Refinement of Practice Expense Inputs

Doctor Zwolak began the committee's discussion by identifying specific areas of concern regarding the future refinement of practice expense inputs:

- Possibility of reviewing the direct inputs of specific codes reviewed early on in the Practice Expense Advisory Committee (PEAC) review process.
- The possibility of another Socioeconomic Monitoring Systems (SMS) survey in the near future.
- Possible revisions in the CMS' practice expense RVU methodology.

Doctor Zwolak first commended the efforts of Doctor Moran and the PEAC members in providing such an accurate set of direct practice expense data, however he noted that there may be more work to be done. Doctor Moran expressed three areas where the data/methodology could be further refined.

1. Most PEAC members would readily say that codes refined early in the process (1999-early 2001), were not evaluated at the same level as other codes reviewed later in the process. The PEAC evolved over time and used a more sophisticated evaluating process, using standards for certain clinical labor activities and supplies.
2. Over time there can be a significant change in the costs incurred for disposable medical supplies, and it is important to keep up to date prices of those supplies as well as having an understanding that there could be lower priced substitutes.
3. There could be a shift of practice patterns from one site of service to another, and there is no current mechanism going forward, other than the Practice Expense Review Committee (PERC) process.

Some members of the subcommittee believed that there is a need to go back to early PEAC recommendations and bring all of the recommendations back for review. Others subcommittee members believed that it should be up to the specialty as to what codes should be re-reviewed. Regardless of the methodology used, the value of revisiting the direct inputs of the codes would be to improve the accuracy of the data. If this type of review were initiated, some subcommittee members believed that a larger committee with more specialty diversity (more than the current PERC), would be necessary to achieve more checks and balances in the refinement process.

One option mentioned, in an effort to improve the data, was to apply the standard clinical labor times to these earlier refined codes. There was some support for this option. CMS

representatives believed that there wouldn't be a large number of codes that would need further review because the PEAC and PERC process has already re-reviewed several codes. The goals that CMS sees in any future practice expense review are to assure themselves of having the most accurate set of direct practice expense inputs and to provide stability in the practice expense relative values. CMS does not now foresee a need for an extensive re-review of all of the direct inputs in the near future, since the PEAC and PERC review processes have just concluded. CMS also mentioned that they may be looking into hiring a contractor to review all of the early practice expense recommendations to identify codes where the standards were not applied. The subcommittee had mixed enthusiasm in looking back at the PE inputs and agreed that a decision by the RUC should be postponed until there is clearer understanding of what CMS' review processes may involve.

The subcommittee members also reiterated that the accuracy of SMS data and the scaling factors may have a significant impact on the practice expense relative values and should be updated. CMS representatives reported that they will continue consider a survey of MD and Non-MDs, which may cost at least $1.5 million. It is expected that the Lewin Group will offer suggestions on how to proceed with gathering this new data in a report to be published in March 2005. In addition, CMS is continuing its efforts to transition all specialties out of the non-physician work pool.

The subcommittee also discussed the need for CMS to obtain accurate market data on its medical supply list, since high priced disposable medical supplies within a codes' direct practice expense can cause redistribution in practice expense pools and relative values when the scaling factors are applied. It was commented that the current CMS medical supply list prices may already be outdated even though it was recently updated. It is also understood that updating the medical supply list is a large task.

There was much discussion whether it would be appropriate to separate out the high priced disposable items from the direct practice expense inputs. CMS mentioned that there is a mechanism for this type of separation on the inpatient side and there are specific guidelines and dollar thresholds that apply. CMS also stated that one of the purposes of the resourced based methodology was to include all the items used in the service, but it was noted by a subcommittee member that the costs of drugs have been separated. The subcommittee members and the RUC agreed that some mechanism should be in place to separate out high priced disposables medical supplies, from the practice expense methodology so that the inequities of the scaling factors do not cause as many anomalies in the practice expense specialty pools and in practice expense relative values: The RUC recommends:

CMS be requested to set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

Members of the subcommittee believed that an initial reasonable threshold could be $250.00.

RUC Member Evaluation of Practice Expense Inputs

Doctor Moran presented a slide show for RUC members entitled: "How to Evaluate a Practice Expense Recommendation, Tips for RUC Members". Doctor Moran's presentation was very well received by the group, and PowerPoint slides are available to all by contacting AMA staff.

GAO and MedPAC Reports

The subcommittee briefly discussed the reports in their relevance to future practice expense direct input review, but made no recommendations

AMA/Specialty Society RVS Update Committee
Five-Year Review Workgroup
February 3, 2005

The Five-Year Review Workgroup met on Thursday, February 3, 2004 to discuss the scope of the Five-Year Review of the RBRVS, procedural and practice expense related issues. The following Workgroup members participated: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Scope of the Five-Year Review

The Workgroup was informed that CMS has received comments to review approximately 400 potentially mis-valued CPT codes. These comments were submitted by specialty societies and a few individuals. CMS is also in the process of creating a list of codes that the agency will also include in the Five-Year Review process. It is predicted that the total volume of codes to be reviewed in this Five-Year Review will be less than or within the range of the volume of codes reviewed individually in both the 1995 Five-Year Review (1,000) and the 2000 Five-Year Review (870). Therefore, the Workgroup anticipates that a similar number of workgroups (eight) will be created to accommodate the process. The Five-Year Review Workgroups will be announced in April and will each have the opportunity to have an initial planning meeting at the April 2005 RUC meeting.

Procedural Issues

The Workgroup understands that CPT codes are likely to be included in the Five-Year Review that were not submitted by the specialties. A question arose regarding what action the RUC would take if a specialty chose to not express an interest in participating in reviewing a service identified by CMS. Although, several members noted that it is unlikely that a specialty would choose this course of action, it was recognized that the current action keys do not include an appropriate RUC action for such a scenario. **The Workgroup recommends that an eighth action key be added as follows:**

8 = No Level of Interest submitted, no RUC recommendation submitted.

The Workgroup clarified that each code identified in the Five-Year will be assigned to one of the eight workgroups. The Five-Year Review Workgroups will consider each comment and data and will recommend the action for RUC consideration.

General anxiety was expressed regarding the identification of potentially mis-valued codes, including comments that efficiency in procedure time since the initial Harvard should not be penalized. Another Workgroup member proposed that surveys should not be required to conduct surveys for these codes, and specialties should instead be allowed to use expert panels. The Workgroup suggested that specialties request consideration of

such a methodology by the Research Subcommittee, if they feel it is necessary after reviewing the codes submitted for review.

Practice Expense Issues

The RUC proposal on the Five-Year Review and the CMS discussion in the November 15 *Final Rule* both indicate that the this third Five-Year Review should be based on potential mis-valuation of physician work. This decision was made after consideration that all CPT codes have recently been reviewed under the PEAC process. However, modification to the number and level of post-operative office visits and modifications to physician intra-service time for services performed in the office will result in changes to the clinical staff time. AMA staff will be supplying specialty societies with current information on the ratio of intra-service clinical staff to physician time and office visit information to all specialty societies involved in the Five-Year Review process. **The Five-Year Review Workgroup proposes that a short addendum be included in the Specialty Summary of Recommendation form to capture these changes to allow for easy CMS application of these modifications.**

One Workgroup member expressed concern that all of practice expense inputs should be open for refinement for each code in the Five-Year Review as changes in the service may apply to both practice expense and physician work.

AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
February 3, 2005

The following members of the Professional Liability Insurance (PLI) Workgroup met on February 3, 2005 to discuss numerous issues related to the CMS methodology to compute PLI relative values. Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith. Steve Phillips, Rick Ensor from the Centers for Medicare and Medicaid Services (CMS) and Doctor Stephen Kamenetzky participated in the meeting via conference call.

Professional Liability Insurance Premium Data

Doctor Stephen Kamenetzky provided an update to the PLI Workgroup on his efforts to secure PLI premium data from the Physician Insurer Association of America (PIAA) for use in CMS' PLI relative value methodology. He indicated that CMS has requested a pilot study of data related to six states: Iowa, Colorado, New York, Florida, Pennsylvania, and Texas. Doctor Kamenetzky believes that PIAA will be able to supply premium data for all physician specialties. PIAA has expressed an interest in cooperating on this project. PIAA has requested that confidentiality be ensured and that the AMA request PIAA cooperation in writing. Doctor Kamenetzky stated that PIAA may have a more complete dataset for the 93 Medicare specialties as well as tail coverage data, which CMS has acknowledged should be considered, but the data is not provided in their survey.

CMS staff participating in the meeting indicate that they would review the data related to the six states and would determine if such data could be utilized as a substitute for data currently utilized. If the data is helpful, CMS will request that the data be expanded to include all states. It was clarified that the earliest potential implementation of any such data would be in 2007. Therefore, CMS asked that PIAA submit 2004 and 2005 premium data as they are interested in using the most current data.

The PLI Workgroup recommends that the RUC send a letter to PIAA requesting their provision of PLI premium data to CMS. The letter should state that PIAA should only send the data if CMS will ensure confidentiality.

Review of Current Crosswalks and Risk Factor Assignments

CMS assigned PLI risk factors using PLI premium data for a specialty/non-surgical premium data for nephrology of $9,289 as an anchor with a 1.51 risk factor. CMS utilized various sources of premium data, including: 1) surveyed national premium data; 2) rating manuals from five insurers; 3) a combination of surveyed premium data and rating manuals; 4) crosswalk to another specialty; or 5) no risk factor was assigned for 34 specialties. The use of rating manuals alone was observed to possibly be associated with anomalous risk factor assignment. Mr. Ensor stated that the methodology utilizing

weight-averaging by relative value and location was the same for the rating manual and actual premium methods.

CMS indicated in the November 15 *Final Rule* they were interested in any RUC input on the appropriateness of the crosswalk assumptions. **The PLI Workgroup reviewed comments submitted by specialty societies and a summary table prepared by AMA staff and recommends the following modifications to the risk factor assignments:**

- **As the PLI Workgroup understands that the following professions would not incur PLI premium rates greater than $6,152 per year, it appears appropriate to assign the current lowest risk factor of 1.00 for both non-surgical and surgical codes. This recommendation is considered an interim step. The PLI Workgroup believes that the PLI premium rates for the following may be substantially less than $6,152 and requests that CMS collect premium data for these professions.**

Clinical Psychologist
Licensed Clinical Social Worker
Occupational Therapist
Psychologist
Optician
Optometry
Chiropractic
Physical Therapist

- **The PLI Workgroup expresses concern about a number of specialties/professions that were assigned to an average "all physician" risk factor (3.04 non-surgical / 3.71 surgical). The Workgroup recommends that the following groups should have been treated as the other 34 Medicare specialties that were excluded from the analysis:**

Certified Clinical Nurse Specialist
Clinical Laboratory
Multi-Specialty Clinic or Group Practice
Nurse Practitioner
Physician Assistant
Physiological Laboratory (Independent)

- **The PLI Workgroup recommends that CRNAs should be crosswalked to Anesthesiology (2.84), rather than to the "all physicians" category.**

- **The PLI Workgroup also noted that the rank order premium data appeared problematic for colorectal surgery and gynecologist/oncologist and recommends that these two specialties be crosswalked as follows:**

  Gynecologist/oncologist (current 5.63) should be crosswalked to surgical oncology (6.13 – based on crosswalk to general surgery).

  Colorectal surgery (4.08) should be crosswalked to general surgery (6.13).

- **The RUC recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

The PLI Workgroup recommends that the RUC HCPAC review and discuss the above recommendations. The Workgroup would also be willing to review any data provided by a professional group to refute the understanding that the annual PLI premium data is less than $6,100.

ACC Request for Reconsideration of Previous Action

The American College of Cardiology (ACC) has requested that the RUC correct a clerical mistake created when the PLI Workgroup updated exceptions to the surgical risk factor assignment. **The PLI Workgroup agrees that it appears that a clerical mistake was made as the society never intended that these services be removed from the exception list. The PLI Workgroup recommends that CMS add back the following codes to the surgical risk factor list for cardiac catheterization (2.53):**

92980-92984
92985-92998
93617-93641

The PLI Workgroup also recommends that 92975 be added to the cardiac catheterization (surgical risk factor) list based on their own review of the cardiology codes.

The PLI Workgroup did not agree to add CPT code 93556 to this list as it is an imaging supervision and interpretation service.

Dominant Specialty Approach/Review of Aberrant Data Patters in Low Utilization Services

In the November 15, 2004 *Final Rule* for the 2005 Medicare Physician Payment Schedule, CMS implemented the RUC recommendation to remove the assistant at surgery claims from the utilization data. In addition, CMS agreed to work with the RUC

to review aberrant data patterns in CPT codes with low utilization. However, CMS has stated that they do not plan to implement the dominant specialty approach at this time.

The PLI Workgroup discussed the dominant specialty approach and **recommends reaffirmation of the RUC recommendation that CMS utilize the dominant specialty in determining which specialty risk factor to apply to each CPT code.** The Workgroup noted that it was flexible regarding the percentage threshold in determining the definition of dominant specialty. CMS staff indicated an interest in discussing this issue via conference call with interested members of the PLI Workgroup. AMA staff will arrange this call in the near future. In addition, CMS indicated that it was performing an analysis of removing specialties from the utilization data if the specialty performs a small percentage of the service (eg, less than 5% of total utilization). CMS will share this analysis with the PLI Workgroup.

The PLI Workgroup also recommends that the RUC engage in a review of aberrant data in low utilization services. AMA staff will list all CPT codes with Medicare utilization data of less than 100 claims. This list will include the current utilization by specialty and then an "expected specialty" indication based on staff review of placement in CPT, who reviewed at RUC/PEAC, etc. This list will be forwarded to all RUC Advisors for review and comment prior to the April 2005 RUC meeting.

<u>Other Issues – AMA House of Delegates recent actions</u>

The consideration of removing PLI from the RBRVS system was revisited. Several Workgroup members commented that premiums are not based on the type and volume of procedures performed by the physician but rather the specialty of that physician. A resolution to the AMA House of Delegates as submitted by AANS-CNS requesting the AMA to study alternative methods to the current reimbursement of PLI in the RBRVS system. The resolution was referred to the AMA Board of Trustees for a report back to the AMA House of Delegates at the June 2005 Annual meeting. AMA RUC staff are responsible for preparation of this report. RUC members may contact Ms. Sherry Smith by March 1 if they have any information on this report.

AMA/Specialty Society RVS Update Committee
Research Subcommittee
February, 2005

Doctors Borgstede (chair), Blankenship, Cohen, Gage, Gerety, Levy, Lichtenfeld, Pfeifer, Plummer, Topping, and Tuck participated in the meeting.

Alternative Methodologies for the Five-Year Review
The Society of Thoracic Surgeons and the American Society of General Surgery presented proposed methodologies for the Research Subcommittee review for use in the upcoming five-year review.

STS presented a proposal for using a new methodology that would use the STS National adult Cardiac Database for the purpose of data acquisition and analysis. This database contains data for 2.8 million patients from 1989-2003 and includes intra-service time, length of ICU stay, and length of stay. The presenters contend that using these data and expert panels rather than the RUC survey would provide more accurate physician work relative value recommendations. Doctor Peter Smith explained in detail the database and the data validation that occurs nationally, regionally, and at the data entry point. STS plans on using 2004 data but also supplement with additional years if the volume is not sufficient on a code by code basis It is important to use the most recent data since these data include skin to skin operative time, which is a critical component of the building block methodology. STS proposed the following methodology using the STS database and expert panels and Rasch analysis:

1. Utilize mean STS database intra-operative time for skin-to-skin time.
2. Utilize an expert panel to develop a consistent pre-service time and post-discharge office visit profile for each code within the range of RUC database data.
3. Utilize STS database LOS and ICU data as a template for an expert panel to determine a consistent E&M profile of postoperative hospital visits for each code.
4. Utilize Rasch paired analysis to assist the expert panel in developing relative postoperative E/M work.
5. Utilize an expert panel to determine an IWPUT for each code, by either Rasch paired comparison or a modified Delphi technique, within the range of RUC database data.
6. Utilize STS database information to determine the number of additional postoperative E&M visits for add-on codes, assigning visit levels to match the E&M profile for each primary procedure code.
7. Apply the building block methodology to the data collected as described above to calculate total physician work for each code.

The Research Subcommittee members discussed the STS proposal in detail and complimented Doctor Peter Smith on his comprehensive presentation. Some members thought that the STS data would be highly accurate and possibly more accurate than the RUC survey. Others were concerned that more information on the composition of the expert panels and the Rasch analysis would be needed before making a final decision on

the appropriateness of the methodology. Also it was suggested that any potential data bias would need to be explained such as under reporting of intra-service time. The subcommittee discussion focused on the STS proposal to use the mean rather than the median, which has been the standard used by the RUC. STS presenters stated that since actual surgery time data are being used, and there is a high volume of data, a mean is more appropriate as is captures the entire range of physician work. STS also stated that the mean was more appropriate since the data show a non normal distribution of intra-service times and length of stay. The median values are used for time estimates collected by the RUC survey because generally there is a low number of responses with a wide range of values. Using a median value in these instances provides a more accurate representation of the typical physician work. It was also suggested that in addition to the mean, standard deviations should be provided.

A motion to accept the proposed methodology was not accepted. The subcommittee requested that STS provide additional information relating to:

- IWPUT calculations
- Detailed rationale of using mean as opposed to median
- Detailed explanation of Rasch paired analysis to assist the expert panel in developing relative postoperative E/M work.
- Implications of eliminating outliers from analysis, such as removing the top 10% of times and the bottom of 10%.
- The committee requested that STS demonstrate that the data is not biased such as most of the data coming from academic centers.

The Research Subcommittee will hold a conference call prior to the April RUC meeting, to review the additional material prepared with by STS. It was suggested that after this additional information is provided to the subcommittee, the subcommittee should develop a recommendation to either approve or reject the proposed methodology.

American Society of General Surgeons
The ASGS presented a proposal for a new survey methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work. The responders will be given intra-service time and a calculated IWPUT. Several subcommittee members were concerned that this was providing too much information and recommended that the intra-service time and IWPUT be collected rather than provided. The intent of the ASGS is to change the survey so that it is more physician friendly in an attempt to increase response rate and RVU estimates. The ASGS will select approximately 50 high volume codes that have been submitted by ACS, STS, and possibly SVS. ACS would use the traditional RUC survey and ASGS would use this methodology as a experiment to check the values for the high volume codes. The subcommittee was concerned that if the two methodologies produce two different relative value recommendations, the two numbers will need to be reconciled. The subcommittee agreed that it will be the responsibility of the presenting specialties to develop a single recommendation through a consensus panel, but the RUC should be presented data developed from both methodologies**. The subcommittee recommends approving the**

methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work but the survey should not contain intra-service times and IWPUT calculations.

Previously Approved Alternative Methodologies for the Five-Year Review
During the September, 2004 RUC meeting, the RUC agreed that if the RUC has previously approved an alternative methodology for a prior five-year review, then specialties should not have to come back to the subcommittee to request approval again. So that all specialties will know which methodologies have been approved, the Research Subcommittee was asked to list all previously approved methodologies and determine if additional explanation and/or examples are needed. The Subcommittee agreed to again distribute the document to specialty societies for informational purposes.

Changes to the RUC Survey for the Five-Year Review
In prior five-year reviews the RUC added a question to the RUC survey to assist RUC members in evaluating how physician work has changed over the previous five years. The results were reported in the RUC Summary of recommendation form. The following question was added at the end of the survey during the last five-year review and the Research Subcommittee agreed to include the following question to the RUC survey for use in the upcoming five-year review.

> **Additional Question: The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.**
>
> **Has the work of performing this service changed in the past 5 years?** Yes No
>
> **If Yes, please circle the your response to questions a-c:**
>
> **d. This service represents new technology that has become more familiar (i.e., less work).** I agree I do not agree
>
> **e. Patients requiring this service are now:**
> more complex (more work) less complex (less work) no change
>
> **f. The usual site-of-service has changed:**
>
> from outpatient to inpatient from inpatient to outpatient no change

Guidelines for Reference Service Lists
At the September, 2004 RUC meeting the Research Subcommittee and the RUC approved a list of guidelines for developing reference service lists. The Subcommittee asked that the list be distributed to specialties as an opportunity for specialties to comment. The guidelines were distributed and no comments were received, therefore, the subcommittee reaffirmed its prior approval of the following guidelines to be added to the RUC survey instructions document.

