**AMA/Specialty RVS Update Committee**
**February 7-9,1997**

**The Scottsdale Renaissance Cottonwoods Resort**
**Scottsdale, Arizona**

## I. Call to Order and Opening Remarks.

Doctor Rodkey called the meeting to order at 9:30 am. The following RUC members were in attendance:

Grant V. Rodkey, MD
David Berland, MD
Melvin Britton, MD
Robert Florin, MD
John O. Gage, MD
William Gee, MD
Tracy R. Gordy, MD
Larry P.Griffin, MD*
Kay K. Hanley, MD
Alexander Hannenberg, MD
W. Benson Harer, JR., MD
James Hayes, MD
Emily Hill, PA-C
David F. Hitzeman, DO
James Hoehn, MD
Alan Jensen, MD *
Charles Koopmann Jr. MD
Leonard Lichtenfeld, MD
John Mayer, MD
David McCaffree, MD
James M. Moorefield, MD
Alan Morris, MD
Willard B. Moran, MD*
Michael Powe, MD
William Rich, MD
Peter Sawchuk, MD*
Chester Schmidt, MD
Bruce Sigsbee, MD
William Winters, Jr. MD
Sheldon Taubman, MD*
John Tudor, MD
Charles Vanchiere, MD

(*Indicates alternate member)

Grant Bagley,MD,Health Care Financing Administration (HCFA), also attended.

The following facilitation committees were appointed by Doctor Rodkey:

- Doctors McCaffree (Chair), Britton, Gee, Mabry, Moorefield, Schmidt, Taubman,Vanchiere, and Eileen Sullivan-Marx, PhD.

- Doctors Britton (Chair), Powe, Mabry, Hoehn, Berland, Hayes,Griffin and Marc Lenet, DPM.

The following ad-hoc committees were appointed :

- E/M Component in Global Surgical Work: Doctors Sigsbee (Chair), Gage, Gee, Lichtenfeld,McCaffree, Rich and Tudor.

- Minimally Invasive Procedures: Doctors Hannenberg (Chair), Harer, Winters, Vogelzang, Haynes,Hayes, Zwolak,Gage, Powe,Weiner,Koopman

and Marc Lenet, DPM.

## II. Approval of September, 1996 Minutes

The minutes were approved after the following revisions were noted: Doctor Hayes was added to the list of attendees; Doctor Zwolak was added to the list of nominees presenting on the RUC Rotating Seat; Doctor Hanley's comment that the Co-Chair of HCPAC Review Board will be selected by all members of Review Board and not only non-MD/DO representatives was added; and Charles Weissman represents the American Society of Clinical Oncologists, not the American Society of Hematology.

## III. Calendar of Meeting Dates

The RUC was informed that the April 24-27, 1997 meeting will be held at the Renaissance in Chicago and the September 26-28 RUC meeting will be held at The Meridian in San Diego, California. Sherry Smith also announced that the date of the Spring 1998 RUC Meeting will be changed from April to May 1-3. In addition, the February 1998 CPT meeting has been moved a week earlier, so there will be two weeks more between the final CPT and RUC meetings in 1998 than in 1997.

## IV. CPT Update

Doctor Gordy reported that 75 issues are included on the February CPT Agenda. Doctor Gordy also informed the RUC that several issues that had been referred to the CPT process during the Five-Year Review remained unresolved. These issues will be formally placed on the RUC's April agenda. Specialty societies will be expected to inform the RUC of their current status in the CPT process or present a recommendation which responds to the initial RUC comment.

Representatives from the American Society for Therapeutic Radiation Oncology (ASTRO) informed the RUC that they planned to submit a coding proposal on the weekly radiation treatment services for the CPT 1999 cycle.

## V. Further Discussion of November 22, 1996 Final Rule

The RUC discussed two issues from the November 22, 1996 Final Rule: rank order anomalies created during the Five-Year Review process and the newly created Level II codes for psychotherapy. ACOG is concerned with the rank order anomalies that exist in laparoscopic procedures and formally asked the RUC to support its request to HCFA to reevaluate the entire family of laparoscopic codes. In response, Doctor Bagley acknowledged that HCFA did not correct the rank order anomalies last fall, but assured ACOG that the issue is still on the table. Therefore, Doctor Bagley recommends that the RUC review this issue and forward any comments or recommendations to HCFA. The RUC reaffirmed its recommendations for codes 56300 & 56305 while suggesting that ACOG review the remaining codes for the April meeting. A motion was made that an ad hoc group be formed to look at the entire issue surrounding minimally invasive procedures.

The motion passed and the members of this new committee are Doctors Hannenberg (Chair), Harer, Winters, Vogelzang, Haynes, Hayes, Zwolak, Gage, Powe, Weiner, Koopman and Marc Lenet, DPM.

The American Psychiatric Association and the American Psychological Association also expressed concern over HCFA's newly established HCPCS Level II alphanumeric codes for reporting psychotherapy services to Medicare. This has created tremendous disruption and confusion in physician practices.

## VI. Evaluation and Management Component of Global Surgical Procedures

Since the RUC Meeting last September, several initiatives have been made to devise a methodology for incorporating increases in Evaluation and Management (E & M) service work into global surgical work. As he had described at the September RUC meeting, Dan Dunn from the Cambridge Health Economics Group used an incremental approach to derive the new work RVU's for global surgical services and assess the impacts of changes in global surgical work on Medicare payments for services, categories of service and specialties. Dr.Dunn used several available data sources, including RUC and Harvard study data. In addition, this methodology required many assumptions to be made about "time and work". The RUC and Dan Dunn agreed that this study method and data provide a useful starting point for reassessing global surgical work. However, several issues and concerns were raised by the RUC regarding this study that should be addressed in any further analysis including the validity of the data used in the analysis and the use of time as a proxy for codes.