Existing Guidelines:

- **Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.**
- **Services on the list should be those which are well understood and commonly provided by physicians in the specialty.**
- **Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)**

New Guidelines

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**
- **Include several high volume codes typically performed by the specialty.**

Psychological and Neuropsychological Testing Presentation

The American Psychological Association requested that the Research Subcommittee review proposed changes to the RUC survey for the psychological and neuropsychological testing codes. The changes include changing references to "physician" to "professional" and including generic pre, intra, and post service time period definitions. **The subcommittee recommends approving the changes to the APA survey.**

Ultrasound

The Research Subcommittee has been assigned the task of examining the family of ultrasound codes to determine if there rank order anomalies exist among the codes. A number of issues were raised such as the variability in ultrasound codes according to whether the procedure is a stand alone code, an add-on code or incorporated into another code. The subcommittee reviewed the list of codes and the calculated IWPUT for each of the codes. The subcommittee felt that to begin comparing the codes only the ultrasound portion of the code should be identified and a RVU and IWPUT be calculated. AMA staff in association with the Research Subcommittee will develop these calculations for subcommittee review. The subcommittee will attempt to use these calculations as a first step in identifying potential anomies.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 3, 2005

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

CPT/RUC Meeting Date Discussion
AMA Staff announced that at the April/May 2004 CPT Editorial Panel meeting, the Panel Members approved a motion changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. The Administrative Subcommittee was informed by AMA staff that CPT has finalized its annual calendar. The Administrative Subcommittee reviewed the timeline between all CPT and RUC Meetings and determined that there was sufficient time for specialty societies to develop RUC recommendations. **The Administrative Subcommittee recommends approval of all RUC meeting dates for the 2007 CPT RUC cycle**.

Re-review of RUC Recommendations – New Technology
At the April 2004 RUC Meeting, a RUC member indicated that there is no formal process to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. This issue was referred to the Administrative Subcommittee for discussion. **After careful consideration of this issue, the Administrative Subcommittee determined that these codes should be identified, and approved the following process for formalized review:**

> **The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.**

Release of RUC Database to Specialty Society Representatives for Functions Not Pertaining to the RUC Process
At the September RUC meeting the Administrative Subcommittee recommended to the RUC that the RUC Database be released to the Specialty Societies for use outside of the

CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims). The RUC extracted this item and tabled its discussion pending review by the AMA legal department.

AMA Staff met with Andrea Cooper-Finkle, JD, Senior Division Counsel for the AMA to obtain a legal review of this issue. Ms. Cooper-Finkle delivered a presentation to the Administrative Subcommittee to describe the findings of the AMA. Ms. Cooper-Finkle began by describing some history pertaining to this request. She stated that a request to release the RUC database to the public was first made several years ago. The AMA Legal Counsel at that time sought an opinion from the Justice Department which was referred to the Federal Trade Commission (FTC) opinion for legal review of this issue. The FTC in its opinion stated that releasing the RUC database to the public would not violate anti-trust laws and could also potentially have pro-competitive benefits. However, the response also may be interpreted that limiting distribution of the RUC database to selective recipients for use outside the CPT/RUC process may violate anti-trust laws. Therefore it is the opinion of the AMA Legal Counsel that the RUC database not be distributed to specialty society representatives for functions not pertaining to the RUC process as it may lead to a violation of the anti-trust laws.

After much discussion pertaining to the legal issues surrounding the release of the database, the Administrative Subcommittee approved the following motion:

The RUC database will not be distributed to the specialty society representatives for functions not pertaining to the RUC process.

The Administrative Subcommittee then discussed releasing the RUC database to the public. The members of the Administrative Subcommittee discussed the FTC's opinion that the release of the database could potentially have pro-competitive benefits. The Administrative Subcommittee understands the FTC's opinion and agrees that both providers and payors should have equal access to this information. Other issues discussed by the Administrative Subcommittee included: 1.) the logistical distribution of the RUC database, 2.) the creation of new licenses to use the RUC database and 3.) the creation of new potential AMA products that would be affordable to individual proprietors to avoid an asymmetrical distribution of this data. The Administrative Subcommittee approved the following motion:

AMA staff will explore options for the public release of the RUC database with input from AMA Senior Management and AMA Legal Counsel with the objective of a symmetrical distribution amongst all potential recipients.

Clarification of RUC Membership Criterion

In April 2004, The RUC received a request from the American College of Physicians (ACP), to provide clarification regarding the first criterion for a permanent seat on the RUC, as stated in the "Criteria for Participation" section of the RUC Structure and

Functions document. The Criteria for Participation as approved at the April 2002 RUC Meeting reads as follows:

6.) The specialty is an ABMS Specialty
7.) The specialty comprises 1 percent of physicians in practice
8.) The specialty comprises 1 percent of physician Medicare expenditures
9.) Medicare revenue is at least 10 percent of mean practice revenue for the specialty
10.) The specialty us not meaningfully represented by an umbrella organization, as determined by the RUC

In September 2004, this issue was discussed by the Administrative Subcommittee and Doctor Leahy of the ACP gave a brief presentation regarding this request and clarified that not only was his society seeking clarification but also was requesting that this criterion be assessed to determine its suitability as a criterion for a permanent seat on the RUC. The Administrative Subcommittee decided that the further assessment of the first criterion for RUC membership, related to ABMS specialties, was needed.

Since September 2004, AMA staff has received 6 additional letters:

1.) A joint letter from the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), the American Society for Hematology (ASH) and the American Society for Clinical Endocinology (ASCO) requesting three permanent seats on the RUC for pulmonary medicine, gastroenterology and hematology-oncology.
2.) A letter from the American Board of Internal Medicine supporting the original ACP recommendation that general certificates and sub-specialty certificates that are approved by the American Board of Medical Specialties meet the first criterion for a permanent seat on the RUC, the specialty is an ABMS specialty
3.) A letter from ACP supporting the organizations representing the internal medicine subspecialties of gastroenterology, pulmonary medicine and hematology/oncology in their request for each subspecialty to receive a permanent seat on the RUC
4.) A letter form ASH and ASCO requesting a permanent seat on the RUC for hematology/oncology
5.) A letter from ACCP and ATS requesting a permanent seat on the RUC for pulmonary medicine and
6.) A letter from ACG, AGA and ASGE requesting a permanent seat on the RUC for gastroenterology

The Administrative Subcommittee, after much discussion amongst its members and members of the aforementioned societies, determined that before the requests made by the specialties could be assessed, the charge of the Subcommittee must be addressed, namely the clarification of the term ABMS specialty. The Administrative Subcommittee determined after reviewing documents from June 1991 pertaining to the proposed

composition of the RUC that this criterion upon its creation refers to the 24 approved ABMS specialty boards. Therefore the Administrative Subcommittee approved the following motion:

The first criterion for a permanent seat on the RUC, as currently stated in the "Criteria for Participation" section of the RUC Structure and Functions document, the specialty is an ABMS specialty, refers to the 24 approved ABMS specialty boards. All other specialties currently represented on the RUC with permanent seats should be grandfathered on the RUC regardless of inclusion or exclusion on this list of 24 ABMS specialties.

After this criterion had been clearly defined, the Administrative Subcommittee discussed the suitability of this criterion. Several members felt that this criterion as defined is an antiquated view of the ABMS certification. Therefore, the Administrative Subcommittee approved the following motion:

The first criterion for a permanent seat on the RUC, as currently state in the "Criteria for Participation" section of the RUC Structure and Functions document, "The specialty is an ABMS specialty," should be amended to read,

1.) The specialty or subspecialty has an approved general certificate or subspecialty certificate of an ABMS Member Board.

(The RUC passed a motion to record the vote on this subcommittee recommendation. The RUC did not approve this motion by a two-thirds vote. Twenty-six members voted, thirteen members voted in favor of the motion and thirteen members opposed the motion.)

WASHINGTON UPDATE

Lee J. Stillwell
February 2005

Full Court Press for Federal Medical Liability Reform

- Top priority for President Bush, House and Senate GOP leadership
- West Wing meeting w/senior White House staff in mid-December
- Action Plan unveiled at AMA State Legislation Meeting

Together we are **stronger.**

MLR Action Plan

- AMA all Congress mailing re: Town Hall meetings. Week of February 21 (President's Day recess)
- Conference calls with state and national medical specialty societies on organizing Town Hall meetings
- New websites to collect physician and patient stories:

  -- physicians: www.liabilitycrisis.com

  -- patients: www.patientsactionnetwork.com

Together we are **stronger.**

AMA/Specialty Society MLR Work Group

- Modeled after successful SGR Work Group
- Lobbyists from ACS, ACOG, AANS/CNS, AAOS, ACEP, AATS/STS, CAP, AOA, AAFP, ACR, ASA, ASGS, AUA, ACC
- Coordinate lobbying strategy and tactics

Together we are **stronger.**

Public Opinion Research

- Focus groups in Chicago, Phoenix, and Des Moines
- National poll conducted January 19-20
- 73% of voters support caps
- Cost and access most effective messages
- Dial groups to further refine messages

Together we are stronger.

House of Representatives

- House has passed MICRA-style bill with $250,000 cap 9 times in last decade
- We have more than 218 votes to pass it again this year
- Awaiting word on who will be the bill manager and timing for a vote

Together we are stronger.

Senate

- Cloture is first hurdle—need 7-9 Democratic votes to get to 60
- After cloture, need 51 to block poison pills
- Key Democratic prospects: Carper (DE), Lincoln (Ark), Lieberman (CT), Cantwell (WA), Baucus (MT), Kohl (WI), Nelson (NE), Bingaman (NM), Dayton (MN), Johnson (SD), Jeffords (VT), Feinstein (CA), Conrad (ND) and Salazar (CO)

Together we are **stronger.**

Formula for 60 Senate Votes?

- Need to explore with Democratic prospects
- Pass best possible bill
- Critical negotiations in Conference Committee

Together we are **stronger.**

Conference Committee Report

- Reconcile differences between House and Senate bills
- Need 60 votes in Senate for motion to proceed
- Only 51 votes to pass
- No amendments

Together we are stronger.

AMA Principles

- Protect strong state laws (do no harm)
- Final product must achieve goal of stabilizing/ultimately reducing premiums

Together we are stronger.

Concurrent Action on Two Critical Priorities ---

Medical Liability Reform (MLR) and Sustainable Growth Rate (SGR)

- Performance on the former may affect the latter
- Patient Action Network key to both issues
- Dual campaigns will be challenge from grassroots and media perspectives

Together we are **stronger.**

The Un-Sustainable Growth Rate

- Medicare MD payment cuts of 31% from 2006 through 2013
- Contrast with 19% increase in overhead
- First cut of 5% effective January 1, 2006
- 331 calendar days to stave off cuts

Together we are **stronger.**

SGR: A Short History

- 1997 Balanced Budget Act
- Positive updates until 2002
- Two separate but temporary legislative fixes staved off cuts in 2003, 2004 and 2005

Together we are stronger.

Fatal Flaws

- Link to GDP
- Targets not adjusted to reflect changes in law and regulation
- Arbitrary volume growth targets bear no relation to medical practice trends
- Compounding cumulative deficit = loan shark deal

Together we are stronger.

Huge Political Obstacles

- Tyranny of the budget baseline
- Congress/Administration are Code Red on deficit reduction
- All other provider groups hope to push action on omnibus Medicare bill into next year
- Focus on Social Security

Together we are stronger.

Step One: Remove Rx Drugs from the formula

- -5.2% to +1.1%
- Legal opinion by former HCFA General Counsel
- All three Medicare committees of jurisdiction support removing drugs
- More than 300 Members of Congress asked Bush Administration to stop the cuts

Together we are stronger.

Step Two: MedPAC Recommendation

- Replace formula with update system used for hospitals
- Full MEI unless Congress enacts legislation for lower update

Together we are stronger.

Why Hasn't Administration Acted?

- Focus on Nov 2, 2004 not Jan 1, 2006
- Adds to deficit, flak about MMA price tag and record premium increases
- Problem generated by Act of Congress
- Issue not ripe in a political sense

Together we are stronger.

331 Calendar Days Before Cuts Go Into Effect

- Every interaction with Members of Congress and their staff must stress need for urgent action to avert access meltdown
- Intensity creates political will to act
- A matter of priorities

Together we are **stronger.**

SGR Bumper Sticker

Warning for the U.S. Congress:
Stop Medicare Physician Pay Cuts. The SGR is Harmful to Seniors' Health Care

Together we are **stronger.**

Elements of the SGR Campaign

- Focus groups to hone messaging
- Physician surveys to measure access problems
- Patient Action Network
- SGR Ads
- AMA House Calls
- Beyond the Beltway meetings
- Periodic conference calls

Together we are stronger.

Together We Are Stronger

- SGR Work Group
- AAMSE CEO Meetings
- SGR Research Fund
- Fiscal Support from AMA Senior Mgt and BOT
- Unified, coordinated and consistent message is critical to success

Together we are **stronger.**

SGR Campaign Time Line

- January: Flood Congressional offices with calls for action to stop Medicare MD cuts
- February-March: Utilize committee hearing process to highlight urgency of SGR fix
- March 14-16 : AMA Nat'l Advocacy Conf (NAC)
- March-May: House-Senate Budget Res.
- June: CMS MD Payment NPRM
- Summer/Fall: Medicare Reconciliation Bill

Together we are stronger.

SGR Campaign Time Line (cont'd)

- November: Final CMS MD Payment Rule
- November/December: CMS Dear Doctor Letter
- January 1, 2006: Judgment Day

Together we are stronger.

Other Important Issues

- Coverage for the Uninsured
- Patient Safety
- Medicaid Reform

Together we are **stronger.**

Other Important Issues (cont'd)

- Quality Improvement
- Electronic Medical Records
- Pay for Performance
- Funding for Medical Research and Public Health Programs

Together we are **stronger.**

Other Important Issues (cont'd)

- Specialty Hospitals
- Regulatory Relief
- Anti-trust Relief

Together we are **stronger.**

RUC
February 3-6, 2005

Tucson, Arizona

- Financial Disclosure Forms-must be on file prior to presentation
- Cell phones
- April work load: presentations deferred from this meeting will not be given preferential treatment on the schedule-advise your staff and consultants to be present for the entire April meeting in Chicago

CMS representatives

- Edith Hambrick, MD
- Carolyn Mullen
- Ken Simon, MD
- Pamela West

GAO staff

- Nancy Edwards
- Beth Feldpush
- Marc Feuerberg
- Nora Hoban

Ad Hoc Practice Expense Review Committee

- James Anthony, MD
- Katherine Bradley, PhD, RN
- Joel Brill, MD
- Manuel Cerqueira, MD
- Neal Cohen, MD
- Thomas Felger, MD
- Gregory Kwasny, MD
- Peter McCreight, MD*
- Bill Moran, MD*
- Tye Ouzounian, MD*
- James Regan, MD
- Anthony Senagore, MD
- **official representatives at the RUC meeting to assist Doctor Moran with inputs*

Facilitation Committee #1

- **Michael Bishop, MD (Chair)**
- Robert Barr, MD
- John Derr, Jr., MD
- Mary Foto, OTR*
- David Hitzeman, DO
- Barbara Levy, MD
- John Mayer, Jr., MD
- Charles Mick, MD
- Gregory Przybylski, MD*
- Susan Strate, MD
- Maurits J. Wiersema, MD

Facilitation committee 2

- **John Gage, MD (Chair)**
- James Blankenship, MD
- Eddy Fraifeld, MD
- Peter Hollmann, MD
- Scott Manaker, MD, PhD*
- Bill Moran, MD*
- Chester W. Schmidt, Jr., MD
- Dennis Stone, MD
- Trexler Topping, MD
- Richard Tuck, MD
- Richard Whitten, MD
- Robert Zwolak, MD

Facilitation committee #3

- **Neil Brooks, MD (Chair)**
- James Borgstede, MD*
- Norman Cohen, MD
- William Gee, MD
- Anthony Hamm, DC
- Charles F. Koopman, Jr., MD
- J. Leonard Lichtenfeld, MD
- Keith Naunheim, MD
- Bernard Pfeifer, MD
- Daniel Mark Seigel, MD*
- J. Baldwin Smith, III, MD
- John Zitelli, MD

RUC observers

- Deb Abel American Academy of Audiology
- David Beyer, MD American Society for Therapeutic Radiology and Oncology
- Kathryn Buettner Northern Illinois University
- Michael Chaglasian, OD American Optometric Association
- Brett Coldiron American Academy of Dermatology
- John Conte Society of Thoracic Surgeons
- Jeffrey DeManes, MD American Society for Therapeutic Radiology and Oncology
- Aidnag Diaz, MD Northern Illinois University
- Kim French American College of Chest Physicians

- Patricia Golden American Society of Hematology
- Gerald Hanson, MD College of American Pathologists
- Samuel Hassenbusch, MD American Academy of Pain Medicine
- Wayne Holland American Speech, Language, and Hearing Association
- Kirk Kanter Society of Thoracic Surgeons
- Jenna Kappel American Society for Therapeutic Radiology and Oncology
- Wayne Koch, MD American Academy of Otolaryngology - Head and Neck Surgery
- Robert Kossmann, MD Renal Physicians Association
- Judy Mitchell, RN American College of Physicians

- Doc Muhlbaier Society of Thoracic Surgeons
- Elizabeth Mullikin American Academy of Neurology
- Irvin Muszynski
- Daniel O'Keefe, MD Society of Maternal and Fetal Medicine
- Robert Park, MD American Academy of Ophthalmology
- Diane Pedulla American Psychological Association
- Antonio Puente, PhD American Psychological Association
- Ellen Riker American Academy of Sleep Medicine

- Henry Rosenberg, MD American Society of Anesthesiologists
- Jason Scull Infectious Diseases Society of America
- Christopher Senkowski, MD American College of Surgeons
- Patricia Serpico American Association of Oral and Maxiollfacial Surgery
- Richard Smith Society of Thoracic Surgeons
- Frank Spinosa American Podiatric Medical Association
- Robert Weinstein, MD American Society of Hematology
- Eric Whitacre, MD American Society of Breast Surgeons
- Andrew Whitman

Pay for Performance

Why Performance measurements now?

- Only 50% of time patient receives EBM care
-
- Costs spiraling out of control- unacceptable/unsustainable
- Companies (purchasers) demanding lower costs and better value
- Belief that improved quality and efficiency will drive down cost

Performance measures

- Information technology
- Processes of care
- Outcomes measures

Information technology

- Insurers and health policy mavens are touting IT as a source of savings to the system despite the fact there is no accepted backbone for an EMR
- Development of EMR will improve quality and decrease medical errors
- IT has never been shown to increase physician productivity
- Economic benefits flow to insurers while docs are expected to pay

P4P

- Commercial
- Federal

P4P commercial

- Insurers use 5% of payments to encourage use of evidence based performance measures
- Directed to primary care
- “New” money?????
- Chronic diseases with large impact

P4P Federal

- Congress, Medpac, CMS all state that P4P should be an integral part of physician payments
- Adjustments to SGR **will** be linked to P4P
- MMA enabled three P4P demonstration projects-HIT, chronic care, and physician group quality improvement in FFS

P4P Federal Process

- AMA Consortium on Physician Performance Measures
- Approved measures forwarded to the National Quality Forum
- NQF measures sent to CMS
- AMA CPT evaluates level II performance measurement codes to enable MDs to document performance

P4P Policy Questions

- Should Medicare P4P payments be new money or revenue neutral?
- What % of physician fees will be set aside? (1% of all payments or 5% per claim)?
- How are payments distributed (large intervals of care vs. per claim)?
- How do we insure level II CPT codes adequately reflect intent of the improvement measure?

AMA Positions

- New money
- Measures evidence based, broadly accepted, clinically relevant, and continuously updated
- Physician paid for administrative expense

CPT/RUC Implications

- Validity of new level II codes as reflection of approved measures
- Will RUC be asked to comment on equivalency of work and expenses of approved Level II codes?

Problems

- How do surgical and medical specialties get approved new measures when there is little Level I evidence for newer processes?
- Are the AMA Consortium criteria for eligible measures broad enough to include all specialties?
- Is there enough capacity in primary care practices to implement P4P measures? (Medpac Dec. report on PE impacts)
- Will CMS recognize the methodologic problems of secondary increases in volume of services?

American Medical Association
Physicians dedicated to the health of America

April 1, 2005

Lawrence Smarr
President
Physician Insurers Association of America
2275 Research Boulevard, Suite 250
Rockville, Maryland 20850

Dear Mr. Smarr: Larry

We are writing to express the appreciation of the American Medical Association (AMA) and the AMA/Specialty Society RVS Update Committee (RUC) for the assistance the PIAA has promised for a project to improve the Medicare payment process for professional liability insurance (PLI) for physicians. We understand that you have been in communication with Stephen Kamenetzky, MD, Chairman of the Finance Committee at the Ophthalmic Mutual Insurance Company, and will encourage member companies to provide 2004-2005 premium data, by specialty, to a contractor for the Centers for Medicare and Medicaid Services (CMS).

CMS previously utilized a private contractor to solicit individual State Departments of Insurance to provide premium data. Despite its best effort, the premium data that CMS was able to collect for physician's PLI costs is both outdated and incomplete. The current payment values are based on actual premium data for 2001 (48 states) and 2002 (33 states). Specific premium data could only be obtained for eight specialties. The premiums for all other specialties are based on some combination of actual premium data, rating manuals from five insurers, and crosswalks to other specialties. Organized medicine has repeatedly called on CMS to improve this data collection. To date, CMS has been unsuccessful in that effort and we appreciate the cooperation the PIAA has pledged to improve the process.

We understand that your member companies may have concerns regarding confidentiality of their premium data. Members of the RUC have consulted with CMS on this issue. CMS has assured the RUC that it will pool the state data by specialty, and individual company premium data will not be revealed.

The AMA and the RUC look forward to working with you on this project of great importance to practicing physicians. If you have any specific questions regarding this data collection effort, please contact Sherry Smith by e-mail at Sherry.Smith@ama-assn.org or by phone at (312) 454-5604.

Sincerely,

Michael D. Maves, MD, MBA
Executive Vice President/CEO
American Medical Association

William L. Rich, III, MD, FACS
Chairman
AMA/Specialty Society RVS Update Committee

cc: AMA Board of Trustees
RUC Participants

American Medical Association

Physicians dedicated to the health of America

William L. Rich III, MD, FACS
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
Chicago, Illinois 60610

312 464-5604
312 464-5849 Fax

March 4, 2005

Stephen Phillips
Director, Division of Practitioner Services
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard, C4-03-06
Baltimore, Maryland 21244

Dear Mr. Phillips:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) has reviewed the current crosswalks and risk factor assignments utilized in the professional liability insurance (PLI) relative value methodology and offers recommendations for revisions for consideration in the rulemaking processes this year.

As you know, the Centers for Medicare and Medicaid Services (CMS) indicated in the November 15 *Final Rule* that the agency was interested in RUC input on the appropriateness of the crosswalk assumptions. The RUC provided all specialty societies and Health Care Professionals Advisory Committee (HCPAC) organizations with the opportunity to submit comments on the crosswalks listed in the November 15 *Final Rule*. The RUC reviewed comments submitted by specialty societies and recommends a number of modifications to the risk factor assignments.

1. The RUC understands that the professions list below would not incur PLI premium rates greater than $6,152 per year (your current base for a 1.00 risk factor). It would, therefore, be appropriate to assign the current lowest risk factor of 1.00 for both non-surgical and surgical codes for each of these professions. This recommendation should be considered an interim step. The RUC believes that the PLI premium rates for the these professions may be substantially less than $6,152. The RUC also recommends that the RUC HCPAC review and discuss these recommendations. The RUC would be willing to review any data provided by a professional group to refute the understanding that the annual PLI premium data is less than $6,100. We urge CMS to set the risk factors to 1.00 and then work to collect PLI premium data for the following professions:

   Clinical Psychologist
   Licensed Clinical Social Worker
   Occupational Therapist
   Psychologist
   Optician
   Optometry
   Chiropractic
   Physical Therapist

2. The RUC expresses concern about a number of specialties/professions that were assigned to an average "all physician" risk factor (currently 3.04 non-surgical / 3.71 surgical). The RUC recommends that the following groups should have been treated as the other 34 Medicare specialties that were excluded from the analysis:

   Certified Clinical Nurse Specialist
   Clinical Laboratory
   Multi-Specialty Clinic or Group Practice
   Nurse Practitioner
   Physician Assistant
   Physiological Laboratory (Independent)

3. The RUC recommends that certified registered nurse anesthetists (CRNA) be cross-walked to Anesthesiology (currently 2.84), rather than to the "all physicians" category.

4. The RUC also notes that the rank order premium data appeared problematic for colorectal surgery and gynecologist/oncologist and recommends that these two specialties be cross-walked as follows:

   Gynecologist/oncologist (currently 5.63) should be crosswalked to surgical oncology (currently 6.13 – based on crosswalk to general surgery).

   Colorectal surgery (currently 4.08) should be crosswalked to general surgery (currently 6.13).

5. The RUC recommends that CMS publish a separate impact analysis in the *Notice of Proposed Rulemaking (NPRM)*, by specialty, resulting from the acceptance of the above RUC recommended modifications to crosswalks.

Correction of Previous RUC Action

The American College of Cardiology (ACC) requested that the RUC correct a clerical mistake created when the RUC's PLI Workgroup updated exceptions to the surgical risk factor assignment. The PLI Workgroup agreed that it appears that a clerical mistake was made as the society never intended that these services be removed from the exception list. The RUC recommends that CMS add back the following codes to the surgical risk factor list for cardiac catheterization (2.53 in 2005):

92980-92984
92985-92998
93617-93641

The RUC also recommends that 92975 be added to the cardiac catheterization (surgical risk factor) list based on their own review of the cardiology codes.

The RUC has also engaged in a review of aberrant data in low utilization services. We will review this information at our April 27-May 1, 2005 meeting and plan to forward recommendations related to this issue following this meeting. AMA staff will also be in contact with you to set up a conference call to discuss the Medicare utilization data used in the PLI methodology and the RUC's preferred dominant specialty approach.

We appreciate this opportunity to provide recommendations to improve the methodology utilized in developing PLI relative values. If you have any questions, please contact Sherry Smith at (312) 464-5604.

Sincerely,

William L. Rich, III, MD, FACS

cc: RUC Participants

How to Evaluate a Practice Expense Recommendation

Tips For RUC Members

Practice Expense Subcommittee

Thursday, February 3, 2005

Why is Practice Expense Important?

- Medicare Practice Expense Reimbursement is over 43% of the total Medicare payments or over $22 Billion annually
- High Practice Expense Inputs for some codes can shift PE RVUs away from other codes
- Anomalies in total RVUs could result from an inaccurate RUC practice expense recommendation to CMS

Practice Expense Data Collection

- Specialties have two options for collecting direct input data:
  - Practice Expense Survey
  - Specialty Society Panel
- Specialties are required to use a panel (rather than an individual physician) to review practice expense data
  - Look at first page of summary of recommendation page to determine how PE inputs were complied by the specialty. It should tell you the size and make up of panel.
- Specialties are required to describe, in writing, the composition of their panel, ie. If subspecialties were represented

Site of Service – Basic Assumptions

- Administrative type activities should not be included, as they are already accounted for as an indirect expense, eg. Secretarial work
- Non-Facility Setting – Physician bears cost of clinical labor, supplies, and equipment
- Facility Setting –the clinical labor, supplies, and equipment are paid for by the facility (under Medicare Part A), not the physician

What are the Practice Expense Components? What is the Standard of Care and are all these items typically used?

- Clinical Labor – distinguished from physician work. 43 CMS categories of clinical labor, all with different costs per minute
- Medical Supplies – disposable, one time use only supplies, that are necessary for performing the procedure. 842 CMS identified items, 7 items are priced over $1000.00, and 40 priced over $200.00
- Equipment – Medical equipment > $500.00 that are dedicated for the procedure. 553 CMS identified items. 7 of these are priced at $1 million or more.

Clinical Labor

- Standards and Benchmarks
  - Practice Expense Direct Input Benchmarks
    - "Cheat Sheet" and Rules in Excel Spreadsheet
    - Are the benchmarks typical and appropriate for the service provided?
  - Global Period Benchmarks
    - RN/LPN/MTA = $.37 per minute or $37,440/year
    - 000 and 010 day global codes, pre-service time = 0 unless justified.
    - 090 day global codes, pre-service time, 35 and 60
    - Is the Clinical Labor Assist Physician Time appropriate for the procedure, varies from 0% to 100% of physician time depends on rationale?
    - 010, and 090 day global procedures – office visits should equal physician office visits in RUC database

Medical Supplies

- Are they all needed for the typical service?
- High Price Disposable Medical Supplies – Magnifying Effect of the Scaling Factors – 30 codes with PE RVUs > 20.00. All Top 2005 Non-Facility PE RVUs have high priced disposables
  - What is a high priced disposable? How should they be defined?
- Kits, Packages, and Trays – What is included in each, and is it listed elsewhere on the spreadsheet? eg, kit, transurethral needle ablation (TUNA); pack, drapes, ortho, large; tray, thoracentesis

Equipment

- Over $500, and used exclusively for the procedure
- Surgical Instrument Packages – Specialty Specific Package – Clinical Labor Cleaning Time added with it
  - Basic Surgical Instrument Package - $500
  - Medium Surgical Instrument Package - $1500
  - No Large Surgical Instrument Package – on case by case basis

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report – April 2005

Doctors Zwolak, (Chair), Allen, Foto, Koopman, Moran, Siegel, Strate, and Weirsema participated in the subcommittee's business via email. The Practice Expense Subcommittee reviewed physician time allocations for four codes that were reviewed for practice expenses at the February 2005 RUC/PERC meeting. The codes were refined by PERC without physician intra-service time being used as benchmarks as is typically done during discussions.

The subcommittee considered four time submissions from two different specialties. The Practice Expense Subcommittee approved and recommends the following practice expense physician time allocations to the RUC:

CPT Code	Global Period	Specialty	Pre-Service time	Intra-Service time	Immediate Post Service time	Total Recommended physician time	Total CMS "PR" time
11975	**000**	**ACOG**	**3**	**33**	**3**	**39**	**39**
11976	**000**	**ACOG**	**3**	**38**	**3**	**39**	**39**
11977	**000**	**ACOG**	**3**	**63**	**3**	**39**	**39**
31730	**000**	**ACCP**	**10**	**69**	**10**	**89**	**89**

Additional Code Information:

Code Global Long Descriptor
11975 000 *Insertion, implantable contraceptive capsules*

11976 000 *Removal, implantable contraceptive capsules*

11977 000 *Removal with reinsertion, implantable contraceptive capsules*

31730 000 *Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tub for oxygen therapy*

Physician Time Components Accepted by the RUC - February 2005

CPT Code	Tracking Number	RUC Agenda Tab	RUC Meeting Date	Issue	Global Period	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub, Dress	Median Intra-Service Time	Immediate Post Service time	x99231	x99232	x99233	x99291	x99292	x9 92 38	x99239	x99211	x99212	x99213	x99214	x99215	x99296	x99297	Total Physician Time
92520	B1	10	Feb-05	Laryngeal Function Studies	XXX	10	0	0	11	10															31
2825X	N1	8	Feb-05	High Energy Extracorporeal Shock Wave	090	15	5	10	25	18						0.5			3						136
3659X	P1	6	Feb-05	Radiologic Venous Catheter Evaluation	000	5	5	5	10	10															35
442X1	S1	17	Feb-05	Laparoscopic Enterostomy Closure	090	45	25	10	150	30	1	1	2			1			1	2					488
442X2	T1	18	Feb-05	Laparoscopic Splenic Flexure	ZZZ	0	0	0	45	0															45
442X3	U1	19	Feb-05	Laparoscopic Stomas	090	45	25	10	75	30	1	2				1			1	2					361
442X4	U2	19	Feb-05	Laparoscopic Stomas	090	45	25	10	90	30	1	2				1				3					384
454X1	V1	20	Feb-05	Laparoscopic Proctectomy	090	45	35	10	210	30	2	2	1			1			1	2	1				604
454X2	V2	20	Feb-05	Laparoscopic Proctectomy	090	45	35	10	240	30	2	2	1			1			1	2	1				634
454X3	W1	21	Feb-05	Laparoscopic Protopexy	090	45	25	10	100	30	3	1				1			1	2					394
454X4	W2	21	Feb-05	Laparoscopic Protopexy	090	45	35	10	150	30	1	2				1			1	2					446
465X1	X1	23	Feb-05	Anal Sphincter Chemodenervation	010	20	10	5	15	10						0.5				1					101
4670X1	Y1	22	Feb-05	Ileoanal Pouch Fistula Repair	090	60	20	10	90	30	1	1				1			1	2					356
4670X2	Y2	22	Feb-05	Ileoanal Pouch Fistula Repair	090	60	20	10	240	30	1	2	2			1			1	2					618
89XXX	CC1	27	Feb-05	Caffeine Halothane Contracture Test	XXX	5	0	0	0	40															45
910XX	I1	28	Feb-05	Antroduodenal Manometry	000	15	0	0	30	16															61
9525X	J1	29	Feb-05	Continuous Glucose Monitoring	XXX	0	0	0	30	0															30

AMA/Specialty RVS Update Committee
Meeting Minutes
February 3 – 5, 2005

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 4, 2005 at 8:00am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD*
Michael D. Bishop, MD
James Blankenship, MD
James P. Borgstede, MD
Neil H. Brooks, MD
Ronald Burd, MD*
Norman A. Cohen, MD
James Denneny, MD*
John Derr, Jr., MD
Mary Foto, OT
John O. Gage, MD
William F. Gee, MD
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
George Kwass, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Scott Manaker, MD
John E. Mayer, Jr., MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Sandra Reed, MD*
Chester W. Schmidt, Jr., MD
Daniel Mark Siegel, MD
J. Baldwin Smith, III, 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 made the following announcements:

- Doctor Rich welcomed the CMS Staff attending the meeting, which 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, PT, CMS Health Insurance Specialist

- Doctor Rich welcomed Lee Stillwell, Senior Vice President of Advocacy, and Kathy Kuntzman, the Vice President of Health Policy at the AMA.

- Doctor Rich welcomed the following staff from the General Accounting Office (GAO) who were in attendance Feb 2-3, 2005:
    - Nancy Edwards
    - Beth Feldpush
    - Marc Feuerberg
    - Nora Hoban

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting are:

  James Anthony, MD
  Joel Brill, MD
  Manuel Cerqueira, MD
  Neal Cohen, MD
  Thomas Felger, MD
  Gregory Kwasny, MD
  Peter McCreight, MD
  Bill Moran, MD
  Tye Ouzounian, MD
  James Regan, MD
  Anthony Senagore, MD

- The following individuals were observers at the February 2005 meeting:

Deb	Abel	American Academy of Audiology
David	Beyer, MD	American Society for Therapeutic Radiology and Oncology
Kathryn	Buettner	Northern Illinois University
Michael	Chaglasian, OD	American Optometric Association
Brett	Coldiron	American Academy of Dermatology
John	Conte	Society of Thoracic Surgeons
Jeffrey	DeManes, MD	American Society for Therapeutic Radiology and Oncology
Aidnag	Diaz, MD	Northern Illinois University
Kim	French	American College of Chest Physicians
Patricia	Golden	American Society of Hematology
Gerald	Hanson, MD	College of American Pathologists
Samuel	Hassenbusch, MD	American Academy of Pain Medicine
Wayne	Holland	American Speech, Language, and Hearing Association

Kirk	Kanter	Society of Thoracic Surgeons
Jenna	Kappel	American Society for Therapeutic Radiology and Oncology
Wayne	Koch, MD	American Academy of Otolaryngology - Head and Neck Surgery
Robert	Kossmann, MD	Renal Physicians Association
Judy	Mitchell, RN	American College of Physicians
Doc	Muhlbaier	Society of Thoracic Surgeons
Elizabeth	Mullikin	American Academy of Neurology
Irvin	Muszynski	
Daniel	O'Keefe, MD	American Academy of Ophthalmology
Robert	Park, MD	American Academy of Ophthalmology
Diane	Pedulla	American Psychological Association
Antonio	Puente, PhD	American Psychological Association
Ellen	Riker	American Academy of Sleep Medicine
Henry	Rosenberg, MD	American Society of Anesthesiologists
Jason	Scull	Infectious Diseases Society of America
Christopher	Senkowski, MD	American College of Surgeons
Patricia	Serpico	American Association of Oral and Maxiollfacial Surgery
Richard	Smith	Society of Thoracic Surgeons
Frank	Spinosa	American Podiatric Medical Association
Robert	Weinstein, MD	American Society of Hematology
Eric	Whitacre, MD	American Society of Breast Surgeons
Andrew	Whitman	

- Doctor Rich welcomed the Korean Medical Association (KMA) and presented them with gifts. The KMA observers include:

Name	Title (Position)	Organization
Mr. Hyo-keel PARK*	Vice President, M.D.	Korean Medical Association
Mr. Chang-rok SHIN	Director of Health Insurance M.D	Korean Medical Association
Mr. Sang-keun Park	Director of Health Insurance M.D	Korean Hospital Association
Ms. Sook-ja Lee	General Manager	Korean Hospital Association
Ms. Jong-Nam JOH*	Director of Health Insurance M.D	Korean Society of Obstetrics and Gynecology
Mr. Young-Jae KIM*	Director of Health Insurance M.D	Korean Association of Family Medicine
Mr. Seoung-Wan Chae	Director of Health Insurance M.D	Korean Society of Pathologists
Mr. Joo-Seung Kim	Director of Health Insurance M.D	Korean Neurosurgical Society
Mr. Myung-Soo Choo	Director of Health Insurance M.D	Korean Urological Association

Mr. JAE-HO BAN	Member of Health Insurance M.D	Korean Society of Otolaryngology
Ms. Seon-Kui LEE	Researcher	Asian Institute for Bioethics and Health Law, Yeonsei University
Ms. Young-joo Cha	Director of Health Insurance M.D	Korean Society for Laboratory Medicine
Mr. Soon-Hyun Kim	Director of Health Insurance M.D	Korean Opthamological Society
Mr. Young-hoon Ryu*, MD	Director of Health Insurance	Korean Society of Nuclear Medicine

**Also attended September 2004 RUC Meeting*

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1
Michael Bishop, MD (Chair)
Robert Barr, MD
John Derr, Jr., MD
Mary Foto, OTR*
David Hitzeman, DO
Barbara Levy, MD
John Mayer, Jr., MD
Charles Mick, MD
Gregory Przybylski, MD*
Susan Strate, MD
Maurits J. Wiersema, MD

Facilitation Committee #2
John Gage, MD (Chair)
James Blankenship, MD
Eddy Fraifeld, MD
Peter Hollmann, MD
Scott Manaker, MD, PhD*
Bill Moran, MD*
Chester W. Schmidt, Jr., MD
Dennis Stone, MD
Trexler Topping, MD
Richard Tuck, MD
Richard Whitten, MD
Robert Zwolak, MD

Facilitation Committee #3
Neil Brooks, MD (Chair)
James Borgstede, MD*
Norman Cohen, MD
William Gee, MD

Anthony Hamm, DC
Charles F. Koopman, Jr., MD
J. Leonard Lichtenfeld, MD
Keith Naunheim, MD
Bernard Pfeifer, MD
Daniel Mark Seigel, MD*
J. Baldwin Smith, III, MD
John Zitelli, MD

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

- Doctor Rich discussed the following:
  - Financial forms must be on file prior to presentation
  - April 2005 RUC meeting - presentations deferred from the February 2005 RUC meeting will not be given preferential treatment on the schedule. Doctor Rich advises staff and consultants to be present for the entire April meeting in Chicago
- Doctor Rich made comments regarding pay for performance in his **PowerPoint presentation, which is attached to these minutes.**

III. Approval of Minutes for the September 30- October 2, 2005, RUC meeting

The minutes were reviewed by the RUC and all changes were accepted as editorial.