Dr. Gage made a motion to accept Dan Dunn's analysis on a code by code basis to be reviewed by HCFA. The motion failed.

Dr. Rodkey appointed an ad-hoc committee (Doctors Sigsbee (Chair), Gage, Gee, Lichtenfeld, McCaffree, Rich and Tudor) to review the issue and present a recommendation to the RUC.

The ad-hoc committee met on Saturday and made the following recommendations:

- The increases in global service work should be calculated on a code-by-code basis for each code with a global period of 010 or 090.

- The work of postoperative hospital visits has increased in a similar way to that of other subsequent hospital visit services. The full 1997 increase in evaluation and management work for these CPT codes (99231, 99232, 99233,99238) should be incorporated into global service work relative values.

- The work of postoperative office visits has also increased. However, due to the nature of these services when performed following surgery, the full 1997 increase in evaluation and management service work for these CPT codes (99211, 99212, 99213, 99324, and 99215) should not be incorporated into global surgical work. Instead, the intrawork per unit time for postoperative office visits should be increased by 10% (consistent with HCFA's assumption for the evaluation and management codes), and pre- and postservice work for these services, as a percentage of intrawork, should be increased by 12% (rather than the 25% increase HCFA applied to the office visits).

- The most recent and accurate data should be used to determine the number and level of hospital and office visits included in global service work. Dr. Dunn's analysis includes data from both the Harvard and the RUC surveys. HCFA may wish to adjust these data if more recent data on numbers of visits or lengths of stay are available from other sources.

## VII. Relative Value Recommendation for New or Revised Codes

**Intraoperative Endovascular Angioscopy (Tab 15), Tracking Numbers: I1-I2**
**Presenter: Robert Zwolak, MD, Society of Vascular Surgeons**

CPT code 372XX *Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)* was created to describe a modality which allows direct "real-time" visualization of critical portions of a bypass procedure such as mechanical disruption of the fine valves within a vein, minimizing the risk of vein injury. The use of the angioscope also reduces the risk of postoperative skin edge necrosis and wound infection in chronically ischemic limbs.

The RUC recommends a work RVU of 3.0, which is based on the survey responses of nearly 50 vascular surgeons. The time and intensity of 372XX is comparable with both codes 35700 *Reoperation, femoral-popliteal or femoral (popliteal) - anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation (List separately in addition to code for primary procedure)* (3.08) and 35390 *Reoperation, carotid, thromboendarterectomy, more than one month after original operation (List separately in addition to code for primary procedure)* (3.19).

Code 935XX *Angioscopy (coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)* during therapeutic intervention will be surveyed by the American College of Cardiology and presented at the April RUC meeting.

**Percutaneous Abscess Drainage (Tab 16), Tracking Numbers: K1-K21**
**Presenters: Robert Vogelzang, MD, Society of Cardiovascular and Interventional Radiology and Robert Bree, MD, American College of Radiology**

A survey was conducted of interventional radiologists to determine the work of several new percutaneous abscess drainage codes. The survey respondents were asked to consider a global period of 90 days for these services. The RUC chose not to use this survey data in developing its recommendations because the global period of 90 days is not appropriate for these services. The RUC recommends that all percutaneous drainage codes be assigned a global period of 0 days. Patients receiving these services do not typically receive their follow-up care by the interventional radiologist who performs the procedure and, therefore, a global period of 90 days is not appropriate.

The RUC recommends work RVUs for these services based on comparison to established CPT codes with global periods of 0 days. The codes were grouped by level of difficulty and are valued as follows:

Similar in work to CPT code 32020 *Tube thoracostomy with or without water seal (EG, for abscess, hemothorax, empyema) (separate procedure) (work rvu = 3.98)*:

| Code | Tracking # | Description | RVU Recommendation |
|---|---|---|---|
| 3220X | K2 | Pneumonostomy; with percutaneous drainage of abscess or cyst | 4.00 |
| 4851X | K8 | External drainage, pseudocyst of pancreas; | 4.00 |

| | | | |
|---|---|---|---|
| | | of abscess or cyst | |
| 4904X | K10 | Drainage of subdiaphragmatic or subphrenic abscess; percutaneous | 4.00 |

Recommend mid-point between CPT codes 32020 and 50392:

| | | | |
|---|---|---|---|
| 470XX | K6 | Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages | 3.70 |
| 4906X | K12 | Drainage of retroperitoneal abscess; percutaneous | 3.70 |

Similar in work to 50392 *Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous (work rvu = 3.38):*

| | | | |
|---|---|---|---|
| 4490X | K4 | Incision and drainage of appendiceal abscess; percutaneous | 3.38 |
| 49021 | | Drainage of peritoneal abscess or localized peritonitis, exclusive or appendiceal abscess; percutaneous | 3.38 |
| 50020 | K14 | Drainage of perirenal or renal abscess; percutaneous | 3.38 |
| 588XX | K17 | Drainage of pelvic abscess, transvaginal or or transrectal approach, percutaneous (eg ovarian, pericolic) | 3.38 |

The RUC also recommends a work rvu for 49XX1 (K18) equivalent to code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (work rvu =.76).