IV. CPT Editorial Panel Update

Doctor Peter Hollmann briefed the RUC on the following issues:

- The annual CPT meeting, November 4-6, 2004, Bal Harbour, Florida included sessions on:
  - Drafting vignettes
  - Care plan oversight as a method of addressing all pre- and post-service work involved in complex care coordination. Care management was considered as a potential solution and will be submitted to the CPT Editorial panel in February 2005.

- The conscious sedation workgroup met at the November 2004 meeting and will be presenting at the February 2005 meeting.

- The CPT Editorial Panel indicated that it is trying to continuously improve the interaction between the RUC and the CPT Editorial Panel to ensure that societies properly prepare surveys and have them ready for

the RUC meeting immediately following the CPT Editorial Panel. As well as what actions may be taken if societies are not adequately prepared for the RUC after they have been given a CPT code.

- Sherry Smith Announced: The CPT Editorial Panel now offers one RUC representative the opportunity to attend each Panel meeting, all expenses paid, to observe and participate in the Panel process. Doctor Zwolak will be attending the February 2005 meeting, Doctor Gage will attend the June 2005 meeting and Doctor Bishop will be attending the October 2005 meeting. A RUC representative is still needed to attend the June 2005 meeting.

V. CMS Update

Doctor Ken Simon stated that:

- CMS has been working on implementing many of the elements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The main focus this year will be on the issue of quality and pay for performance. CMS will be making an effort to change the paradigm from having payment based entirely on resources to identify ways to provide payment for excellence and care.

- Other areas of refinement are the issue of ASP +6% as it relates to drug payments. There will be opportunities for public comment for competitive bidding for drugs, a part of the MMA legislation that will materialize later this year.

Doctor Simon responded to several questions from the RUC members, including:

- A RUC member questioned if pay-for-performance will be a real method to improve quality. Doctor Simon responded that the payment side of the agency is statutorily limited to a resourced-based payment system currently. There are restraints and pay-for-performance still needs to be thoroughly identified. This issue will be further examined in the near future.

- A RUC member queried CMS about ASP methodology and the competitive bidding process for drugs. Doctor Simon responded that CMS is working on issues related to the competitive bidding process and methods to ensure level playing fields as it pertains to the majority of the drugs. This area is dynamic because ASP data comes in quarterly and new things surface as the agency acquires more information under ASP and the pricing for numerous drugs.

VI. CMD Update

Doctor William Mangold, Contractor Medical Director (CMD) for Arizona and Nevada, indicated that the CMDs have not put together a formal public comment during the Five-Year Review process.

VII. Washington Update

Lee Stillwell, Senior Vice President of Advocacy for the American Medical Association, addressed the following issues:

- *Medical Liability Reform:* Senior White House staff meeting in mid-December indicated that Medical Liability Reform is a high priority of the president. An action plan was unveiled at the AMA State Legislation meeting. Each state is working on reform. However, the focus of reform is at the national level.
    - *AMA Action Plan:* planning conference calls with state and national medical specialty societies to organize town hall meetings for physicians to interact with congressmen and senators.
    - *The House of Representatives and Senate Bills:* The House has passed a MICRA-style bill nine times in the last decade. The Senate is where the hurdle is when trying to pass a non-economic damages capitation. Sixty Senate votes are needed for the motion to proceed to the Conference Committee and only 51 votes are needed to pass the bill (without amendments).
    - *AMA Principles*
        - Protect strong state laws
        - Final product must achieve goal of stabilizing/ultimately reducing premiums
- *Political Obstacles*
    - Budget, deficit reduction
    - Provider groups hope to push action on Omnibus Medicare bill into next year
    - Social Security
- *Sustainable Growth Rate (SGR)*
    - Step 1: Remove prescription drugs from the formula
    - Step 2: Implement MedPac recommendation
    - Elements of the SGR Campaign
        - Focus groups to hone messaging
        - Physician surveys to measure access problems
        - Patient Action Network – patients supporting physicians
        - Ads

        - AMA House Calls – board members participating in press conferences
        - Beyond the beltway meetings – talk to local congressmen and senators
        - Periodic conference calls – coordination
    - Together we are Stronger – SGR workgroups, meetings and research to coordinate a consistent message
- *Other Important Issues*
    - Coverage for the Uninsured
    - Patient Safety – last year was passed in both the House and Senate, but it did not pass in the Conference Committee
    - Medicaid Reform – task force
    - Quality Improvement (linked to SGR)
    - Electronic Medical Records (linked to SGR)
    - Pay for Performance (linked to SGR)
    - Funding for Medical Research and Public Health Programs
    - Specialty Hospitals
    - Regulatory Relief
    - Anti-trust Relief

The full PowerPoint presentation is attached to these minutes.

Questions

- A RUC member posed the question, would linking patient safety legislation with tort reform provide enough for the swing democrats to vote in favor of such a bill? Several RUC members commented on the importance of medicine tying in patient safety with tort reform discussions. Lee Stillwell responded that the AMA tried to link patient safety with tort reform the last time around but it did not work. The reality is that the patient safety bill must pass separately.
- A RUC member questioned if CMS/AMA will be conducting an SMS survey. The RUC recommended that the AMA reconsider conducting this survey. Mr. Stillwell responded that it is a budgetary problem and a problem finding a way to effectively perform the survey. AMA would consider performing it again if there was a legitimate plan to perform what CMS needs and if the funds were available. Carolyn Mullen, CMS, announced that CMS is still hoping to produce the funds to conduct the SMS survey, but would also hope that the AMA would partner with CMS and its contractor in conducting the surveys.

VIII. Directors Report

Sherry Smith made the following announcements:

- The 2005 RUC database is available. Recipients must sign the license agreement. The non-facility total payment rate is incorrect. An updated version will be available at the April 2005 RUC meeting.

IX. Relative Value Recommendations for CPT 2005

Gastric Restrictive Procedure (Tab 4)
Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

The RVU work recommendation for code 43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)* has been postponed until April 2005 RUC meeting. The specialty requested more time to adequately prepare the survey and present this code. **The RUC does not make a recommendation at this time.**

X. Relative Value Recommendations for CPT 2006

TMJ Manipulation Under Anesthesia (Tab 5)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American Dental Association

The two following codes 21XXX1 *Manipulation, therapeutic, temporomandibular joint (TMJ); requiring conscious sedation* and 21XXX2 *requiring general anesthesia* have been referred back to CPT for clarification. **The RUC does not make any recommendations at this time.**

Radiologic Venous Catheter Evaluation (Tab 6)
Bibb Allen, Jr., MD, American College of Radiology (ACR)
Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR)
Facilitation Committee # 3

In 2004, the CPT Editorial Panel significantly changed the family of codes describing central venous access procedures. However, the radiological evaluation of an existing venous access device was not addressed. New code, 3659X *Contrast injection(s) for radiologic evaluation of existing venous access device, including fluoroscopy, image documentation and report* will be added to delineate the radiological evaluation and maintenance of existing venous access within the CPT.

The RUC discussed the possibility of code 3659X being billed with de-clotting procedures such as 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (Work RVU = 3.59) or 36596 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen* Work RVU = 0.75). RUC members commented that a parenthetical should be placed in CPT for the code not to be billed with these codes.

The RUC reviewed and compared the work of this code to reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (000 day global, Work RVU= 0.76) and to code 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)* (000 day global, Work RVU = 0.76) . The RUC believed that the physician work was closely aligned with both codes 50394 and 49424, considering there was more time spent in the pre and post time periods. The RUC also believed that the 25th percentile survey results were consistent with the physician work involved, and therefore **recommends a relative work value of 0.74 for code 3659X.**

Practice Expense

The RUC made some modifications to the specialty's original practice expense recommendation. Specifically, the clinical labor activity time was reduced on the following lines:

- Review Charts, line 25
- Provide pre-service education/obtain consent, line 28
- Assist physician in performing the procedure, line 34

In addition, the RUC increased the quantity of the exam table paper by one foot. The modified practice expense inputs recommended by the RUC are attached.

Physician Liability Crosswalk

The RUC recommends that an appropriate crosswalk code for the physician liability is its reference code 50394 *Injection procedure for pyelography (as nephrostrogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter.*

Vertebral Augmentation - Kyphoplasty (Tab 7)
American Association of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pain Medicine
American College of Radiology
American Society of Anesthesiologists
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology
American Society of Neuroradiology

The following three codes 2252X1, 2252X2 and 2252X3 have been referred back to CPT for clarification **The RUC does not make any recommendations at this time.**

High Energy Extracorporeal Shock Wave Therapy (Tab 8)
Tye Ouzounian American Academy of Orthopaedic Surgeons (AAOS)
Lloyd S. Smith, DPM, American Podiatric Medical Association (APMA)
Frank Spinosa, American Podiatric Medical Association (APMA)
Facilitation Committee #1

The CPT Editorial Panel created a new code to differentiate between high energy and low energy Extra Corporeal Shock Wave Therapy in the treatment of plantar fascitis. CPT also revised a category III code that describes other extracorporeal shock wave procedures. The RUC evaluated the procedure performed in the facility setting since the CPT RUC representative confirmed that during the CPT presentation, the Panel approved the code based on the presenters' statements that it is only performed in the facility setting because the procedure requires general anesthesia due to the high level of pain involved. However, during the RUC presentation, a presenter stated that the procedure is also performed in the non-facility setting. The RUC did not take formal action on the non-facility practice expense for CPT code 2825X, but will forward the specialty recommendation for CMS' independent evaluation.

During the RUC review, the presenters agreed to reduce the pre-service time and eliminate one post-service office visit from the survey results as the presenters felt that the results overstated the total time. By reducing these inputs a revised recommended value of 3.85 was presented for RUC consideration. The RUC agreed that code 25001 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* (work RVU, 3.37, 090 day global) should be used as an additional reference service because the physician time for 25001 (pre time = 30, intra = 30, immediate post=30, ½ day discharge, 2 x 99212, and 1x99213) is very similar to the new code. The RUC concluded that the new code should be valued slightly below this reference procedure. Also, the RUC made a number of changes to the physician time:

- **Pre-Evaluation time = 15 minutes**
- **Pre-Positioning time= 5 minutes**
- **Pre-Wait (related to ultrasound)= 10 minutes**
- **Intra-Service Time = 25 minutes**
- **Immediate Post time = 18 minutes**
- **Half Day Discharge = 18 minutes**
- **Three post operative visits at a level of 99212 (most typically at 1 week, 4 weeks, and 8 weeks following the procedure)**

Based on these changes and in comparison to code 25001, the RUC concluded that a work RVU of 3.30, which is slightly below the value of the reference service 25001 would place the code in proper rank order. **The RUC recommends a work RVU of 3.30 for code 2825X.**

Practice Expense

Facility Setting

The RUC altered the post-operative visit clinical labor time, medical supplies, and equipment to reflect the reduction in physician post operative visits. The RUC agreed with the specialty proposed 24 minutes of pre-service time. Attached are the revised practice expense recommendations for this site of service.

Non-Facility Setting

The RUC did not take formal action on the non-facility practice expense for CPT code 2825X, but will forward the specialty recommendation for CMS' independent evaluation.

Professional Liability

The RUC recommends that the Professional Liability Insurance (PLI) RVU be cross-walked to code 28430 *Closed treatment of talus fracture, without manipulation* since it is a non invasive procedure.

Inferior Turbinate Procedures (Tab 9)

James Denney, MD, American Academy of Otolaryngology-Health and Neck Surgery (AAO-HNS)

The CPT Editorial Panel revised codes 30130 *Excision inferior turbinate, partial or complete, any method* (Work RVU=3.37), 30140 *Submucous resection inferior turbinate, partial or complete, any method* (Work RVU=3.42), 30801 *Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method, (separate procedure); superficial* (Work RVU=1.09), and 30930 *Fracture nasal inferior turbinate(s), therapeutic* (Work RVU=1.26) to clarify the appropriate use as private payors were not processing claims appropriately for inferior turbinates. The specialty society presented that these changes are editorial, which identifies that these procedures only include the inferior turbinate (not the superior or middle turbinate). The

RUC did not feel that these codes need to be surveyed again. **The RUC recommends that the revisions are editorial. The RUC recommends to maintain the current values of 30131, 30140, 30801, 30802 and 30930.**

Laryngeal Function Studies (Tab 10)
James Denney, MD, American Academy of Otolaryngology-Health and Neck Surgery (AAO-HNS)

The CPT Editorial Panel revised code 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* to reflect more specifically its current clinical usage and to remove ambiguity by specifying types of testing. Further, with the adoption of code series 92612-92617 [describing flexible fiberoptic evaluation of swallowing and sensory testing with or without physician interpretation/report] there has been concern that 92520 would be utilized inappropriately to report these services.

The specialty society reviewed the survey results for 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* and proposed a work RVU of 0.75 which is lower than the surveyed low outlier (0.80). The response rate was high, however the sample size was small. Therefore a specialty society expert panel convened and recommended a lower value than the survey respondents because the panel felt that the survey respondents overvalued their work. Reference codes 92613 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only* (Work RVU=0.71) and 92617 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by or video recording; physician interpretation and report only* (Work RVU=0.79) were used because they reflected a comparable amount of work and intensity. In addition, the intra-service time for code 92520 (10 minutes) is comparable to the intra-service times for the reference service codes, 92613 (intra-service time = 10 minutes) and 92617 (intra-service time = 15 minutes). **The RUC recommends a work RVU of 0.75 for code 92520.**

The specialty society clarified that this procedure typically can not be performed in any outpatient centers because of the elaborate laboratory set-up that is used. Code 92520 will typically be billed incident-to a physician.

Practice Expense
The RUC reviewed the revised recommended practice expense inputs in detail and agreed to reduce the clinical labor time in the pre-service time period and the intra-service time period. **The revised practice expense inputs are attached and recommended by the RUC.**

Pre-service time = 10 minutes
Intra-service time = 11 minutes
Post-service time = 10 minutes

Coronary Artery Anomaly Unroofing (Tab 11)
Society of Thoracic Surgeons

Code 3350X *Repair of anomalous (eg intramural) aortic origin of coronary artery by unroofing or translocation* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey data were flawed and unusable and that the overall survey responses were inadequate. The specialty society will re-survey and present at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Ventricular Restoration (Tab 12)
Society of Thoracic Surgeons

Code 3354X *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Cavopulomary Shunting (Tab 13)
Society of Thoracic Surgeons

Code 3376X *Anastomosis, cavopulmonary, second superior vena cava (List separately into addition to primary procedure)* has been postponed to the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Repair of Pulmonary Artery Arborization Anomaly (Tab 14)
Society of Thoracic Surgeons

Codes 3392X1 *Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass* and 3392X2 *with cardiopulmonary bypass* have been postponed until the April 2005 RUC meeting. The specialty society felt that some survey responses were flawed and unusable and that the overall survey response was inadequate. The specialty society will re-survey and present recommendations at the April 2005 RUC meeting. **The RUC does not make a recommendation at this time.**

Partial Gastrectomy (Tab 15)
Charles D. Mabry, MD, American College of Surgeons (ACS)

The CPT Editorial Panel deleted CPT codes 43638 *Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;* and 43639 *Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloplasty or pyloromyomotomy* which are outmoded procedures. The Panel originally created a cross-reference that these deleted codes should now be reported with CPT codes 43122 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty* and 43123 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es).* 43122 and 43123 have work relative values greater than the deleted codes 43638 and 43639 which would lead to a work neutrality issue. At the February 2005 meeting, the Editorial Panel removed the cross-reference as obsolete services should not be referred to other CPT codes when the codes are deleted. *Staff Note: the CPT Editorial Panel did remove these cross references.*

Laparoscopic Gastric Restrictive Procedure, with Gastric Band (Tab 16)
Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

The laparoscopic gastric restrictive procedures, with gastric band, codes 4XXX1 – 4XXX8 have been postponed until the April 2005 RUC meeting. The specialty society did not have adequate time to develop, run, interpret and process the data for all 8 codes in time to present at the RUC meeting for the February deadline. **The RUC does not make any recommendations at this time.**

Laparoscopic Enterostomy Closure (Tab 17)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created a new code 442X1 *Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)* to report the laparoscopic approach of an enterostomy closure. The RUC reviewed the survey data of over 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. During it review, the RUC made the following observation about performing laparoscopic procedures, that once the techniques for performing laparoscopic surgery have been mastered for any existing procedure, the

learning curve for performing a new procedure laparoscopically is not as dramatic as the learning curve for performing the laparoscopic techniques themselves. The RUC observed that although the societies' reference service code, CPT code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU=25.32) has a greater total time than the new code, 524 minutes and 488 minutes, respectively, the reference code requires less technical skill and less intra-operative intensity/complexity when compared to the new code. Therefore, the specialty societies recommended the survey median RVU of 26.50. The RUC agreed with the specialty societies' recommendation and agreed that this value for the new code is appropriately placed between 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04) and 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure* (RVW=29.96) as 442X1 requires greater exposure and represents a more complex re-operation than 44204 and 44206 includes more intra-operative work and the post-operative work is more intense/complex than the surveyed code. **The RUC recommends a work RVU of 26.50 for CPT code 442X1**.

Practice Expense

The RUC recommends the standard inputs for this 090 day global period code that is performed only in the facility setting.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance Crosswalk for 442X1 is 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure).* The PLI for 44206 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44206 is very similar to the new code.

Laparoscopic Splenic Flexture (Tab 18)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created a new code 442X2 *Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)* to report the laparoscopic approach of a splenic flexure. The RUC reviewed the survey data of over 35 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that reference code 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (work RVU=2.23) had less intra-service time than the surveyed code, 30 minutes and 45 minutes respectively.

In addition, the RUC observed that the surveyed code requires more technical skill and has a higher intra-operative intensity than the reference code. Therefore the specialty societies recommended the survey median RVU of 3.50. The RUC agreed with the specialty societies' recommendation and in addition felt that this value for the new code is appropriate as it is less that 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis* (RVW=4.44), which has an intra-operative time of 60 minutes (15 minutes more than the surveyed code). **The RUC recommends a work RVU of 3.50 for CPT code 442X2**.

Practice Expense

The RUC agreed with the specialty societies' recommendation of no additional practice expense inputs for this code, as all of the practice expense inputs are accounted for in the base code.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance (PLI) Crosswalk for 442X2 is 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* (Work RVU=4.44). The PLI for 44203 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work is very similar to the new code.

Laparoscopic Stomas (Tab 19)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes 442X3 *Laparoscopy, surgical; ileostomy or jejunostomy, non-tube* and 442X4 *Laparoscopy, surgical; colostomy or skin level cecostomy* to report the laparoscopic approach of an ileostomy or jejunostomy and the laparoscopic approach of a colostomy or skin level cecostomy.

442X3

The RUC reviewed the survey data of almost 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that the reference code describing the open procedure, 44310 *Ileostomy or jejunostomy, non-tube* (Work RVU=15.93) has a similar total time as the surveyed code, 367 minutes and 361 minutes, respectively. It was also noted by the RUC that the reference code and the surveyed code had similar intensity and complexity. Therefore, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 15.93. **The RUC recommends a work RVU of 15.93 for CPT code 442X3.**

442X4

The RUC reviewed the survey results of almost 80 colon/rectal surgeons and gastrointestinal endoscopic surgeons. Upon reviewing the specialty societies' recommendations, the RUC determined that a 99214 office visit should be removed and a 99213 office visit should be added as this allocation of office visits more accurately reflected the treatment of a typical patient. With this modification, the RUC observed that although the reference code describing the open procedure 44320 *Colostomy or skin level cecostomy;* (Work RVU=17.61) has a greater total time than the surveyed code, 465 minutes and 384 minutes, respectively, there is additional skill and intra-operative intensity required to perform this procedure as compared to the reference code. Therefore, the RUC recommended that the work RVU for the new code be cross-walked to the work RVU of the existing code. A work RVU of 17.93 for 442X4 will appropriately identify the additional intra-operative work associated with 442X4 as compared to 442X3, 90 and 75 minutes respectively. **The RUC recommends a work RVU of 17.61 for CPT code 442X4.**

Practice Expense

The RUC recommends the standard inputs for these 090 day global period codes that is performed only in the facility setting with a modification to reflect the change of an office visit from a 99214 to a 99213 in the 442X4 code. In addition, the RUC recommends that 7 minutes be included for both 442X3 and 442X4 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance (PLI) crosswalk for 442X3 and 442X4 is 44205 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy* (Work RVU=22.20). The PLI for 44205 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44205 is very similar to 442X3 and 442X4.

Laparoscopic Protectomy (Tab 20)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes 454X1 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* and 454X2 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* to report the laparoscopic approach of a complete protectomy and a proctectomy that is combined with an abdominoperineal pull-through procedure.

454X1
The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic suregeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 210 minutes and 180 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity that the reference code. Therefore the RUC agreed with the specialty societies' recommendation of the survey median RVU of 30.50. **The RUC recommends a work RVU of 30.50 for CPT code 454X1**.

454X2
The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic suregeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 240 minutes and 210 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity that the reference code. Therefore the specialty society recommended the survey median RVU of 34.00. The RUC agreed with the specialty societies recommendation of the survey median RVU of 34.00 and felt that the survey median RVW of 34.00 is appropriately greater than 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (work RVU=31.95) and less than 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (work RVU=34.95). **The RUC recommends a work RVU of 34.00 for CPT Code 454X2.**

Practice Expense
The RUC recommends the standard inputs for these 090 day global period codes that is performed only in the facility setting. In addition, the RUC recommends that 7 minutes be included for both 454X1 and 454X2 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

Professional Liability Insurance Crosswalk
The RUC's recommendation for the Professional Liability Insurance Crosswalk for 454X1 is 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (Work RVU=31.95) and for 454X2 is 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (Work RVU=34.95). The PLI for these existing codes incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for these existing codes is very similar to the new codes.

Laparoscopic Proctopexy (Tab 21)

David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

The CPT Editorial Panel created two new codes to describe the laparoscopic approach for proctopexy so that they are differentiated from the open procedures that can not be used to report the laparoscopic procedures. The RUC compared codes 454X3 *Laparoscopy, surgical; proctopexy (for prolapse) and code* 454X4 *Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection* to their open procedure counterparts, code 45540 *Proctopexy for prolapse; abdominal approach* (work RVU = 16.25) and code 45550 *Proctopexy combined with sigmoid resection, abdominal approach* (work RVU= 22.97). The RUC agreed with the presenters that the new codes had significantly higher risk and were technically more difficult than the open procedures and to establish proper rank order, the new procedures needed to be valued higher than the open procedures. Additionally, if there was not sufficient RVU difference between the new codes and the open codes there would be a rank order anomaly among the family of laparoscopic codes.

In addition to examining the survey results, the RUC also examined the IWPUT calculations as an additional rationale and felt that using the 25th percentile RVU of 18.06 for code 454X3 produced an IWPUT of 0.097 and the RUC was comfortable that this value placed the code in proper rank order. Also, the 25th percentile value places 454X3 appropriately greater than 44200 (*Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure*) (work RVU, 14.42) and is less than 44205 (*Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy*) (work RVU, 22.05)

The RUC used an additional reference code 44204 *Laparoscopy, surgical; colectomy, partial with anastomosis* (work RVU=25.04 and IWPUT of 0.097) to compare to 454X4. The total time for code 44204 is 439 minutes compared to 446 minutes for 454X4. However, the intra service time for 44204 is 30 minutes longer. The committee felt that the intensity of code 454X4 is greater than this reference code but the total RVU should be the same. At an RVU of 25.04, the IWPUT for 454X4 is .110. The committee felt that this reflected the higher intensity while the total RVU of 25.04 kept the code in proper rank order especially compared to 44204. This value also is similar to the 25th percentile as determined by the RUC survey.

The RUC recommends a work RVU of 18.06 for code 454X3.
The RUC recommends a work RVU of 25.04 for code 454X4.

Practice Expense
The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Ileoanal Pouch Fistula Repair (Tab 22)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

CPT created two new codes to accurately describe circumferential transanal pouch advancement to repair a pouch-vaginal or pouch-perineal fistula or long exit conduit of S-pouch. The RUC reviewed code 4670X1 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* and felt that the recommended median RVU of 18.00 resulted in an IWPUT of .119 that was too high for this procedure. Therefore, it was agreed to use a work relative value between the 25th % and the median value that would produce an IWPUT that would place the code in proper rank order such as with code 454X3 *Laparoscopy, surgical; proctopexy (for prolapse)* (recommended RVU = 18.06). Using a work relative value of 16.00 results in an IWPUT of .097 that is the same as code 454X3. The RUC determined that this intensity value and work relative value was appropriate and placed the code in proper rank order especially with code 454X3, which the RUC felt had the same intra-service intensity as 4670X1. **The RUC recommends a work RVU of 16.00 for code 4670X1.**

The presenters explained that code 4670X2 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach* involved some of the most difficult cases that colon and rectal surgeons see and the procedure involves significant risk. The RUC examined the new code in comparison to the reference procedure, code 45119 *Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy* (work RVU, 30.79). Total times of these two codes were similar with code 4670X2 having 30 additional minutes of intra-service time. Also, the intensity measures of the surveyed code were higher in each category when compared to the reference service. Therefore, the RUC agreed that the median survey RVU of 34.00 would place the code in proper rank order and reflect the additional complexity and technical skill needed in comparison with the reference service. Also, the presenters explained that the higher RVU is warranted because the procedure is always performed in a reoperative field in a patient that already has a pouch with inherent sphincter pouch disfunction and chronic inflammation. More than reoperative surgery, this deep pelvic operation

is techincally difficult because of the tenuous blood supply to the pouch and risk of ureter damage that requires slow, detailed dissections in a confined space. Failure of this operation would result in a permanent stoma. **The RUC recommends a work RVU of 34.00 for code 4670X2.**

Practice Expense
The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Anal Sphincter Chemodenervation (Tab 23)
David Margolin, MD, American Society of Colon and Rectal Surgeons (ASCoRS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCoRS)

CPT created code 465X1 *Chemodenervation of internal anal sphincter* to describe a new medical modality that involves injecting Botulinum toxin for the medical management of anal fissures. The RUC reviewed the specialty society's survey data and was comfortable with the median RVU, however the RUC noted that the median value was based on the inclusion of a full discharge day management service. Since this is an outpatient procedure, the RUC concluded that the physician work associated with half of a visit would be more typical and therefore reduced the recommended value by 0.64 RVUs , which is half a discharge day management service. Therefore the RUC concluded that a work RVU of 2.86 was appropriate especially compared to reference service 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU= 2.20), which does not include a post service office visit or any discharge day management. **The RUC recommends a work RVU of 2.86 for code 465X1.**

Practice Expense
The RUC approved practice expense inputs for the facility and non-facility setting. Intra-service assist time was set equal to the physician time and in the non-facility setting a local anesthetic is typically used, which is reflected in the supplies.

Hyperhidrosis Chemodenervation (Tab2 24)
American Academy of Dermatology
American Academy of Neurology

Daniel Mark Siegel, MD, excused himself from the table due to a disclosed conflict of interest.

Codes 6468X1-6468X4 have been postponed until the April 2005 RUC meeting. The surveying specialties felt that too few survey responses were

received and have postponed presenting recommendations until April 2005 when sufficient data can be collected.

The RUC agreed with the specialty societies to use a global period of 000-days for purposes of conducting their survey. The RUC does not make any recommendations at this time.

Belphatoptosis Repair, Harvest of Fascia (Tab 25)
Gregory Kwasny, MD, American Academy of Ophthalmology (AAO)
Jeffrey Paul Edelstein, MD, American Academy of Ophthalmology (AAO)
Facilitation Committee # 2

The CPT Editorial Panel revised two existing codes, 67901 *Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)* and 67902 *frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* to differentiate between repair of blepharoptosis frontalis muscle technique with autologous fascial sling requiring harvesting and blepharoptosis frontalis muscle technique with suture or banked graft.

At the November 2004 CPT Editorial Panel, the specialty society requested that both codes be resurveyed since there was a clarification on how the fascia is being obtained and these services had never been reviewed before. Previously 67901 would be reported for either banked fasica or other methods of obtaining grafts. This coding change directs all banked fascia to be reported with 67901 and all autologous fascia be reported the 67902. Typically, the RUC would have expected a work neutrality adjustment. However, the specialty society feels that both codes are currently undervalued. Specialty societies must present compelling evidence in such a review and this was not presented in February 2005. The specialty society will request that this issue either be addressed the Five-Year review or they will re-present in April 2005 with compelling evidence available. **At this time the RUC offers no recommendation on these two codes.**

Neutron Therapy (Tab 26)
David Beyer, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)
Jeffrey DeManes, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)

The CPT Editorial Panel created two new codes and revised one code to allow for more specificity in CPT for radiation treatment delivery, and to recognize high energy neutron therapy that is greater than 45MeV. The new codes now reflect the actual resources used in delivering neutron therapy and enable tracking and monitoring of this modality. Neutron therapy facilities require a

high capital investment, and therefore only three neutron therapy facilities exist in the United States for this non-physician service. These facilities continue to draw patients from all over the United States, and many countries throughout the world.

The RUC then carefully reviewed the practice expense inputs for the two new codes. The RUC had minor changes regarding the clinical staff type and medical supplies in the non-facility setting. **The RUC recommends a total of 46 minutes of clinical labor time for code 774XX1 and 76 minutes for 774XX2. The RUC recommends no facility practice expense inputs for the codes, only non-facility practice expense inputs are recommended. The full revised practice expense recommendations from the RUC are attached.**

Caffeine Halothane Contracture Test (Tab 27)
James D. Grant, MD, American Society of Anesthesiologists (ASA)
Brenda Lewis, DO, American Society of Anesthesiologists (ASA)
Henry Rosenberg, MD, American Society of Anesthesiologists (ASA)
Joseph Tobin, MD, American Society of Anesthesiologists (ASA)

The CPT Editorial Panel created a new code under its Pathology and Laboratory procedures section, to identify individuals who are susceptible to malignant hyperthermia. Exposure to some common anesthetic agents can cause patients to develop an extremely high metabolic rate resulting in symptoms such as muscular rigidity and hyperthermia in excess of 110 degrees. Susceptibility to malignant hyperthermia is inherited, and the Caffeine Halothane Contracture Test is performed on patients who have a family history or past medical history that indicates susceptibility to this condition.

The RUC reviewed the physician work associated with the new code 89XXX *Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report.* The RUC and the specialty society believed that the survey responses included technical clinical time (60 minutes of pre-service time, 90 minutes of intra-service time and 60 minutes post service for a total of 210 minutes). The RUC and the specialty society agreed that the physician work reflected a much lower total time of 45 minutes (5 minutes pre-service and 40 minutes of post-service time). The RUC and the specialty society believed the revised physician time should be used in a building block approach resulting in a physician work relative value of 1.40.

The RUC also assimilated the work intensity of 89XXX to code 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (Work RVU = 1.33) and RUC approved code 88361 *Morphometric analyis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual using computer assisted technology* (Work RVU = 1.18). In addition, the work intensity of new code 89XXX was

understood to be similar to that of an E/M service for 45 minutes (.031 * 45 minutes = 1.40 RVUs). Considering the building block approach, and the comparison of codes with similar physician work intensity, **the RUC recommends a relative value of 1.40 for code 89XXX.**

The RUC recommends the following physician time for code 89xxx:

- **Total Pre-Service Time = 5 minutes**
- **Total Intra-Service Time = 0 minutes**
- **Immediate Post Service time = 40 minutes**

Practice Expense:
The RUC examined the direct practice expense inputs for code 89XXX with the understanding that the test requires significant clinical labor time to perform. This service is performed so rarely that a technologist may be required to dedicate as many as 5 hours per patient when the service is performed. The RUC recommends the attached non-facility direct practice expense inputs, and zero facility direct inputs for code 89XXX.

<u>Antroduodental Manometry (Tab 28)</u>
Joel Brill, MD, American Gastroenterological Association (AGA)

The CPT Editorial Panel created a new code 910XX *Duodenal motility (manometric) study* to assess small intestinal motility. It was believed that neither esophageal nor gastric motility studies provide information about duodenal and jejunal motility, and the new code allows for the reporting of this specific procedure.

The RUC discussed the work relative values in relation with the specialty selected key reference services: 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;*(000 global, Work RVU=1.25) and 91020 *Gastric motility study* (000 global, Work RVU=1.44).

The RUC agreed that this new code fits into the same family as its key reference services and believed that code 91020 was very similar in physician work, time, and effort. **The RUC recommends a relative value of 1.44 Work RVUs new code 910XX.**

The RUC reviewed the physician time components from the specialty survey and discussed them in relation to recently RUC reviewed codes: (91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation (*Work RVU=0.97) 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (Work RVU= 1.59), and 91037 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;*(Work RVU=0.97), and believed this new code

should have similar time components as the rest of its' family. The codes intra-service work per unit of time was agreed to be approximately equivalent to .025. With this knowledge**, the RUC recommends the following physician time components for code 910XX**:

- **Pre-Service Evaluation time = 15 minutes**
- **Intra-Service Time = 30 minutes**
- **Immediate post operative time = 16 minutes**

Practice Expense

The RUC made some modifications to the clinical labor time to reflect changes in physician time, and reallocated existing time to appropriate clinical activity components. In addition, the specialty believed that the disposable catheter in line 73 of the medical supplies should be deleted as it would not typically be used. **The modified practice expense inputs are attached to this report and recommended by the RUC.**

Physician Liability Crosswalk

The facilitation committee believed that an appropriate crosswalk code for the physician liability is its reference code 91020 , and recommends this crosswalk to the RUC.

Continuous Glucose Monitoring Interpretation (Tab 29)
Sethu K. Reddy, MD, American Association of Clinical Endocrinologists (AACE)

The CPT Editorial Panel created a new CPT code 9525X *Ambulatory continuous glucose monitoring of for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report* as a substitute for reporting an Evaluation and Management code for this service. The RUC reviewed survey data from 37 endocrinologists and agreed that the 25th percentile of the survey work value (0.85) appeared to be appropriate. The RUC also agreed that this service would require approximately 30 minutes of physician time, including interpretation of over 900 glucose values, overlayed with a patient log of several variables (caloric intake, physical activity, symptoms of hypo- or hyper-glycernia, and other symptoms as they occur). **The RUC recommends a work relative value of 0.85 for CPT code 9525X.**

Practice Expense Inputs

All practice expense inputs associated with this service are included in CPT code 95250. Therefore, there are no direct practice expense input recommendations for CPT code 9525X.

Education and Training for Patient Self Management (Tab 30)
Sethu K. Reddy, MD, American Association of Clinical Endocrinologists (AACE)
Jane White, PhD, American Dietetic Association (ADiA)

The CPT Editorial Panel created new codes to describe educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional. There is no physician work associated with these services. The RUC considered recommendations for direct practice expense inputs only. The RUC reviewed inputs for CPT code 97XX1 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient* only. The RUC recommended that the coding for group education be referred back to CPT for further consideration.

The revised practice expense inputs are attached to this recommendation.

Inpatient Follow-Up and Confirmatory Consultations (Tab 31)

The RUC briefly discussed the work neutrality implications of deleting the inpatient follow-up and confirmatory consultation CPT codes in CPT with cross-references to report other existing CPT codes. The RUC understands that CMS will have the work neutrality impact analysis complete by the April RUC meeting. The RUC will discuss this issue at that time.

XI. Practice Expense Review Committee Report (Tab A)

Doctor Moran called the group to order and explained to the members that the committee was under a tight timeframe to finish all of its work during the meeting. Doctor Moran also reminded the group that the PERC will refine all of the remaining unclaimed codes in tab V of the agenda book with or without specialty input from the specialty groups. Tab V of the agenda book contained codes that had no specialty society interest. AMA staff had contacted specialties for the refinement of the codes several times however no inputs were received for any of the codes. The PERC reviewed all of its existing codes (156) on its agenda, and the practice expense recommendations for the RUC. At the conclusion of this meeting, the PEAC/PERC's refinement of existing codes was complete.

XII. RUC HCPAC Review Board Report (Tab B)

The HCPAC welcomed the American Occupational Therapy Association's (AOTA) new HCPAC alternate Terry A. Moon, OTR/L and announced the American Nurses Association's (ANA) new HCPAC member Katherine Bradley, PhD, RN. Then the HCPAC approved the revised HCPAC MPC List.

The American Psychological Association's (APA) updated the HCPAC on its efforts to seek the Research Subcommittee input and approval of the proposed education information, survey edits and reference services list of the neurobehavioral status exam and psychological testing codes which will be presented to the HCPAC in April 2005.

The American Speech-Language-Hearing Association (ASHA), informed the HCPAC on codes which they have submitted to CMS for the upcoming Five-Year Review. ASHA is requesting that services performed by speech-language pathologists and audiologists be assigned a physician work value similar to the physical and occupational therapists.

The American Dietetic Association (ADiA), updated the HCPAC on issues surrounding the medical nutrition therapy codes due to a change in the services provided. ADA is currently trying to discern the best method to address these issues, which could potentially include (1) modifying existing codes to adequately reflect the services performed and (2) determining the benefits of their payment remaining in the non-physician work pool, changing their payment to traditional practice expense inputs or changing their payment to include physician work.

The HCPAC also heard discussions from various allied health professionals pertaining to changing their payment methodology, including requests made by ASHA and the issues surrounding the medical nutrition therapy codes. The HCPAC has decided to further study this issue and determine possible solutions.

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

XIII. Practice Expense Subcommittee Report (Tab C)

The Practice Expense Subcommittee met to discuss the future refinement of practice expense inputs, RUC member evaluation of practice expense inputs, and recent GAO and MedPAC reports.

The committee discussed specific areas of concern regarding the refinement of practice expense inputs and its methodology:

- Possibility of reviewing the direct inputs of specific codes reviewed early on in the Practice Expense Advisory Committee (PEAC) review process.
- The possibility of another Socioeconomic Monitoring Systems (SMS) survey in the near future.
- Possible revisions in the CMS' practice expense RVU methodology, specifically concerning the possibility of creating J codes for high priced disposable medical supplies

Doctor Moran and PEAC members have said that codes refined early in the process (1999-early 2001), were not evaluated at the same level as other codes reviewed later in the process. The PEAC evolved over time and used a more sophisticated evaluating process, using standards for certain clinical labor activities and supplies. The subcommittee discussed the possibility of re-reviewing all or some of the codes from the early years of the PEAC. However, CMS informed the committee that they were discussing the possibility of standardizing these codes and looking for outliers. The subcommittee had mixed enthusiasm in looking back at the PE inputs and agreed that this discussion should be postponed until there is clearer understanding of what CMS' review processes may involve.

The Subcommittee members also reiterated that the accuracy of SMS data and the scaling factors may have a significant impact on the practice expense relative values and should be updated. CMS representatives reported that they continuing to pursue a survey of MD and Non-MDs. It is expected that the Lewin Group will offer suggestions on how to proceed with gathering this new data in a report to be published in March 2005. In addition, CMS is continuing its efforts to transition all specialties out of the non-physician work pool.

In addition, Subcommittee also discussed the need for CMS to obtain accurate market data on its medical supply list, since high priced disposable medical supplies within a codes' direct practice expense can cause redistribution in practice expense pools and relative values when the scaling factors are applied. It was commented that the current CMS medical supply list prices may already be outdated even though it was updated last year.

The RUC members agreed that some mechanism should be in place to separate out high priced disposables medical supplies from the practice expense methodology, so that the inequities of the scaling factors do not cause as many anomalies in the practice expense specialty pools and in practice expense relative values: The RUC recommends that:

CMS be requested to set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

RUC Member Evaluation of Practice Expense Inputs

Doctor Moran presented a slide show for RUC members entitled: "How to Evaluate a Practice Expense Recommendation, Tips for RUC Members". Doctor Moran's presentation was very well received by the group, and PowerPoint slides are available to all by contacting AMA staff.

GAO and MedPAC Reports

The subcommittee briefly discussed the reports in their relevance to future practice expense direct input review, but made no recommendations

XIV. Five-Year Review Workgroup Report (Tab D)

Doctor Meghan Gerety, Chair of the Five-Year Review Workgroup, presented the Workgroup report to the RUC. Doctor Gerety informed the RUC that at this time, it is estimated specialty societies have submitted comments on more than 400 individual CPT codes. In addition, CMS is planning to submit codes that are potentially mis-valued. It is expected that the final list of codes will be submitted to the AMA by mid-February.