A work rvu of 1.46 is recommended for 49XX2 (K19), which is equivalent to code 50398 *Change of nephrostomy or pyelostomy tube.*

**Closure of Colostomy (Tab 17), Tracking Number: L2**
**Presentation: Frank Opelka, MD, American Society of Colon and Rectal Surgeons**

A new CPT code 446XX combines the work involved in a Hartmann's procedure with the closure of a colostomy. The new procedure is usually performed on patients that have previously undergone the Hartmann's colostomy. The Hartmann's procedure that is described by CPT code 44143 involves a partial colectomy and closure of the distal segment of the colon. The Hartmann's colostomy is characterized by the removal of a lesion on the colon and the oversewing of the rectum. The disadvantage of the Hartmann's is that patients often experience loss of bowel function. The new closure of colostomy procedure restores bowel function in many patients however, since this surgery is considered a secondary resection it is often very difficult. This new procedure involves mobilization of the splenic flexure that is not usually part of a colostomy closure. The typical patient that undergoes this procedure has a diagnosis of perforated diverticulitis or obstructing colon cancer. At the time of surgery, many patients are experiencing peritonitis resulting in severe inflammation and adhesions which greatly increases the difficulty

of the surgery. In female patients the surgery is complicated by the possibility of injury to the vaginal area.

This procedure was previously reported as CPT code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* (work RVU = 21.29) or 44625 *Closure of enterostomy, large or small intestine; with resection and anastomosis* (work RVU = 12.10). The RUC agreed with the specialty society contention that the survey median was too low and accepted the specialty society recommendation of 21.29 RVUs.

**Proctectomy with Coloanal Anastomosis (Tab 18), Tracking Number: M1**
**Presentation: Frank Opelka, MD, American Society of Colon and Rectal Surgeons**

A new CPT code 4511X was established to report a proctocolectomy with reservoir. This is a new procedure that is being performed on a limited basis in colorectal tertiary centers. This procedure is done to restore colonic reservoir which has been damaged due to disease, usually rectal cancer or extensive rectal polyposis. The ability for a surgeon to perform a proctocolectomy with reservoir is due to a better understanding of physiology and reduces the chance that post-op patients will be left with severe bowel dysfunction.

During this procedure the entire colon is rotated on a vascular pedicle and then secured to the anal canal by anastomosis. The procedure also includes formation of a loop ileostomy. This operation is long and requires an ICU stay to manage post-op complications in particular, fluid shifts. The work described by 4511X is similar in nature to 44153 *Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy* (work RVU = 24.69), except that 44153 requires the resection of the entire colon and the creation of an ileal J-Pouch. 4511X is currently reported as 45112 *Proctectomy, combined abdominoperineal, pull through procedure (eg colo-anal anastomosis)* (work RVU = 24.02) with a -22 modifier appended to the code. The RUC accepted the specialty society recommendation of 23.50 RVUs for 4511X which represents the survey median.

**Laparoscopy with Intestinal Resection (Tab 19), Tracking Number: O1**
**Presentation: Paul Collicott, MD, and Charles Mabry, MD American College of Surgeons, Frank Opelka, MD, American Society of Colon and Rectal Surgeons**

A new CPT code 563XX was established to report an intestinal resection with anastomosis performed via laparoscopy. The work involved in 563XX is a really a combination of procedures that can be performed as one procedure through the laparoscope. The majority of the patients that would be receiving this procedure are suffering from the effects colorectal neoplasms, diverticular disease, and localized inflammatory bowel disease. During this procedure the diseased segment of the bowel is mobilized and the mesenteric transection, bowel transection, and anastomosis are performed. These procedures can be performed intracorporeally or extracorporeally, depending on conditions and the experience of the surgeon. Intestinal laparoscopic surgery is considered extremely difficult and less safe than the open procedure therefore, surgeons prefer to perform these cases as open procedures. However, when given the option patients prefer to have surgical procedures performed laparoscopically.

In the absence of a specific code, this surgery was most frequently reported as CPT code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* (work RVU = 21.29). The specialty society noted that although the intra-service work of 563XX is of much greater intensity than similar open procedures, the post-operative care involves the same amount of work and the

pre-operative care involves less work. The RUC accepted the specialty society recommendation of 20.00 RVUs for this procedure which is slightly less than the survey median.

**Closure of Rectovaginal Fistula (Tab 20), Tracking Number: N1**
**Presentation: Frank Opelka, MD, American Society of Colon and Rectal Surgeons and Larry Griffin, MD American College of Obstetrics and Gynecology**

A new CPT code 5730X was established to report the work involved in closure of a rectovaginal fistula. This type of fistula most often occurs in women as a result of a normal vaginal delivery. In many instances a vaginal repair described by CPT code 57300 is attempted soon after delivery but fails, resulting in recurrence of the fistula and loss of spinchter function. The work described by 5730X is a complicated procedure that involves repair of the rectal mucosal defect, reapproximation of the spinchter muscle, and reconstruction of the perineal body. In the absence of a separate CPT code this service was reported as a combination of CPT codes 57300 *Closure of rectovaginal fistula; vaginal or transanal approach* (work RVU = 6.81) and 56810 *Perineoplasty, repair of perineum, nonobstetrical (separate procedure)* (work RVU= 3.97), or CPT codes 57300 *Closure of rectovaginal fistula; vaginal or transanal approach* (work RVU= 6.81) and 46750 *Sphincteroplasty, anal, for incontinence or prolapse; adult* (work RVU= 7.35). The new code more adequately describes these services in combination. The RUC accepted the specialty society recommendation of 9.31 RVUs for CPT code 5730X which is lower than the survey median of 11.00 RVUs.

**Laparoscopic Surgery (Tab 21), Tracking Numbers: P2, P3, P5, P6**
**Presentation: Frank Opelka, MD, Charles Mabry, MD, Paul Collicott, MD, American College of Surgeons and Thomas Cooper, MD, American Urological Association**

A series of new codes have been established which recognize the advances in laparoscopic surgery.

The work described by **563X1** is a procedure that involves enterolysis performed laparoscopically. Enterolysis performed via the laparoscope is more complicated than the open procedure because the surgeon often experiences difficulty feeling the loops of the bowel making it hard to lyse adhesions without damaging the bowel. Adhesions often occur in patients who have had previous surgery which increases the difficulty of this procedure. This procedure was previously reported as CPT code 44005 *Enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU= 12.52). The RUC accepted a recommendation of 13.50 RVUs for this procedure which represent the specialty society survey median.

The work described by **563X2** involves gastrostomy performed laparoscopically. This procedure represents a new approach to gastrostomy and has a very low frequency. The procedure which is done for alimentation purposes involves suturing the tube into position and then suturing the stomach to the abdominal wall. Unlike the open procedure, the surgeon must visually identify structures through the laparoscope that should be cut or preserved which increases the difficulty of the procedure. Due to the suturing that is an integral part of this procedure more work is involved in the control of bleeding. This procedure was previously reported as CPT code 43840 *Gastrorrhaphy, suture for perforated duodenal gastric ulcer, wound or injury* which at the time the new code was surveyed had a work RVU of 4.84. The RUC recommended an RVU of 7.18 which is slightly lower than the specialty survey median but reflects the fact that the reference code RVU was increased for the 1997 Medicare Fee Schedule due to the Five-Year Review.

The work described by **563X4** involves an orchiectomy performed laparoscopically. This procedure is typically performed on young males to correct the condition of undescended testicles. In a small percentage of these undescended testicle patients, the testicle is not palpable in the inguinal canal therefore, the operating surgeon often does not the exact location of the testicle which adds significant risk to this surgical procedure. There is a somewhat greater success associated with treating the nonpalpable cases laparoscopically as opposed to the open procedure described by code 54560 (work RVU= 10.46). The RUC recommended an RVU of 10.63 for this procedure which represents the specialty society survey median.

The work described by **563X5** involves esophagogastric fundoplasty performed laparoscopically. This procedure is considered very difficult and performed by only the most experienced laparoscopic surgeons. Which is reflected in the specialty society survey data which shows that there is no difference in the amount of time based on the number of procedures that the surgeon has performed. This procedure is typically performed on patients to relieve the symptoms that are associated with esophagogastric reflux disease. The purpose of the procedure is to increase the angle at which the esophagus enters the stomach. The difficulty of the surgery is due in part to the fact that the surgeon cannot rely on tactile information during the procedure. Additionally, there is more work involved in the control of bleeding. This procedure was previously reported as CPT code 43324 *Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)* (work RVU= 15.18). The new procedure is considered more difficult than the laparoscopic cholecystectomy described by code 56342 (work RVU= 13.46), because the surgeon must dissect the short gastric vessels. The RUC recommended an RVU of 17.75 for this procedure which represents the specialty society survey median.

**Lymphocele Drainage (Tab 22), Tracking Numbers: CC1, CC2**
**Presentation: Thomas Cooper, MD, American Urological Association**

The work described by the new code 49XXX describes the open drainage of a lymphocele. Although this procedure does not represent new technology the new code will more adequately describe that services that are involved. The typical patient usually develops lymphoceles as a result of renal transplant surgery or retropubic prostatectomy. This procedure is equivalent in terms of work to CPT code 49060 *Drainage of peritoneal abscess* (work RVU= 10.55). Since the conditions that result in this type of surgery are uncommon, the procedure is performed on a relatively limited basis. Although this procedure achieves the same result as percutaneous abscess drainage, the patient undergoing the procedure described by 49XXX has failed the percutaneous procedure. When a patient presents for surgery, the surgeon will determine based on their skill and experience whether or not the procedure should be performed as an open or laparoscopic procedure. The RUC recommended an RVU of 10.78 for this procedure which was based on a survey median from over 30 urologists.

A new code 563XX was added for laparoscopic lymphocele drainage. This work involved in this procedure is the same as the open lymphocele drainage and involves similar patients. This procedure is based on the experience of the surgeon not he availability of the technology. The RUC recommended an RVU of 8.93 which was based on a survey median from over 30 urologists.

**Transurethral Microwave Therapy (TUMT) (Tab 23), Tracking Number: J1**
**Presentation: Thomas Cooper, MD, American Urological Association**

A new code 5246X was added to describe the work involved in transurethral microwave thermotherapy. This procedure is used primarily for the treatment of benign prostatic hyperplasia

(BPH). The procedure provides minimally invasive, non-surgical partial destruction of prostatic tissue by combining microwave heating and conductive cooling. Since TUMT is a relatively new treatment many patients that present with symptomatic BPH undergo transurethral resection of the prostate which is described by CPT codes 52601, 52612, and 52614. TUMT requires no anesthesia and has a minimal period of convalescence. Since patients are awake during the procedure, the physician is required to provide constant assurance to the patient. The work involved in TUMT is more difficult than lithotripsy which is described by code 50590. The RUC recommended an RVU of 9.58 for this service which is based on the survey median from over 30 urologists.