Doctor Gerety explained that CPT codes are likely to be included in the Five-Year Review that were not submitted by the specialties. A question arose regarding what action the RUC would take if a specialty chose to not express an interest in participating in reviewing a service identified by CMS. Although, several members noted that it is unlikely that a specialty would choose this course of action, it was recognized that the current action keys do not include an appropriate RUC action for such a scenario. **The Workgroup recommends that an eighth action key be added as follows:**

8 = No Level of Interest submitted, no RUC recommendation submitted.

The RUC proposal on the Five-Year Review and the CMS discussion in the November 15 *Final Rule* both indicate that the this third Five-Year Review should be based on potential mis-valuation of physician work. This decision was made after consideration that all CPT codes have recently been reviewed under the PEAC process. However, modification to the number and level of post-operative office visits and modifications to physician intra-service time for services performed in the office will result in changes to the clinical staff time. AMA staff will be supplying specialty societies with current

information on the ratio of intra-service clinical staff to physician time and office visit information to all specialty societies involved in the Five-Year Review process. **The Five-Year Review Workgroup proposes that a short addendum be included in the Specialty Summary of Recommendation form to capture these changes to allow for easy CMS application of these modifications.**

The Five-Year Review Workgroup Report was approved and is appended to these minutes.

XV. Professional Liability Insurance Workgroup Report (Tab E)

Doctor Gregory Przybylski, Chair of the Professional Liability Insurance (PLI) Workgroup, presented the Workgroup report to the RUC. Doctor Stephen Kamenetzky had presented the Workgroup with a progress update on his ability to obtain PLI data from the Physician Insurer Association of America (PIAA) for use in the CMS PLI methodology. The RUC is supportive of these efforts and offered to **send a letter to PIAA requesting their provision of PLI premium data to CMS. The letter should state that PIAA should only send the data to CMS if the agency is able to ensure confidentiality.**
Doctor Przybylski presented the PLI Workgroup recommendations to modify the crosswalk assumptions utilized by CMS. **The RUC recommends the following modifications to the risk factor assignments:**

- **As the PLI Workgroup understands that the following professions would not incur PLI premium rates greater than $6,152 per year, it appears appropriate to assign the current lowest risk factor of 1.00 for both non-surgical and surgical codes. This recommendation is considered an interim step. The PLI Workgroup believes that the PLI premium rates for the following may be substantially less than $6,152 and requests that CMS collect premium data for these professions.**

  Clinical Psychologist
  Licensed Clinical Social Worker
  Occupational Therapist
  Psychologist
  Optician
  Optometry
  Chiropractic
  Physical Therapist

- **The PLI Workgroup expresses concern about a number of specialties/professions that were assigned to an average "all**

physician" risk factor (3.04 non-surgical / 3.71 surgical). The Workgroup recommends that the following groups should have been treated as the other 34 Medicare specialties that were excluded from the analysis:

Certified Clinical Nurse Specialist
Clinical Laboratory
Multi-Specialty Clinic or Group Practice
Nurse Practitioner
Physician Assistant
Physiological Laboratory (Independent)

- **The PLI Workgroup recommends that CRNAs should be crosswalked to Anesthesiology (2.84), rather than to the "all physicians" category.**

- **The PLI Workgroup also noted that the rank order premium data appeared problematic for colorectal surgery and gynecologist/oncologist and recommends that these two specialties be crosswalked as follows:**

  Gynecologist/oncologist (current 5.63) should be crosswalked to surgical oncology (6.13 – based on crosswalk to general surgery).

  Colorectal surgery (4.08) should be crosswalked to general surgery (6.13).

- **The RUC recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

The RUC recommends that the RUC HCPAC review and discuss the above recommendations. The PLI Workgroup would also be willing to review any data provided by a professional group to refute the understanding that the annual PLI premium data is less than $6,100.

A RUC member expressed concern that the impact of these changes is unknown and requested that CMS publish this impact prior to any implementation. The RUC agreed and **recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

Doctor Przybylski explained that the American College of Cardiology (ACC) has requested that the RUC correct a clerical mistake created when the PLI Workgroup updated exceptions to the surgical risk factor assignment. The

PLI Workgroup agrees that it appears that a clerical mistake was made as the society never intended that these services be removed from the exception list. **The RUC recommends that CMS add back the following codes to the surgical risk factor list for cardiac catheterization (2.53):**

92980-92984
92985-92998
93617-93641

The RUC also recommends that 92975 be added to the cardiac catheterization (surgical risk factor) list based on the PLI Workgroup review of the cardiology codes.

The PLI Workgroup and the RUC discussed the dominant specialty approach and **recommends reaffirmation of the RUC recommendation that CMS utilize the dominant specialty in determining which specialty risk factor to apply to each CPT code.** The Workgroup noted that it was flexible regarding the percentage threshold in determining the definition of dominant specialty. CMS staff indicated an interest in discussing this issue via conference call with interested members of the PLI Workgroup. AMA staff will arrange this call in the near future. In addition, CMS indicated that it was performing an analysis of removing specialties from the utilization data if the specialty performs a small percentage of the service (eg, less than 5% of total utilization). CMS will share this analysis with the PLI Workgroup.

The RUC also agreed to engage in a review of aberrant data in low utilization services. AMA staff will list all CPT codes with Medicare utilization data of less than 100 claims. This list will include the current utilization by specialty and then an "expected specialty" indication based on staff review of placement in CPT, who reviewed at RUC/PEAC, etc. This list will be forwarded to all RUC Advisors for review and comment prior to the April 2005 RUC meeting.

XVI. Research Subcommittee Report (Tab F)

The Research Subcommittee discussed a proposal for a new survey methodology using magnitude estimation of intra-service work and using a building block methodology for pre and post-service work. **The subcommittee recommends approving the methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work but the survey should not contain intra-service times and IWPUT calculations.**

The subcommittee then discussed changes to the RUC survey for the Five-Year Review. In prior five-year reviews the RUC added a question to the

RUC survey to assist RUC members in evaluating how physician work has changed over the previous five years. The results were reported in the RUC Summary of recommendation form. The following question was added at the end of the survey during the last five-year review and the Research Subcommittee agreed to include the following question to the RUC survey for use in the upcoming five-year review.

Additional Question: The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.

Has the work of performing this service changed in the past 5 years?
Yes No

If Yes, please circle the response to questions a-c:

a. **This service represents new technology that has become more familiar (i.e., less work).**
   I agree
   I do not agree

b. **Patients requiring this service are now:**
   more complex (more work)
   less complex (less work)
   no change

c. **The usual site-of-service has changed:**
   from outpatient to inpatient
   from inpatient to outpatient
   no change

The Research Subcommittee reaffirmed its prior approval of the following Reference Service List guidelines to be added to the RUC survey instructions document. The new guidelines are as follows:

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**
- **Include several high volume codes typically performed by the specialty.**

The Research Subcommittee reviewed proposed changes to the RUC survey for the psychological and neuropsychological testing codes. The changes include changing references to "physician" to "professional" and including generic pre, intra, and post service time period definitions. **The subcommittee recommends approving the changes to the APA survey.**

The Research Subcommittee has been assigned the task of examining the family of ultrasound codes to determine if there rank order anomalies exist among the codes. A number of issues were raised such as the variability in ultrasound codes according to whether the procedure is a stand alone code, an add-on code or incorporated into another code. The subcommittee reviewed the list of codes and the calculated IWPUT for each of the codes. The subcommittee felt that to begin comparing the codes only the ultrasound portion of the code should be identified and a RVU and IWPUT be calculated. AMA staff in association with the Research Subcommittee will develop these calculations for subcommittee review. The subcommittee will attempt to use these calculations as a first step in identifying potential anomies.

The full report of the Research Subcommittee was approved by the RUC and is attached to these minutes.

XVII. Administrative Subcommittee Report (Tab G)

Doctor Chester Schmidt presented the Administrative Subcommittee report to the RUC. The Administrative Subcommittee met to discuss several issues including: 1.) CPT/RUC Meeting Dates, 2.) Re-review of RUC Recommendations- New Technology, 3.) Release of RUC Database to Specialty Society Representatives for Functions Not Pertaining to the RUC Process and 4.) Clarification of RUC Membership Criterion.

In its discussion of the CPT/RUC meeting dates, AMA Staff announced that at the April/May 2004 CPT Editorial Panel meeting, the Panel Members approved a motion changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. The Administrative Subcommittee was informed by AMA staff that CPT has finalized its annual calendar. The Administrative Subcommittee reviewed the timeline between all CPT and RUC Meetings and determined that there was sufficient time for specialty societies to develop RUC recommendations. **The Administrative Subcommittee recommended and the RUC approved the all of the RUC meeting dates for the 2007 CPT RUC cycle.**

At the April 2004 RUC Meeting, a RUC member indicated that there is no formal process to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. This issue was referred to the Administrative Subcommittee for discussion. **After careful consideration of this issue, the Administrative Subcommittee recommended and the RUC approved that these codes should be identified, and the following process for formalized review should be implemented:**

The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.

At the September RUC meeting the Administrative Subcommittee recommended to the RUC that the RUC Database be released to the Specialty Societies for use outside of the CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims). The RUC extracted this item and tabled its discussion pending review by the AMA legal department.

AMA Staff met with Andrea Cooper-Finkle, JD, Senior Division Counsel for the AMA to obtain a legal review of this issue. Ms. Cooper-Finkle delivered a presentation to the Administrative Subcommittee to describe the findings of the AMA. Ms. Cooper-Finkle began by describing some history pertaining to this request. She stated that a request to release the RUC database to the public was first made several years ago. The AMA Legal Counsel at that time sought an opinion from the Justice Department which was referred to the Federal Trade Commission (FTC) opinion for legal review of this issue. The FTC in its opinion stated that releasing the RUC database to the public would not violate anti-trust laws and could also potentially have pro-competitive benefits. However, the response also may be interpreted that limiting distribution of the RUC database to selective recipients for use outside the CPT/RUC process may violate anti-trust laws. Therefore it is the opinion of the AMA Legal Counsel that the RUC database not be distributed to specialty society representatives for functions not pertaining to the RUC process as it may lead to a violation of the anti-trust laws.

After much discussion pertaining to the legal issues surrounding the release of the database, the Administrative Subcommittee recommended and the RUC approved the following motion:

The RUC database will not be distributed to the specialty society representatives for functions not pertaining to the RUC process.

The Administrative Subcommittee then discussed releasing the RUC database to the public. The members of the Administrative Subcommittee discussed the FTC's opinion that the release of the database could potentially have pro-competitive benefits. The Administrative Subcommittee understands the FTC's opinion and agrees that both providers and payors should have equal access to this information. Other issues discussed by the Administrative Subcommittee included: 1.) the logistical distribution of the RUC database, 2.) the creation of new licenses to use the RUC database and 3.) the creation of new potential AMA products that would be affordable to individual proprietors to avoid an asymmetrical distribution of this data. The Administrative Subcommittee recommended and the RUC approved the following motion:

AMA staff will explore options for the public release of the RUC database with input from AMA Senior Management and AMA Legal Counsel with the objective of a symmetrical distribution amongst all potential recipients.

In April 2004, The RUC received a request from the American College of Physicians (ACP), to provide clarification regarding the first criterion for a permanent seat on the RUC, as stated in the "Criteria for Participation" section of the RUC Structure and Functions document. The Criteria for Participation as approved at the April 2002 RUC Meeting reads as follows:

1.) The specialty is an ABMS Specialty
2.) The specialty comprises 1 percent of physicians in practice
3.) The specialty comprises 1 percent of physician Medicare expenditures
4.) Medicare revenue is at least 10 percent of mean practice revenue for the specialty
5.) The specialty us not meaningfully represented by an umbrella organization, as determined by the RUC

In September 2004, this issue was discussed by the Administrative Subcommittee and Doctor Leahy of the ACP gave a brief presentation regarding this request and clarified that not only was his society seeking clarification but also was requesting that this criterion be assessed to determine its suitability as a criterion for a permanent seat on the RUC. The Administrative Subcommittee decided that the further assessment of the first criterion for RUC membership, related to ABMS specialties, was needed.

Since September 2004, AMA staff has received 6 additional letters:

1.) A joint letter from the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), the American Society for Hematology (ASH) and the American Society for Clinical Endocinology (ASCO) requesting three permanent seats on the RUC for pulmonary medicine, gastroenterology and hematology-oncology.
2.) A letter from the American Board of Internal Medicine supporting the original ACP recommendation that general certificates and sub-specialty certificates that are approved by the American Board of Medical Specialties meet the first criterion for a permanent seat on the RUC, the specialty is an ABMS specialty
3.) A letter from ACP supporting the organizations representing the internal medicine subspecialties of gastroenterology, pulmonary medicine and hematology/oncology in their request for each subspecialty to receive a permanent seat on the RUC
4.) A letter form ASH and ASCO requesting a permanent seat on the RUC for hematology/oncology
5.) A letter from ACCP and ATS requesting a permanent seat on the RUC for pulmonary medicine and
6.) A letter from ACG, AGA and ASGE requesting a permanent seat on the RUC for gastroenterology

The Administrative Subcommittee, after much discussion amongst its members and members of the aforementioned societies, determined that before the requests made by the specialties could be assessed, the charge of the Subcommittee must be addressed, namely the clarification of the term ABMS specialty. The Administrative Subcommittee determined after reviewing documents from June 1991 pertaining to the proposed composition of the RUC that this criterion upon its creation refers to the 24 approved ABMS specialty boards. Therefore the Administrative Subcommittee recommended and the RUC approved the following motion:

The first criterion for a permanent seat on the RUC, as currently stated in the "Criteria for Participation" section of the RUC Structure and Functions document, the specialty is an ABMS specialty, refers to the 24 approved ABMS specialty boards. All other specialties currently represented on the RUC with permanent seats should be grandfathered on the RUC regardless of inclusion or exclusion on this list of 24 ABMS specialties.

After this criterion had been clearly defined, the Administrative Subcommittee discussed the suitability of this criterion. Several members felt that this criterion as defined is an antiquated view of the ABMS certification.

Therefore, the Administrative Subcommittee recommended the following motion:

The first criterion for a permanent seat on the RUC, as currently state in the "Criteria for Participation" section of the RUC Structure and Functions document, "The specialty is an ABMS specialty," should be amended to read,

1.) The specialty or subspecialty has an approved general certificate or subspecialty certificate of an ABMS Member Board.

The RUC carefully reviewed this language and after lengthy discussion with input from the societies requesting RUC membership, voted on the subcommittee recommendation.

The motion failed.

The RUC passed a motion to record the vote on this subcommittee recommendation. The RUC did not approve this motion by a two-thirds vote. Twenty-six members voted, thirteen members voted in favor of the motion and thirteen members opposed the motion.

XVIII. Other Issues

<u>Immunization Administration (PE only) (Tab H)</u>
Richard Tuck, MD, American Academy of Pediatrics (AAP)

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) presented the direct practice expense input recommendations for consideration during the February 2005 RUC meeting. In an effort to ensure that the direct practice expense inputs for the immunization administration codes are also consistent with the Drug Administration inputs, AAP, AAFP, and AAP presented revised direct practice expense input recommendations for the RUC's consideration. The RUC agreed with these revised recommendations and will submit them to CMS when the recommendations from the February 2005 PERC recommendations are submitted in March.

A RUC member requested that AMA legal staff brief the RUC on the legal liability protection provided to RUC participants. Specifically it was requested that the RUC receive a briefing as well as a written description of the type of legal protection provided to RUC participants in the event of a lawsuit related to participation in the RUC process. Doctor Rich agreed to have AMA

staff request that AMA legal staff provide a briefing during the April RUC meeting.

Doctor Whitten then reminded RUC members that they are not to serve as both RUC members and RUC advisors. This is apparent in the Structure and Functions book, Advisory Committee section B(3) "Specialty Society representatives, to the extent practicable, shall not be the same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee."

A RUC member requested that the AMA HOD Resolution regarding criteria for individuals who are members of the RUC and CPT Editorial Panel. AMA staff has responded to the HOD by including the following statement in all RUC nomination letters: "The AMA requests that you nominate an individual who is currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely-related activities."

The meeting adjourned on Saturday, October 2, 2004 at 12:00 p.m.

AMA/Specialty RVS Update Committee
Practice Expense Review Committee
February 1-2, 2005

Bill Moran, MD (Chair)	Gregory Kwasny, MD
James Anthony, MD	Peter McCreight, MD
Joel Brill, MD	Tye Ouzounian, MD
Neal Cohen, MD	James B. Regan, MD
Thomas A. Felger, MD	Anthony Senegore, MD

Call to Order
Doctor Moran called the group to order and explained to the members that the committee was under a tight timeframe to finish all of its work during the meeting. Doctor Moran also reminded the group that the PERC will refine all of the remaining unclaimed codes in tab V of the agenda book with or without specialty input from the specialty groups. Tab V of the agenda book contained codes that had no specialty society interest. AMA staff had contacted specialties for the refinement of the codes several times however no inputs are received for any one of the codes. At the conclusion of this meeting, the PEAC/PERC's refinement of existing codes was complete.

CMS Update Ken Simon, MD of CMS provided the following CMS update to the group:

- CMS continues its effort to implement many of the components of the MMA legislation.
- CMS will provide a list of codes they believe should be reviewed at the upcoming 5 year review. This list is expected to be sent to the AMA late in Februrary.
- Pay for performance initiatives are in the works at CMS for physicians that provide outstanding care to Medicare and Medicaid beneficiaries and link it to electronic medical records keeping. The idea is to provide incentives for high quality physician services. Currently, there are some demonstration projects underway, however many details still need to be finalized. Any national change in the payment methodology however, would need Congressional approval.

Specialty Society Requests and Specific Committee Recommendations

The committee discussed and made decisions on the following Specialty Society Special Requests:

1. The American Academy of Pediatrics and the Society of Thoracic Surgeons requested that code 33961 *(prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours)* be added to the PERC agenda with code 33960 *(prolonged extracorporeal circulation for cardiopulmonary insufficiency: initial 24 hours).* The PERC granted the society's request to add code 33961 to the agenda, and both codes were recommended to have no direct practice expense inputs per the specialty's request.

2. The American Academy of Neurology (AAN) requested the PERC add the family of Electroencephalography codes 95812 – 95822 to its agenda to update the direct practice expense inputs. The Centers for Medicare and Medicaid Services encouraged AAN to revisit the codes at this meeting. The PERC granted the society's request and made a revised direct practice expense recommendation for the family of codes.
3. The American Dietetic Association requested the PERC add three medical nutrition therapy (MNT) codes (97802, 97803, and 97804) to its agenda. The PERC reviewed the society's request, provided their recommendations to the society, and referred the issue to the RUC's HCPAC for resolution, because these codes had been previously reviewed by the HCPAC.
4. The American Academy of Pediatrics requested the PERC that code 92551 (*screening test, pure tone, air only)* be reviewed for direct practice expense inputs during this meeting. Code 92551 had not been through the RUC and had zero total relative value units assigned on the Medicare physician fee schedule. The PERC granted the specialty's request, and reviewed and refined the specialty recommendations.
5. The American Society of Gastrointestinal Endoscopy and the American Gastroenterological Association requested codes 89105-89141 be added to the PERC agenda in order to complete the family of codes that were on the agenda under the unclaimed code section. The PERC granted the society's request and reviewed and revised the entire family of codes together.
6. The Joint Council of Allergy, Asthma and Immunology provided direct practice expense inputs to the PERC for codes 95071 and 95075, however were unable to present. The PERC reviewed the Council's recommendations and modified them according to PERC standards and its understanding of the procedures.