**Cystourethroscopy, with insertion of urethral stent (Tab 24), Tracking Number: DD1**
**Presentation: Thomas Cooper, MD, American Urological Association**

A new code 5228X was added to describe the use of endoprosthetic stents in the treatment of urethral stricture disease. The treatment of a urethral stricture involves a cystoscopy and the excision of the stricture using cold knife technique. Once the stricture is excised, a stent is placed over the stricture site. This a very difficult procedure due to the many complications that are associated with stent placement. The patient often experiences incontinence therefore, sometimes the stent is placed across the urogenic bladder to make the continent. Since the stent cannot be moved once it is placed, it is imperative the stent placement will not result in the patient becoming incontinent. The work involved in this procedure is similar to the reference services 52276 *Cystourethroscopy with direct vision urethrotomy* (work RVU= 5.00) and 52277 *Cystourethroscopy, with resection of external spinchter* (work RVU= 6.17). Based on the survey median of over 30 urologists, the RUC recommended an RVU of 6.40 for this procedure.

**Kyphectomy (Tab 25), Tracking Numbers: AA1-AA2**
**Presenters: Richard Haynes, MD and Laura Tosi, MD, American Academy of Orthopaedic Surgeons and Steven Crew, MD, American Academy of Pediatrics**

New CPT codes were added to describe Kyphectomy, a procedure to performed on spina bifida patients to allow correction and stabilization of the deformity, decreased skin problems, increased pulmonary function, and improved sitting balance. Fewer than 150 of these procedures are performed each year in the United States by fewer than 100 pediatric orthopaedic surgeons. The procedure has high mortality and morbidity rates.

The RUC recommends work relative values based on the survey results of more than 40 pediatric orthopaedic surgeons who perform this procedure. The majority of the survey respondents compared code 228X1 *Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or two segments* to CPT code 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s) lower thoracic or lumbar; single segment* (work rvu = 33.91). Both services require similar amounts of intra-service time (240 minutes) and intensity. The intra-service time of 63087 has been confirmed by the Harvard study (258 minutes), Five-Year Review data (265 minutes), and this survey (240 minutes). Associated arthrodesis, instrumentation, and bone grafting are not included in either of these services and are reported separately. The RUC recommends 30.00 for 228X1.

The RUC recommends 34.50 for code 228X2 *Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments*, which is also based on the survey median. The 15% increase in the work value for an additional segment is comparable to the 16% increase established for the additional segments for the spine codes, which has been validated in both the RUC process and Harvard's Phase IV study.

**Echography of Infant Hips (Tab 26), Tracking Numbers: Z1-Z2**
**Presenters: Robert Bree, MD, American College of Radiology and Richard Gravis, MD, American Academy of Pediatrics**

The RUC recommends that code 768X1 *Echography of infant hips, real time with imaging documentation; dynamic (eg, requiring manipulation)* be assigned a work rvu of .74, based on the survey of nearly 60 radiologists and pediatricians. The work is equivalent to code 76770 *Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete* (work rvu = .74). A physician should be in attendance during this service and will typically manipulate the infant's hip.

The RUC recommends a work rvu of .62 for new CPT codes 768X2 *Echography of infant hips, real time with imaging documentation; limited, static (eg, not requiring manipulation)*. This recommendation is also based on the radiology/pediatrics survey results. The infant is typically in a harness or cast. Code 76880 *Echography, extremity, non-vascular, B-scan and/or real time with image documentation* (.59) is similar in work to this new service.

**PET Myocardial Perfusion Imaging(Tab 27), Tracking Numbers: Q1-Q2**
**Presenters: Robert Bree, MD, American College of Radiology and Kenneth McKusick, MD, American College of Nuclear Physicians and Society of Nuclear Medicine**

This issue was referred to Facilitation at the April RUC meeting. The Facilitation Committee will be chaired by Doctor Britton and will include Doctors Powe, Mabry, Hoehn, Berland, Hayes, Griffin, and Mark Lenet, DPM.

**Renal Nuclear Medicine (Tab 28), Tracking Numbers: R1-R6**
**Presenters: Kenneth McKusick, MD, American College of Nuclear Physicians and Society of Nuclear Medicine**

This issue was referred to Facilitation at the April RUC meeting. The Facilitation Committee will be chaired by Doctor Britton and will include Doctors Powe, Mabry, Hoehn, Berland, Hayes, Griffin, and Mark Lenet, DPM.

**Magnetic Resonance Spectroscopy (Tab 29), Tracking Numbers: FF1**
**Presenters: Robert Bree, MD, American College of Radiology and Kenneth McKusick, MD, American College of Nuclear Physicians and Society of Nuclear Medicine**

This issue was referred to Facilitation at the April RUC meeting. The Facilitation Committee will be chaired by Doctor Britton and will include Doctors Powe, Mabry, Hoehn, Berland, Hayes, Griffin, and Mark Lenet, DPM.

**Trichogram (Tab 30), Tracking Numbers: S1**
**Presenters: James Zalla, MD, American Academy of Dermatology**

This issue was referred to Facilitation at the April RUC meeting. The Facilitation Committee will be chaired by Doctor Britton and will include Doctors Powe, Mabry, Hoehn, Berland, Hayes, Griffin, and Mark Lenet, DPM.

**Sleep Studies (Tab 31), Tracking Numbers: E1-E4**
**Facilitation Committee Review - Doctors Hitzeman (Chair), Hannenberg, Opelka, and Sigsbee, and Emily Hill, PA-C**

History and Review of Current Family of Sleep Study Services

In CPT 1994, code 95828 *Polysomnography; recording analysis and interpretation of the multiple physiological parameters of sleep* (work rvu = 2.79) was replaced with three new codes 95807, 95808, and 95810 to differentiate between the various levels of physician work involved in these services. The RUC recommended that the new relative values be budget neutral and, based on frequency data, provided the following recommendations: 95810 (1.70); 95808 (2.71); and 95810 (3.61). HCFA, after collecting frequency information for one year, agreed with the RUC recommendations.

The RUC reviewed the appropriateness of the current relative for these codes. These services have been reviewed by both the RUC and HCFA and were implemented in a budget neutral manner. In addition, the RUC was convinced that these services require a high level of technical skill. MDs providing these services are required to complete an additional year of fellowship training and an enormous amount of data must reviewed.

New Code 958XX

After determining that CPT Code 95810 was appropriately valued, the RUC determined that the appropriate increment between this service and the new code 958XX *Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.*.

HCFA has recommended that physicians report both 95810 (3.53) and 94660 (.76) when performing the service described by the new code 958XX. The proposed work rvu for this new code (3.80) is less than the relative values of these two codes combined. The increment of .27 appears reasonable. The addition of CPAP requires a separate paragraph in the report which is critical for treatment decisions. This additional work is similar to code 71020 *Radiologic examination, chest, two views, frontal and lateral* (work rvu = .22) and code 93018 *Cardiovascular stress test, interpretation and report only* (work rvu =.30). The RUC recommends a work rvu of 3.80 for 958XX.

## VIII. AMA Legislative Update

Rich Deem gave the RUC an overview of the political climate in Washington as well as detailed highlights of the federal budget, HHS budget and HCFA's budget. Bruce Vladeck , Administrator of HCFA will step down and the leading candidate is Nancy Mins. Also, it is becoming clear that the issue of balancing the budget will continue to drive decision-making in Washington. Highlights of several budget proposals include:

Federal Budget Proposal

- Cuts of $138 billion over six years from Medicare and claims to extend the solvency of the Medicare Part A Trust Fund until at least 2007.

- A firm limit on Federal Medicaid spending to guarantee that per capita-Medicaid costs rise no faster than the nations per-capita economic output.

HHS Budget Proposal

- During the fiscal year 1998, the department plans on spending $376 billion, 55% of which goes to Medicare, 28% goes to Medicaid, 8% for mandatory programs and 9% for discretionary programs.

HCFA Budget Proposal

- Medicare benefit outlays in FY'98 are to be 6.6% higher than FY '97 estimated outlays.
- The Administration's budget for physician services provides for a cut of $7 billion over five years.
- Establish a single conversion factor of $36.63 in 1998.
- Replace OBRA '93 update formula with GDP + 1 effective 1/1/99.
- Withhold physician fees in high volume hospitals.
- Eliminate payments for assistants at surgery.
- Eliminate "mark-up" costs for outpatient drugs administered by physicians.
- Expand Centers of Excellence demos to all urban areas.
- Establish competitive bidding for lab services & durable medical equipment.

In response to the aforementioned budget proposals, the AMA has been working aggressively to assure that the cuts are "fair". Additional items on the AMA agenda include maintaining a close eye on Medicare reform while pushing for professional liability reform. In response to the rapid changes that are affecting the medical community, the AMA's Washington office has set up a web site, electronic network and a toll-free hotline to provide physicians with up-to-date information.

## IX. HCFA Update on RBRVS Practice Cost Study

Grant Bagley provided the RUC with an update on the practice cost study. He emphasized that HCFA intends to meet the January 1, 1998 implementation date specified in the law. Several approaches have been considered in determining how to distinguish and account for direct and indirect costs which was presented at a public briefing on January 22. HCFA has determined that direct costs account for 55% of practice expenses and indirect for 45%. Data from the clinical practice expert panels (CPEPs) will be used for the direct cost relative values and several approaches are being considered for indirect costs.

Dr. Bagley promptly stated that each approach clearly raises many issues. However, the information HCFA released in January is very preliminary and the agency continues to refine its approach to most accurately account for direct and indirect costs.

## X. RUC Database

Sherry Smith reported the status of the RUC database and the availability of the contents to members. Sherry explained that the database is currently being developed into an executable file and should be available for RUC members at the April meeting.

Paul Markowski explained to the RUC that the AMA would like to create joint specialty society/AMA products using the resources from the CPT and RUC processes. The Federation

Coordinating Team (FCT) is very interested in exploring the idea and AMA staff has begun to discuss projects with interested specialty societies. This issue will be discussed further at the next meeting.

## XI. Research Subcommittee Report on Criteria for RUC Seats

Doctor John Tudor presented the Research Subcommittee report to the RUC. The Research Subcommittee addressed several issues including: a report from the Intensity Workgroup; examination of the criteria for a permanent seat on the RUC; and the current policy limiting a specialty society to one term as a rotating seat member.

### Intensity Workgroup

The research subcommittee reviewed the report of a conference call of the Intensity Workgroup. The subcommittee accepted both the workgroups' report and recommendation that a two pronged approach is necessary to study the intensity issue. The first approach involves mathematically evaluating data gathered from surveys of mental effort and judgment, technical skill and physical effort to assess their validity and reliability. The second approach will attempt to refine and expand the concept of physician work intensity through ethnographic interviews with physician. The subcommittee concluded that a two-pronged approach would produce the greatest likelihood for arriving at an acceptable and valid measure of intensity.