Code Specific RUC Practice Expense Recommendation – February 2005
The PERC recommended no practice expense inputs for the following codes in either the non-facility or facility settings:

00104	32960	76975	86585
00124	33960	78182	90997
15852	33961	78350	93561
31730	76940	78351	93562

The PERC also made the recommendations regarding the unclaimed codes that were listed in Tab V of the agenda book:

- Codes 78160, 78162, 78170, 78172, 78182, 78350, 78351, and 78455 were recommended to be NA in the non-facility setting and zero inputs in the facility, and will be recommended for deletion by the Society of Nuclear Medicine and the American College of Radiology in February

2005. *(Staff note: Codes 78160, 78162, 78170, 78172, and 78455 were recommended for deletion in February 2005)*

- 38794 is a 90 day global and the standards would be applied
- The following codes are recommended to have zero inputs in the facility setting and NA in the non-facility setting: 15851, 90997, 93561, 93562, 95060, and 95065
- Codes 95078 will be recommended for deletion by the American Academy of Pediatrics
- Codes 99185 and 99186 will be recommended for deletion by the American Academy of Neurology

Codes Reviewed at the February 2005 PERC Meeting

CPT Code	*Descriptor*	*Specialty*
11975	Insert contraceptive cap	ACOG
11976	Removal of contraceptive cap	ACOG
11977	Removal/reinsert contra cap	ACOG
15342	Cultured skin graft, 25 cm	APMA, ASPS, ABA
15343	Culture skn graft addl 25 cm	APMA, ASPS, ABA
15775	Hair transplant punch grafts	ASPS
15776	Hair transplant punch grafts	ASPS
15851	Removal of sutures	PERC
15852	Dressing change not for burn	ACS
17250	Chemical cautery, tissue	AAD
17304	1 stage mohs, up to 5 spec	AADA
17305	2 stage mohs, up to 5 spec	AADA
17306	3 stage mohs, up to 5 spec	AADA
17307	Mohs addl stage up to 5 spec	AADA
17310	Mohs any stage > 5 spec each	AADA
17360	Skin peel therapy	AADA
19000	Drainage of breast lesion	ACS
19396	Design custom breast implant	ASPS
21300	Treatment of skull fracture	AANS/CNS
21310	Treatment of nose fracture	AAFP
31700	Insertion of airway catheter	ACCP
31730	Intro, windpipe wire/tube	ACCP
31730	Intro, windpipe wire/tube	ACCP
32960	Therapeutic pneumothorax	STS
33960	External circulation assist	AAP, STS
33961	External circulation assist	AAP/STS
36860	External cannula declotting	PERC
36860	External cannula declotting	PERC
38230	Bone marrow collection	ASH
38794	Access thoracic lymph duct	PERC
41250	Repair tongue laceration	AAO-HNS
41251	Repair tongue laceration	AAO-HNS, AAOMS
41252	Repair tongue laceration	AAO-HNS, AAOMS
42100	Biopsy roof of mouth	AAO-HNS
42104	Excision lesion, mouth roof	AAO-HNS, AAOMS
42106	Excision lesion, mouth roof	AAOMS

42107	Excision lesion, mouth roof	AAO-HNS, AAOMS
42160	Treatment mouth roof lesion	AAO-HNS
43750	Place gastrostomy tube	ACS, ACR, SIR
43760	Change gastrostomy tube	ASGE, AGA, ACR, SIR
47000	Needle biopsy of liver	ACR
48102	Needle biopsy, pancreas	ACR, SIR
48102	Needle biopsy, pancreas	ACR, SIR
49080	Puncture, peritoneal cavity	ACR, SIR
49081	Removal of abdominal fluid	ACR, SIR
49428	Ligation of shunt	ACS
51000	Drainage of bladder	AUA
51005	Drainage of bladder	AUA
54450	Preputial stretching	AUA
56420	Drainage of gland abscess	ACOG
57150	Treat vagina infection	ACOG
57170	Fitting of diaphragm/cap	ACOG
57180	Treat vaginal bleeding	ACOG
58300	Insert intrauterine device	ACOG
58323	Sperm washing	ACOG
59160	D & c after delivery	ACOG
59300	Episiotomy or vaginal repair	ACOG
60000	Drain thyroid/tongue cyst	ACS
60001	Aspirate/inject thyriod cyst	ACR, SIR
61888	Revise/remove neuroreceiver	AANS/CNS
62194	Replace/irrigate catheter	AANS/CNS
67221	Ocular photodynamic ther	AAO
67225	Eye photodynamic ther add-on	AAO
69300	Revise external ear	AAO-HNS
76120	Cine/video x-rays	ACR
76940	Us guide, tissue ablation	ACR, SIR
76942	Echo guide for biopsy	SIR
76975	GI endoscopic ultrasound	PERC
78160	Plasma iron turnover	PERC
78162	Radioiron absorption exam	PERC
78170	Red cell iron utilization	PERC
78172	Total body iron estimation	PERC
78282	GI protein loss exam	PERC
78350	Bone mineral, single photon	SNM
78351	Bone mineral, dual photon	PERC
78351	Bone mineral, dual photon	PERC
78455	Venous thrombosis study	PERC
79200	Intracavitary nuclear trmt	SNM
79300	Interstitial nuclear therapy	SNM
79440	Nuclear joint therapy	SNM
86585	TB tine test	AAP
88355	Analysis, skeletal muscle	CAP
88356	Analysis, nerve	CAP
89100	Sample intestinal contents	AGA, ASGE
89105	Sample intestinal contents	AGA, ASGE
89130	Sample stomach contents	PERC
89130	Sample stomach contents	PERC
89132	Sample stomach contents	PERC

89132	Sample stomach contents	PERC
89135	Sample stomach contents	PERC
89135	Sample stomach contents	PERC
89136	Sample stomach contents	PERC
89136	Sample stomach contents	PERC
89140	Sample stomach contents	PERC
89140	Sample stomach contents	PERC
89141	Sample stomach contents	PERC
89141	Sample stomach contents	PERC
90871	Electroconvulsive therapy	PERC
90880	Hypnotherapy	APA
90997	Hemoperfusion	PERC
92551	Pure tone hearing test, air	AAP
93561	Cardiac output measurement	PERC
93562	Cardiac output measurement	PERC
94014	Patient recorded spirometry	ACCP
94014	Patient recorded spirometry	ACCP
94015	Patient recorded spirometry	ACCP
94015	Patient recorded spirometry	ACCP
94016	Review patient spirometry	ACCP
94016	Review patient spirometry	ACCP
94200	Lung function test (MBC/MVV)	ACCP
94200	Lung function test (MBC/MVV)	ACCP
94250	Expired gas collection	ACCP
94250	Expired gas collection	ACCP
94350	Lung nitrogen washout curve	ACCP
94350	Lung nitrogen washout curve	ACCP
94370	Breath airway closing volume	ACCP
94370	Breath airway closing volume	ACCP
94400	CO2 breathing response curve	ACCP
94400	CO2 breathing response curve	ACCP
94620	Pulmonary stress test/simple	ACCP
94620	Pulmonary stress test/simple	ACCP
94660	Pos airway pressure, CPAP	ACCP
94660	Pos airway pressure, CPAP	ACCP
94667	Chest wall manipulation	ACCP
94667	Chest wall manipulation	ACCP
94668	Chest wall manipulation	ACCP
94668	Chest wall manipulation	ACCP
94680	Exhaled air analysis, o2	ACCP
94680	Exhaled air analysis, o2	ACCP
94681	Exhaled air analysis, o2/co2	ACCP
94681	Exhaled air analysis, o2/co2	ACCP
94690	Exhaled air analysis	ACCP
94690	Exhaled air analysis	ACCP
94725	Membrane diffusion capacity	ACCP
94725	Membrane diffusion capacity	ACCP
94750	Pulmonary compliance study	ACCP
94750	Pulmonary compliance study	ACCP
95060	Eye allergy tests	PERC
95065	Nose allergy test	PERC
95071	Bronchial allergy tests	JCAAI

95075	Ingestion challenge test	JCAAI
95078	Provocative testing	PERC
95805	Multiple sleep latency test	ACNS, AASM, AAN
95812	Eeg, 41-60 minutes	AAN
95813	Eeg, over 1 hour	AAN
95816	Eeg, awake and drowsy	AAN
95819	Eeg, awake and asleep	AAN
95822	Eeg, coma or sleep only	AAN
95950	Ambulatory eeg monitoring	ACNS, AAN
95950	Ambulatory eeg monitoring	ACNS, AAN
95954	EEG monitoring/giving drugs	ACNS, AAN
95954	EEG monitoring/giving drugs	ACNS, AAN
95956	Eeg monitoring, cable/radio	ACNS, AAN
95956	Eeg monitoring, cable/radio	ACNS, AAN
99185	Regional hypothermia	PERC
99186	Total body hypothermia	PERC

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
February 3, 2005

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Dale Blasier, MD
Jonathan Cooperman, PT
Robert Fifer, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
Marc Lenet, DPM
Antonio Puente, PhD
Christopher Quinn, OD
Doris Tomer, LCSW
Arthur Traugott, MD
Jane White, PhD, RD, FADA

I. Administrative Issues

Mary Foto, OTR, welcomed the American Occupational Therapy Association's (AOTA) new HCPAC alternate Terry A. Moon, OTR/L and announced the American Nurses Association's (ANA) new HCPAC member Katherine Bradley, PhD, RN.

II. CMS Update

Pam West, MPH, PT, provided a CMS update and informed the HCPAC that there is the new HHS Secretary, Michael Leavitt, former Administrator of the EPA and former Utah Governor. Mr. Leavitt will continue to follow current HHS program initiatives. CMS also indicated that they have received comments from specific societies regarding the November 2005 Final Rule concerning future Five-Year Review refinement.

III. HCPAC MPC

The HCPAC reviewed the revised HCPAC MPC list. The HCPAC identified that the list of societies most frequently performing the procedures listed in the HCPAC MPC list are calculated by CMS based on Medicare frequency data and may not necessarily capture all the top specialties actually performing these services. The HCPAC will submit the approved HCPAC MPC list to CMS.

IV. Psychological Testing Update

Antonio Puente, PhD, and James Georgoulakis, PhD, of the American Psychological Association (APA), informed the HCPAC that they will be seeking the Research Subcommittee's input and approval of the proposed education information, survey edits and reference service list for the neurobehavioral status exam and psychological testing codes. These codes were presented and approved at the November 2004 CPT meeting and the work and practice expense will be presented to the HCPAC at its meeting in April 2005.

V. Work as Part of the Reimbursement Formula

Robert Fifer, PhD, of the Speech-Language-Hearing Association (ASHA), informed the HCPAC that ASHA has submitted codes to CMS to be reviewed in the upcoming Five-

Year Review. ASHA is requesting that the services performed by speech-language pathologists and audiologists be assigned a physician work value similar to the physical and occupational therapists. ASHA contends audiologists and speech-language pathologists independently provide the clinical service and interpret the tests performed. Currently, their efforts are captured in the practice expense component of the RBRVS. However, these services describe their work rather than any staff that they do not employ. CMS indicated that if a society believes that specific codes should now contain physician work and they have pursued this request as part of the Five-Year Review process. CMS is considering this request and will forward this request to the RUC if the agency decides that this work effort should be captured under the work component versus the practice expense component. A RUC member and advisor voiced opposition regarding audiologist's interpretations versus a physician's interpretation of test results.

VI. Other Issues

Jane White, PhD, RD, FADA, of the American Dietetic Association (ADA), updated the HCPAC on issues surrounding the medical nutrition therapy codes due to a change in the services provided. ADA is currently trying to discern the best method to address these issues, which could potentially include (1) modifying existing codes to adequately reflect the services performed and (2) determining the benefits of their payment remaining in the non-physician work pool, changing their payment to traditional practice expense inputs or changing their payment to include physician work.

The HCPAC heard discussions from various allied health professionals pertaining to changing their payment methodology, including requests made by ASHA and the issues surrounding the medical nutrition therapy codes. The HCPAC has decided to further study this issue and determine possible solutions.

The RUC HCPAC reviewed the psychotherapy codes which were approved by the PERC. The practice expense for codes 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient* and 90808 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient* will be cross-walked to 90880 *Hypnotherapy*.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report – February 3, 2005

The Practice Expense Subcommittee met during the February 2005 RUC meeting to discuss the future refinement of practice expense inputs, RUC member evaluation of practice expense inputs, and recent GAO and MedPAC reports. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Siegel, Strate, and Weirsema.

Future Refinement of Practice Expense Inputs

Doctor Zwolak began the committee's discussion by identifying specific areas of concern regarding the future refinement of practice expense inputs:

- Possibility of reviewing the direct inputs of specific codes reviewed early on in the Practice Expense Advisory Committee (PEAC) review process.
- The possibility of another Socioeconomic Monitoring Systems (SMS) survey in the near future.
- Possible revisions in the CMS' practice expense RVU methodology.

Doctor Zwolak first commended the efforts of Doctor Moran and the PEAC members in providing such an accurate set of direct practice expense data, however he noted that there may be more work to be done. Doctor Moran expressed three areas where the data/methodology could be further refined.

1. Most PEAC members would readily say that codes refined early in the process (1999-early 2001), were not evaluated at the same level as other codes reviewed later in the process. The PEAC evolved over time and used a more sophisticated evaluating process, using standards for certain clinical labor activities and supplies.
2. Over time there can be a significant change in the costs incurred for disposable medical supplies, and it is important to keep up to date prices of those supplies as well as having an understanding that there could be lower priced substitutes.
3. There could be a shift of practice patterns from one site of service to another, and there is no current mechanism going forward, other than the Practice Expense Review Committee (PERC) process.

Some members of the subcommittee believed that there is a need to go back to early PEAC recommendations and bring all of the recommendations back for review. Others subcommittee members believed that it should be up to the specialty as to what codes should be re-reviewed. Regardless of the methodology used, the value of revisiting the direct inputs of the codes would be to improve the accuracy of the data. If this type of review were initiated, some subcommittee members believed that a larger committee with more specialty diversity (more than the current PERC), would be necessary to achieve more checks and balances in the refinement process.

One option mentioned, in an effort to improve the data, was to apply the standard clinical labor times to these earlier refined codes. There was some support for this option. CMS

representatives believed that there wouldn't be a large number of codes that would need further review because the PEAC and PERC process has already re-reviewed several codes. The goals that CMS sees in any future practice expense review are to assure themselves of having the most accurate set of direct practice expense inputs and to provide stability in the practice expense relative values. CMS does not now foresee a need for an extensive re-review of all of the direct inputs in the near future, since the PEAC and PERC review processes have just concluded. CMS also mentioned that they may be looking into hiring a contractor to review all of the early practice expense recommendations to identify codes where the standards were not applied. The subcommittee had mixed enthusiasm in looking back at the PE inputs and agreed that a decision by the RUC should be postponed until there is clearer understanding of what CMS' review processes may involve.

The subcommittee members also reiterated that the accuracy of SMS data and the scaling factors may have a significant impact on the practice expense relative values and should be updated. CMS representatives reported that they will continue consider a survey of MD and Non-MDs, which may cost at least $1.5 million. It is expected that the Lewin Group will offer suggestions on how to proceed with gathering this new data in a report to be published in March 2005. In addition, CMS is continuing its efforts to transition all specialties out of the non-physician work pool.

The subcommittee also discussed the need for CMS to obtain accurate market data on its medical supply list, since high priced disposable medical supplies within a codes' direct practice expense can cause redistribution in practice expense pools and relative values when the scaling factors are applied. It was commented that the current CMS medical supply list prices may already be outdated even though it was recently updated. It is also understood that updating the medical supply list is a large task.

There was much discussion whether it would be appropriate to separate out the high priced disposable items from the direct practice expense inputs. CMS mentioned that there is a mechanism for this type of separation on the inpatient side and there are specific guidelines and dollar thresholds that apply. CMS also stated that one of the purposes of the resourced based methodology was to include all the items used in the service, but it was noted by a subcommittee member that the costs of drugs have been separated. The subcommittee members and the RUC agreed that some mechanism should be in place to separate out high priced disposables medical supplies, from the practice expense methodology so that the inequities of the scaling factors do not cause as many anomalies in the practice expense specialty pools and in practice expense relative values: The RUC recommends:

CMS be requested to set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

Members of the subcommittee believed that an initial reasonable threshold could be $250.00.

RUC Member Evaluation of Practice Expense Inputs

Doctor Moran presented a slide show for RUC members entitled: "How to Evaluate a Practice Expense Recommendation, Tips for RUC Members". Doctor Moran's presentation was very well received by the group, and PowerPoint slides are available to all by contacting AMA staff.

GAO and MedPAC Reports

The subcommittee briefly discussed the reports in their relevance to future practice expense direct input review, but made no recommendations

AMA/Specialty Society RVS Update Committee
Five-Year Review Workgroup
February 3, 2005

The Five-Year Review Workgroup met on Thursday, February 3, 2004 to discuss the scope of the Five-Year Review of the RBRVS, procedural and practice expense related issues. The following Workgroup members participated: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, J. Leonard Lichtenfeld, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Scope of the Five-Year Review

The Workgroup was informed that CMS has received comments to review approximately 400 potentially mis-valued CPT codes. These comments were submitted by specialty societies and a few individuals. CMS is also in the process of creating a list of codes that the agency will also include in the Five-Year Review process. It is predicted that the total volume of codes to be reviewed in this Five-Year Review will be less than or within the range of the volume of codes reviewed individually in both the 1995 Five-Year Review (1,000) and the 2000 Five-Year Review (870). Therefore, the Workgroup anticipates that a similar number of workgroups (eight) will be created to accommodate the process. The Five-Year Review Workgroups will be announced in April and will each have the opportunity to have an initial planning meeting at the April 2005 RUC meeting.

Procedural Issues

The Workgroup understands that CPT codes are likely to be included in the Five-Year Review that were not submitted by the specialties. A question arose regarding what action the RUC would take if a specialty chose to not express an interest in participating in reviewing a service identified by CMS. Although, several members noted that it is unlikely that a specialty would choose this course of action, it was recognized that the current action keys do not include an appropriate RUC action for such a scenario. **The Workgroup recommends that an eighth action key be added as follows:**

8 = No Level of Interest submitted, no RUC recommendation submitted.

The Workgroup clarified that each code identified in the Five-Year will be assigned to one of the eight workgroups. The Five-Year Review Workgroups will consider each comment and data and will recommend the action for RUC consideration.

General anxiety was expressed regarding the identification of potentially mis-valued codes, including comments that efficiency in procedure time since the initial Harvard should not be penalized. Another Workgroup member proposed that surveys should not be required to conduct surveys for these codes, and specialties should instead be allowed to use expert panels. The Workgroup suggested that specialties request consideration of

such a methodology by the Research Subcommittee, if they feel it is necessary after reviewing the codes submitted for review.

Practice Expense Issues

The RUC proposal on the Five-Year Review and the CMS discussion in the November 15 *Final Rule* both indicate that the this third Five-Year Review should be based on potential mis-valuation of physician work. This decision was made after consideration that all CPT codes have recently been reviewed under the PEAC process. However, modification to the number and level of post-operative office visits and modifications to physician intra-service time for services performed in the office will result in changes to the clinical staff time. AMA staff will be supplying specialty societies with current information on the ratio of intra-service clinical staff to physician time and office visit information to all specialty societies involved in the Five-Year Review process. **The Five-Year Review Workgroup proposes that a short addendum be included in the Specialty Summary of Recommendation form to capture these changes to allow for easy CMS application of these modifications.**

One Workgroup member expressed concern that all of practice expense inputs should be open for refinement for each code in the Five-Year Review as changes in the service may apply to both practice expense and physician work.

AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
February 3, 2005

The following members of the Professional Liability Insurance (PLI) Workgroup met on February 3, 2005 to discuss numerous issues related to the CMS methodology to compute PLI relative values. Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith. Steve Phillips, Rick Ensor from the Centers for Medicare and Medicaid Services (CMS) and Doctor Stephen Kamenetzky participated in the meeting via conference call.

Professional Liability Insurance Premium Data

Doctor Stephen Kamenetzky provided an update to the PLI Workgroup on his efforts to secure PLI premium data from the Physician Insurer Association of America (PIAA) for use in CMS' PLI relative value methodology. He indicated that CMS has requested a pilot study of data related to six states: Iowa, Colorado, New York, Florida, Pennsylvania, and Texas. Doctor Kamenetzky believes that PIAA will be able to supply premium data for all physician specialties. PIAA has expressed an interest in cooperating on this project. PIAA has requested that confidentiality be ensured and that the AMA request PIAA cooperation in writing. Doctor Kamenetzky stated that PIAA may have a more complete dataset for the 93 Medicare specialties as well as tail coverage data, which CMS has acknowledged should be considered, but the data is not provided in their survey.

CMS staff participating in the meeting indicate that they would review the data related to the six states and would determine if such data could be utilized as a substitute for data currently utilized. If the data is helpful, CMS will request that the data be expanded to include all states. It was clarified that the earliest potential implementation of any such data would be in 2007. Therefore, CMS asked that PIAA submit 2004 and 2005 premium data as they are interested in using the most current data.

The PLI Workgroup recommends that the RUC send a letter to PIAA requesting their provision of PLI premium data to CMS. The letter should state that PIAA should only send the data if CMS will ensure confidentiality.

Review of Current Crosswalks and Risk Factor Assignments

CMS assigned PLI risk factors using PLI premium data for a specialty/non-surgical premium data for nephrology of $9,289 as an anchor with a 1.51 risk factor. CMS utilized various sources of premium data, including: 1) surveyed national premium data; 2) rating manuals from five insurers; 3) a combination of surveyed premium data and rating manuals; 4) crosswalk to another specialty; or 5) no risk factor was assigned for 34 specialties. The use of rating manuals alone was observed to possibly be associated with anomalous risk factor assignment. Mr. Ensor stated that the methodology utilizing

weight-averaging by relative value and location was the same for the rating manual and actual premium methods.

CMS indicated in the November 15 *Final Rule* they were interested in any RUC input on the appropriateness of the crosswalk assumptions. **The PLI Workgroup reviewed comments submitted by specialty societies and a summary table prepared by AMA staff and recommends the following modifications to the risk factor assignments:**

- **As the PLI Workgroup understands that the following professions would not incur PLI premium rates greater than $6,152 per year, it appears appropriate to assign the current lowest risk factor of 1.00 for both non-surgical and surgical codes. This recommendation is considered an interim step. The PLI Workgroup believes that the PLI premium rates for the following may be substantially less than $6,152 and requests that CMS collect premium data for these professions.**

Clinical Psychologist
Licensed Clinical Social Worker
Occupational Therapist
Psychologist
Optician
Optometry
Chiropractic
Physical Therapist

- **The PLI Workgroup expresses concern about a number of specialties/professions that were assigned to an average "all physician" risk factor (3.04 non-surgical / 3.71 surgical). The Workgroup recommends that the following groups should have been treated as the other 34 Medicare specialties that were excluded from the analysis:**

Certified Clinical Nurse Specialist
Clinical Laboratory
Multi-Specialty Clinic or Group Practice
Nurse Practitioner
Physician Assistant
Physiological Laboratory (Independent)

- **The PLI Workgroup recommends that CRNAs should be crosswalked to Anesthesiology (2.84), rather than to the "all physicians" category.**

- **The PLI Workgroup also noted that the rank order premium data appeared problematic for colorectal surgery and gynecologist/oncologist and recommends that these two specialties be crosswalked as follows:**

  Gynecologist/oncologist (current 5.63) should be crosswalked to surgical oncology (6.13 – based on crosswalk to general surgery).

  Colorectal surgery (4.08) should be crosswalked to general surgery (6.13).

- **The RUC recommends that CMS publish a separate impact analysis by specialty resulting from the change to these crosswalks.**

The PLI Workgroup recommends that the RUC HCPAC review and discuss the above recommendations. The Workgroup would also be willing to review any data provided by a professional group to refute the understanding that the annual PLI premium data is less than $6,100.

ACC Request for Reconsideration of Previous Action

The American College of Cardiology (ACC) has requested that the RUC correct a clerical mistake created when the PLI Workgroup updated exceptions to the surgical risk factor assignment. **The PLI Workgroup agrees that it appears that a clerical mistake was made as the society never intended that these services be removed from the exception list. The PLI Workgroup recommends that CMS add back the following codes to the surgical risk factor list for cardiac catheterization (2.53):**

92980-92984
92985-92998
93617-93641

The PLI Workgroup also recommends that 92975 be added to the cardiac catheterization (surgical risk factor) list based on their own review of the cardiology codes.

The PLI Workgroup did not agree to add CPT code 93556 to this list as it is an imaging supervision and interpretation service.

Dominant Specialty Approach/Review of Aberrant Data Patters in Low Utilization Services

In the November 15, 2004 *Final Rule* for the 2005 Medicare Physician Payment Schedule, CMS implemented the RUC recommendation to remove the assistant at surgery claims from the utilization data. In addition, CMS agreed to work with the RUC

to review aberrant data patterns in CPT codes with low utilization. However, CMS has stated that they do not plan to implement the dominant specialty approach at this time.

The PLI Workgroup discussed the dominant specialty approach and **recommends reaffirmation of the RUC recommendation that CMS utilize the dominant specialty in determining which specialty risk factor to apply to each CPT code.** The Workgroup noted that it was flexible regarding the percentage threshold in determining the definition of dominant specialty. CMS staff indicated an interest in discussing this issue via conference call with interested members of the PLI Workgroup. AMA staff will arrange this call in the near future. In addition, CMS indicated that it was performing an analysis of removing specialties from the utilization data if the specialty performs a small percentage of the service (eg, less than 5% of total utilization). CMS will share this analysis with the PLI Workgroup.

The PLI Workgroup also recommends that the RUC engage in a review of aberrant data in low utilization services. AMA staff will list all CPT codes with Medicare utilization data of less than 100 claims. This list will include the current utilization by specialty and then an "expected specialty" indication based on staff review of placement in CPT, who reviewed at RUC/PEAC, etc. This list will be forwarded to all RUC Advisors for review and comment prior to the April 2005 RUC meeting.

<u>Other Issues – AMA House of Delegates recent actions</u>

The consideration of removing PLI from the RBRVS system was revisited. Several Workgroup members commented that premiums are not based on the type and volume of procedures performed by the physician but rather the specialty of that physician. A resolution to the AMA House of Delegates as submitted by AANS-CNS requesting the AMA to study alternative methods to the current reimbursement of PLI in the RBRVS system. The resolution was referred to the AMA Board of Trustees for a report back to the AMA House of Delegates at the June 2005 Annual meeting. AMA RUC staff are responsible for preparation of this report. RUC members may contact Ms. Sherry Smith by March 1 if they have any information on this report.

AMA/Specialty Society RVS Update Committee
Research Subcommittee
February, 2005

Doctors Borgstede (chair), Blankenship, Cohen, Gage, Gerety, Levy, Lichtenfeld, Pfeifer, Plummer, Topping, and Tuck participated in the meeting.

Alternative Methodologies for the Five-Year Review
The Society of Thoracic Surgeons and the American Society of General Surgery presented proposed methodologies for the Research Subcommittee review for use in the upcoming five-year review.

STS presented a proposal for using a new methodology that would use the STS National adult Cardiac Database for the purpose of data acquisition and analysis. This database contains data for 2.8 million patients from 1989-2003 and includes intra-service time, length of ICU stay, and length of stay. The presenters contend that using these data and expert panels rather than the RUC survey would provide more accurate physician work relative value recommendations. Doctor Peter Smith explained in detail the database and the data validation that occurs nationally, regionally, and at the data entry point. STS plans on using 2004 data but also supplement with additional years if the volume is not sufficient on a code by code basis It is important to use the most recent data since these data include skin to skin operative time, which is a critical component of the building block methodology. STS proposed the following methodology using the STS database and expert panels and Rasch analysis:

1. Utilize mean STS database intra-operative time for skin-to-skin time.
2. Utilize an expert panel to develop a consistent pre-service time and post-discharge office visit profile for each code within the range of RUC database data.
3. Utilize STS database LOS and ICU data as a template for an expert panel to determine a consistent E&M profile of postoperative hospital visits for each code.
4. Utilize Rasch paired analysis to assist the expert panel in developing relative postoperative E/M work.
5. Utilize an expert panel to determine an IWPUT for each code, by either Rasch paired comparison or a modified Delphi technique, within the range of RUC database data.
6. Utilize STS database information to determine the number of additional postoperative E&M visits for add-on codes, assigning visit levels to match the E&M profile for each primary procedure code.
7. Apply the building block methodology to the data collected as described above to calculate total physician work for each code.

The Research Subcommittee members discussed the STS proposal in detail and complimented Doctor Peter Smith on his comprehensive presentation. Some members thought that the STS data would be highly accurate and possibly more accurate than the RUC survey. Others were concerned that more information on the composition of the expert panels and the Rasch analysis would be needed before making a final decision on

the appropriateness of the methodology. Also it was suggested that any potential data bias would need to be explained such as under reporting of intra-service time. The subcommittee discussion focused on the STS proposal to use the mean rather than the median, which has been the standard used by the RUC. STS presenters stated that since actual surgery time data are being used, and there is a high volume of data, a mean is more appropriate as is captures the entire range of physician work. STS also stated that the mean was more appropriate since the data show a non normal distribution of intra-service times and length of stay. The median values are used for time estimates collected by the RUC survey because generally there is a low number of responses with a wide range of values. Using a median value in these instances provides a more accurate representation of the typical physician work. It was also suggested that in addition to the mean, standard deviations should be provided.

A motion to accept the proposed methodology was not accepted. The subcommittee requested that STS provide additional information relating to:

- IWPUT calculations
- Detailed rationale of using mean as opposed to median
- Detailed explanation of Rasch paired analysis to assist the expert panel in developing relative postoperative E/M work.
- Implications of eliminating outliers from analysis, such as removing the top 10% of times and the bottom of 10%.
- The committee requested that STS demonstrate that the data is not biased such as most of the data coming from academic centers.

The Research Subcommittee will hold a conference call prior to the April RUC meeting, to review the additional material prepared with by STS. It was suggested that after this additional information is provided to the subcommittee, the subcommittee should develop a recommendation to either approve or reject the proposed methodology.

American Society of General Surgeons
The ASGS presented a proposal for a new survey methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work. The responders will be given intra-service time and a calculated IWPUT. Several subcommittee members were concerned that this was providing too much information and recommended that the intra-service time and IWPUT be collected rather than provided. The intent of the ASGS is to change the survey so that it is more physician friendly in an attempt to increase response rate and RVU estimates. The ASGS will select approximately 50 high volume codes that have been submitted by ACS, STS, and possibly SVS. ACS would use the traditional RUC survey and ASGS would use this methodology as a experiment to check the values for the high volume codes. The subcommittee was concerned that if the two methodologies produce two different relative value recommendations, the two numbers will need to be reconciled. The subcommittee agreed that it will be the responsibility of the presenting specialties to develop a single recommendation through a consensus panel, but the RUC should be presented data developed from both methodologies**. The subcommittee recommends approving the**

methodology using magnitude estimation of intra-service work and also using a building block methodology for pre and post-service work but the survey should not contain intra-service times and IWPUT calculations.

Previously Approved Alternative Methodologies for the Five-Year Review
During the September, 2004 RUC meeting, the RUC agreed that if the RUC has previously approved an alternative methodology for a prior five-year review, then specialties should not have to come back to the subcommittee to request approval again. So that all specialties will know which methodologies have been approved, the Research Subcommittee was asked to list all previously approved methodologies and determine if additional explanation and/or examples are needed. The Subcommittee agreed to again distribute the document to specialty societies for informational purposes.

Changes to the RUC Survey for the Five-Year Review
In prior five-year reviews the RUC added a question to the RUC survey to assist RUC members in evaluating how physician work has changed over the previous five years. The results were reported in the RUC Summary of recommendation form. The following question was added at the end of the survey during the last five-year review and the Research Subcommittee agreed to include the following question to the RUC survey for use in the upcoming five-year review.

> **Additional Question: The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.**
>
> **Has the work of performing this service changed in the past 5 years?** Yes No
>
> **If Yes, please circle the your response to questions a-c:**
>
> **d. This service represents new technology that has become more familiar (i.e., less work).** I agree I do not agree
>
> **e. Patients requiring this service are now:**
> more complex (more work) less complex (less work) no change
>
> **f. The usual site-of-service has changed:**
>
> from outpatient to inpatient from inpatient to outpatient no change

Guidelines for Reference Service Lists
At the September, 2004 RUC meeting the Research Subcommittee and the RUC approved a list of guidelines for developing reference service lists. The Subcommittee asked that the list be distributed to specialties as an opportunity for specialties to comment. The guidelines were distributed and no comments were received, therefore, the subcommittee reaffirmed its prior approval of the following guidelines to be added to the RUC survey instructions document.

Existing Guidelines:

- **Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.**
- **Services on the list should be those which are well understood and commonly provided by physicians in the specialty.**
- **Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)**

New Guidelines

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**
- **Include several high volume codes typically performed by the specialty.**

Psychological and Neuropsychological Testing Presentation

The American Psychological Association requested that the Research Subcommittee review proposed changes to the RUC survey for the psychological and neuropsychological testing codes. The changes include changing references to "physician" to "professional" and including generic pre, intra, and post service time period definitions. **The subcommittee recommends approving the changes to the APA survey.**

Ultrasound

The Research Subcommittee has been assigned the task of examining the family of ultrasound codes to determine if there rank order anomalies exist among the codes. A number of issues were raised such as the variability in ultrasound codes according to whether the procedure is a stand alone code, an add-on code or incorporated into another code. The subcommittee reviewed the list of codes and the calculated IWPUT for each of the codes. The subcommittee felt that to begin comparing the codes only the ultrasound portion of the code should be identified and a RVU and IWPUT be calculated. AMA staff in association with the Research Subcommittee will develop these calculations for subcommittee review. The subcommittee will attempt to use these calculations as a first step in identifying potential anomies.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 3, 2005

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

CPT/RUC Meeting Date Discussion
AMA Staff announced that at the April/May 2004 CPT Editorial Panel meeting, the Panel Members approved a motion changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. The Administrative Subcommittee was informed by AMA staff that CPT has finalized its annual calendar. The Administrative Subcommittee reviewed the timeline between all CPT and RUC Meetings and determined that there was sufficient time for specialty societies to develop RUC recommendations. **The Administrative Subcommittee recommends approval of all RUC meeting dates for the 2007 CPT RUC cycle**.

Re-review of RUC Recommendations – New Technology
At the April 2004 RUC Meeting, a RUC member indicated that there is no formal process to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. This issue was referred to the Administrative Subcommittee for discussion. **After careful consideration of this issue, the Administrative Subcommittee determined that these codes should be identified, and approved the following process for formalized review:**

> **The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.**

Release of RUC Database to Specialty Society Representatives for Functions Not Pertaining to the RUC Process
At the September RUC meeting the Administrative Subcommittee recommended to the RUC that the RUC Database be released to the Specialty Societies for use outside of the

CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims). The RUC extracted this item and tabled its discussion pending review by the AMA legal department.

AMA Staff met with Andrea Cooper-Finkle, JD, Senior Division Counsel for the AMA to obtain a legal review of this issue. Ms. Cooper-Finkle delivered a presentation to the Administrative Subcommittee to describe the findings of the AMA. Ms. Cooper-Finkle began by describing some history pertaining to this request. She stated that a request to release the RUC database to the public was first made several years ago. The AMA Legal Counsel at that time sought an opinion from the Justice Department which was referred to the Federal Trade Commission (FTC) opinion for legal review of this issue. The FTC in its opinion stated that releasing the RUC database to the public would not violate anti-trust laws and could also potentially have pro-competitive benefits. However, the response also may be interpreted that limiting distribution of the RUC database to selective recipients for use outside the CPT/RUC process may violate anti-trust laws. Therefore it is the opinion of the AMA Legal Counsel that the RUC database not be distributed to specialty society representatives for functions not pertaining to the RUC process as it may lead to a violation of the anti-trust laws.

After much discussion pertaining to the legal issues surrounding the release of the database, the Administrative Subcommittee approved the following motion:

The RUC database will not be distributed to the specialty society representatives for functions not pertaining to the RUC process.

The Administrative Subcommittee then discussed releasing the RUC database to the public. The members of the Administrative Subcommittee discussed the FTC's opinion that the release of the database could potentially have pro-competitive benefits. The Administrative Subcommittee understands the FTC's opinion and agrees that both providers and payors should have equal access to this information. Other issues discussed by the Administrative Subcommittee included: 1.) the logistical distribution of the RUC database, 2.) the creation of new licenses to use the RUC database and 3.) the creation of new potential AMA products that would be affordable to individual proprietors to avoid an asymmetrical distribution of this data. The Administrative Subcommittee approved the following motion:

AMA staff will explore options for the public release of the RUC database with input from AMA Senior Management and AMA Legal Counsel with the objective of a symmetrical distribution amongst all potential recipients.

Clarification of RUC Membership Criterion

In April 2004, The RUC received a request from the American College of Physicians (ACP), to provide clarification regarding the first criterion for a permanent seat on the RUC, as stated in the "Criteria for Participation" section of the RUC Structure and

Functions document. The Criteria for Participation as approved at the April 2002 RUC Meeting reads as follows:

6.) The specialty is an ABMS Specialty
7.) The specialty comprises 1 percent of physicians in practice
8.) The specialty comprises 1 percent of physician Medicare expenditures
9.) Medicare revenue is at least 10 percent of mean practice revenue for the specialty
10.) The specialty us not meaningfully represented by an umbrella organization, as determined by the RUC

In September 2004, this issue was discussed by the Administrative Subcommittee and Doctor Leahy of the ACP gave a brief presentation regarding this request and clarified that not only was his society seeking clarification but also was requesting that this criterion be assessed to determine its suitability as a criterion for a permanent seat on the RUC. The Administrative Subcommittee decided that the further assessment of the first criterion for RUC membership, related to ABMS specialties, was needed.

Since September 2004, AMA staff has received 6 additional letters:

1.) A joint letter from the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), the American Society for Hematology (ASH) and the American Society for Clinical Endocinology (ASCO) requesting three permanent seats on the RUC for pulmonary medicine, gastroenterology and hematology-oncology.
2.) A letter from the American Board of Internal Medicine supporting the original ACP recommendation that general certificates and sub-specialty certificates that are approved by the American Board of Medical Specialties meet the first criterion for a permanent seat on the RUC, the specialty is an ABMS specialty
3.) A letter from ACP supporting the organizations representing the internal medicine subspecialties of gastroenterology, pulmonary medicine and hematology/oncology in their request for each subspecialty to receive a permanent seat on the RUC
4.) A letter form ASH and ASCO requesting a permanent seat on the RUC for hematology/oncology
5.) A letter from ACCP and ATS requesting a permanent seat on the RUC for pulmonary medicine and
6.) A letter from ACG, AGA and ASGE requesting a permanent seat on the RUC for gastroenterology

The Administrative Subcommittee, after much discussion amongst its members and members of the aforementioned societies, determined that before the requests made by the specialties could be assessed, the charge of the Subcommittee must be addressed, namely the clarification of the term ABMS specialty. The Administrative Subcommittee determined after reviewing documents from June 1991 pertaining to the proposed

composition of the RUC that this criterion upon its creation refers to the 24 approved ABMS specialty boards. Therefore the Administrative Subcommittee approved the following motion:

The first criterion for a permanent seat on the RUC, as currently stated in the "Criteria for Participation" section of the RUC Structure and Functions document, the specialty is an ABMS specialty, refers to the 24 approved ABMS specialty boards. All other specialties currently represented on the RUC with permanent seats should be grandfathered on the RUC regardless of inclusion or exclusion on this list of 24 ABMS specialties.

After this criterion had been clearly defined, the Administrative Subcommittee discussed the suitability of this criterion. Several members felt that this criterion as defined is an antiquated view of the ABMS certification. Therefore, the Administrative Subcommittee approved the following motion:

The first criterion for a permanent seat on the RUC, as currently state in the "Criteria for Participation" section of the RUC Structure and Functions document, "The specialty is an ABMS specialty," should be amended to read,

1.) The specialty or subspecialty has an approved general certificate or subspecialty certificate of an ABMS Member Board.

(The RUC passed a motion to record the vote on this subcommittee recommendation. The RUC did not approve this motion by a two-thirds vote. Twenty-six members voted, thirteen members voted in favor of the motion and thirteen members opposed the motion.)