### RUC Permanent Seat

In the creation of the RUC, several criteria were used to determine membership on the RUC. The criteria include: membership on the American Board of Medical Specialties (AMBS); the specialty must comprise at least 1% of all physicians in practice; the specialty must comprise at least 1% of all Medicare expenditures; Medicare must comprise 10% of the specialty's mean practice revenue; and the specialty must not be meaningfully represented by an umbrella organization. After careful review of this criteria, the subcommittee determined that this criteria is appropriate and should be retained. However, the subcommittee felt that the steps that have been taken to make the RUC process more inclusive should be continued. This would include allowing all RUC advisors to address the RUC on the floor and participate without constraints in the RUC process as well as inviting more RUC advisors to participate on RUC subcommittees and the facilitation committees.

**The RUC accepted the Research Subcommittee recommendation regarding the RUC permanent seat.**

### RUC Rotating Seat

The subcommittee focused its discussion on whether or not a specialty that had served one term as a rotating seat RUC member would be precluded from serving an additional term in the future. The subcommittee felt that the RUC process would be enhanced by allowing specialties to serve more than one term as rotating seat members. However, in order for all specialties to have a chance to serve on the RUC, a specialty that currently holds or has held a rotating seat would not be eligible for reelection until a specified amount of time has elapsed. The subcommittee adopted a motion to allow specialties that have served one term on the RUC rotating seat to become eligible for re-nomination after 2 two-year terms have passed. This motion would be retroactive

to the formation of the RUC, that is, the Nuclear Medicine and Gastroenterology would be eligible for renomination at the September 1988 election.

**The rotating seat proposal was accepted by the RUC by a voice vote.**

Other Issues-Specialty Society Attendance at RUC Meetings

In discussing the RUC membership, the subcommittee also determined that regular attendance at RUC meetings by all organizations that are represented is very important. Hence, a motion was adopted that requires the AMA staff to monitor attendance while the RUC Chair take the necessary steps to encourage attendance by all RUC members.

The subcommittee also discussed the issues of encounter-level data on managed care and determining work in capitated systems. The subcommittee will review a draft chapter of the PPRC with regard to this issue.

## XII. Consideration of Doctor Sigsbee's Letter on the RUC Survey Process

Doctor Sigsbee began by reiterating the contents of his letter which formally requests a review of the current RUC survey instrument. Sandy Sherman explained that the survey had been substantially revised just last year. The RUC agreed that several issues need further discussion and asked that the Research Subcommittee review the issue of randomness in survey sampling and the use of non-RVS values for the reference service lists (rescaling).

## XIII. Proposed Changes to the RUC Binder

At the September 1996 RUC meeting, a number of changes were adopted in the RUC's *Structure and Functions* document to bring it up-to-date and make it more consistent with commonly understood policies. One of these changes is to formally append to the *Structure and Functions* all other documents included in the binder of procedural documents that are provided at the RUC meetings. This change was adopted by the RUC. The RUC also requested that staff review all of the documents to be appended to the *Structure and Functions* to ensure that they are also up-to-date and that none of the documents provide conflicting information. The staff review has been completed in consultation with the AMA General Counsel.
*Appendix A: Rules and Procedures,* is clearly the oldest of these documents and the only one which was created before the RUC became operational. It has not been revised since then. Most of the provisions of the RUC's *Rules and Procedures* require no revision., as they accurately reflect the procedures the RUC and staff have used since 1992. Several procedures have been a source of confusion at times, however, particularly the Reconsideration Process, and other procedures, such as those which reference the Third Party Advisory Committee, are out-of-date in light of the revisions made to the *Structure and Functions*.

To bring it up-to-date and make it consistent with current RUC operating policies, staff and AMA Counsel proposed a number of changes for *Appendix A: Rules and Procedures*. Only one change was proposed in the remainder of the binder, *Appendices B* through *L* of the *Structure and Functions*. *Appendix J: Guidelines for Developing Compelling Evidence* restates material that is already included on pages 5-6 of *Appendix F: Instructions for Specialty Societies Developing Recommendations*. *Appendix J* is recommended for deletion from the binder.

Proposed deletions are indicated by ~~striking out~~ , insertions are indicated by underlining, and text in a normal font is unchanged from the current document.

**Proposed revisions to *Appendix A: Rules and Procedures***
Section I.Process for Relative Value Development

- Revise B. to read as follows: The RUC, with the assistance of the AMA, will develop a mechanism for those individuals and entities proposing the CPT coding changes to the CPT Editorial Panel, to ~~submit to the RUC preliminary basic materials~~ include information in their proposals that may be necessary later for relative value development.

- Revise the last sentence of D. to read as follows: In the event that the services represented by new codes are provided in meaningful numbers by more than one specialty as determined by the RUC it will be necessary to consider the ~~recommendations of~~ relative value data developed by each of the relevant specialties and their joint recommendation when available.

- Delete E., which states: The RUC will obtain comments from the relevant Health Care Professional Advisory Committee (HCPAC) and the Third Party Advisory Committee (TPAC) (when they are constituted and operational) on all proposed relative values.

- Revise first sentence of F. to read as follows: The RUC will consider the recommendation(s) of and comments from the AC, HCPAC, ~~TPAC~~ and Specialty Society Committees and will formulate annual recommendation(s) for Health Care Financing Administration (HCFA).

Section II. Reconsideration Process

- Insert a new F.after the current E. as follows: The Ad Hoc Facilitation Committee shall vote to recommend to the RUC whether or not the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC.

- Revise current F. (to be renumbered a G.) to read as follows: The Ad Hoc Facilitation Committee shall ~~vote to refer or not to refer a request for reconsideration to the RUC for reconsideration~~ provide its recommendation the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner.

- Renumber current G. as H.

Dr. Griffin raised concerns over the confidentiality and proprietary section of the RUC's Rules and procedures.

**The RUC accepted all changes with the exception of Section IV. as it will be deferred for reconsideration at the April meeting.**

The revised Rules and Procedures document is attached.

**XIV. RUC HCPAC Review Board Report**

Emily Hill, PAC presented the following RUC HCPAC Review Board Report to the RUC:

Health Care Professionals Advisory Committee(HCPAC) Board Report
Psychophysiological Therapy Incorporating Biofeedback

In April of 1996, the HCPAC Review Board adopted interim relative values for new CPT codes describing Psychophysiological therapy incorporating biofeedback equivalent to the relative values for two psychotherapy codes, 90843 and 90844. The American Psychological Association presented new recommendations to the Review Board that reflect the increases to the aforementioned codes in the 1997 Medicare Fee Schedule(MFS). The Board concluded that there was an incremental increase in providing psychotherapy with biofeedback and will make the following recommendations:

| HCPAC | 1996 Interim RVU | APA REC | REC |
|---|---|---|---|
| 90875 | 1.11 | 1.50 | 1.20 |
| 90876 | 1.73 | 2.20 | 1.90 |

Terms of HCPAC Seats

The Review Board revised their organizational structure and processes to eliminate maximum tenure of HCPAC members. The HCPAC member organizations will have the opportunity to nominate a representative for a three year terms. Also, the HCPAC agreed that the MD/DO representatives on the Review Board should vote in the election of the Co-Chair. The Co-Chair will hold a maximum of two, two year terms.

Election of Review Board Chair

Emily Hill, PA-C was reelected as the Co-Chair of the RUC HCPAC Review Board. Ms. Hill will begin her second two year term at the September 1997 Meeting.

November 22,1966 Final Rule-HCPAC Related Issues

The Review Board discussed the refinement process currently used to evaluate the physical medicine and rehabilitation relative values. Representatives from both APTA and AOTA agree that the discussions at HCFA were fair and beneficial.

Coding Issues at HCPAC

There are numerous coding issues currently under review by HCPAC organizations. These include the replacement of HCPCS Level II codes for PT/OT evaluation services with CPT codes and a CPT proposal to describe manual manipulative treatment performed by physical therapists. The Board stressed the importance of seeking the input of MD specialty societies as well as HCPAC organizations when developing coding proposals and relative value recommendations for services that are also provided by non-MD/DO's.

**The RUC approved the report and supports the relative value recommendations developed by the Review Board.**

## XV. Correct Coding Policy Committee Recommendations

Kenneth McKusick MD, Chairman of the Correct Coding Policy Committee briefed the RUC on the Correct Coding Initiative.

Since the January 1, 1996 implementation of HCFA's Correct Coding Initiative, the Correct Coding Policy Committee (CCPC) in conjunction with the national medical specialty societies, has reviewed and made recommendations on over 16,000 CPT code edits. The CCPC finalized and transmitted a report to HCFA on these code edits in September 1996. As soon as HCFA provides feedback to the CCPC on their report, a detailed report will be sent to the national medical specialty societies. The AMA is hopeful that this information will be forthcoming within the next few weeks.

Doctor McKusick commented that although the overall process of reviewing these code edits was arduous, it provided the committee with some insight as to what precipitates the development of code edits. In December the CCPC submitted a report to the CPT Editorial Panel for its consideration. This report made a series of recommendations to the Panel that they believed are necessary to preserve the integrity of the CPT classification system. The recommendations include the following:

- The AMA should launch a major education program on the correct use of modifiers, for both providers and third party payors.

- Incorporation of the concepts of correct coding into the methodology for the evaluation and approval of *new* CPT codes, at both the CPT and RUC levels of action.

- Through comprehensive review of the CPT coding system, the RBRVS and payment policies, consider correct coding problems and issues in the development of CPT-5.

**The complete report with all of the recommendations can found under tab 9 of the agenda book.**

Doctor Florin made a motion that the RUC continue its interest and involvement and will provide oversight over the correct coding initiative. (if necessary by supporting a CCPC committee).

**The motion was accepted by the RUC**.

Doctor Gordy suggested that before the AMA commits to developing guidelines, several issues of feasibility must be evaluated, among them 1) Does the AMA have access to the necessary information 2) Does the AMA have adequate manpower to study the issue and 3) What are the legal ramifications to be reviewed by the legal department.

## XVI. <u>Other Issues</u>

A request was submitted by the surgical specialty societies on the RUC to consider a surgical rotating seat. Doctor Gee immediately made a motion to refer this issue to a Research Subcommittee. Several RUC members suggested that the research subcommittee take a close look at the number of eligible societies in the AMA House of Delegates, as well as membership data. The motion to have a research subcommittee look at this issue was accepted.

Sandy Sherman made a proposal to conduct a trial process of assigning agenda items to groups of 2-3 RUC members prior to the RUC Meeting. These members would serve as discussion leaders

for the codes in question. This process would enhance the RUC's ability to make more considered and timely decisions. The RUC agreed that this proposal will be used on a trial basis and reviewed in greater depth at the April meeting.

The meeting adjourned at 12:00 pm on Sunday, February 9.