AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING

Stouffer Riviere, Chicago
May 30-31, 1992

MINUTES

I. Call to Order

The AMA/Specialty Society RVS Update Committee (RUC) meeting was called to order by Grant V. Rodkey, MD, Chairman, at 10:15 a.m. on Saturday, May 30, 1992. Attachment 1 lists the meeting attendees.

Introduction

Doctor Rodkey began by welcoming all RUC members and alternates including a new addition, the American Osteopathic Association, represented by Ray E. Stowers, DO.

Doctor Rodkey followed with introductory remarks concerning the importance of the RUC in the updating process. He stated that this committee represents an opportunity for the profession to work together in a "spirit of objectivity, open-mindedness, and fairness". The objective is to construct an internally valid work RVS based on skill, risk, and effort that is unbiased by political and budgetary considerations. Each member must consider objectively the presentations brought before him. Failure to reach a consensus could divide the profession.

Doctor Rodkey also briefly addressed the issue of budget and work neutrality. A discussion of whether or not this issue should enter into RUC considerations was deferred until later in the meeting [See Section V.]. At Doctor Slachta's request, Doctor Rodkey confirmed that, based on a motion at the prior meeting, budget neutrality will not be a consideration in RUC deliberations.

II. Approval of February 26 Minutes

A motion was made and seconded to approve the minutes from the February 26, 1992, meeting of the RVS Update Committee. Doctor Novak noted that a revision was needed in the "Structure and Functions" document on page 4 (III.A.7.a.), which was corrected to read "RUC" not "AC". **The minutes were approved as corrected.**

III. Project Update

Mark Segal opened by indicating that he is pleased with how the work of the RUC is proceeding, although he regrets the time constraints. He indicated that the RUC is now complete with the seating of the AOA and that the AC has fifty formal members. Information was given regarding the June meeting:

- questionnaires will be mailed by June 4 and should be returned to the AMA by June 15 since all recommendations must be submitted to HCFA by early July;
- agendas will be mailed by June 18.

Doctor Rodkey then inquired about what documents should be forwarded to HCFA. Mark responded with several options:

- Minimum (simply indicate the work value);
- Include minutes and all recommendations considered;
- Include a combination of the minutes and the accepted code recommendations; or
- Document only those recommendations that are accepted.

Responding to these options, **Doctor Harer moved that the committee wait until the next meeting to decide on the format for the recommendations to give the staff time to prepare a standard format. This motion was seconded and approved, thus deferring a decision on the information that will be presented to HCFA until the forthcoming meeting.**

A second motion was made by Doctor Hoehn that the full minutes from the RUC meeting <u>not</u> be sent to HCFA, only an abstract. This motion was seconded and approved. However, Doctor Rodkey and Mark noted the importance of having the rationale stated clearly, in which case, the minutes could prove helpful.

IV. CPT Update

Doctor Gordy informed the committee that the cycle for the 1993 CPT book was completed at the May meeting of the Editorial Panel. The Panel will also meet on June 13-14 for "housekeeping" purposes, dealing with unclear definitions, and possible modification of evaluation and management (E/M) codes.

V. Report of the Research Subcommittee

Doctor Kwass, Chairman of the Research Subcommittee, reported that the subcommittee had met by conference call on April 6, 1992. **After lengthy discussion, the subcommittee voted (with two opposed) to continue to include the work neutrality discussion and worksheets as part of the material distributed to the Advisory Committee (AC) with the understanding that they are to be used solely at the <u>option</u> of the specialty society.**

An extensive discussion of work neutrality followed:

- Doctor Rodkey and others agreed that each code should be evaluated on its own merit.

- Doctor Berenson stated that the <u>term</u> "work neutrality" is not as important as the methodology and the relationship to the value of the existing code.

- **Doctor Ogrod moved to resolve the issue by changing the term "work neutrality" to "intercode work relationships". This motion was seconded and approved.**

- Doctor Hoehn agreed with the motion but also reemphasized that the section of the survey instrument on "intercode work relationships" should be optional. **He moved that the survey instrument clearly indicate that completion of this section is voluntary on the part of the specialty societies. This motion was also approved.**

(Note: These actions were reflected in the survey instruments prepared in June.)

VI. Old Business

Mark Segal began the review and ratification of the "Proposed Methodology" (Tab D) by citing changes which would bring the document up-to-date:

- Page 6, para. 1 - use "global" versus "pre/post".
- Page 6, para. 2 - options for group leaders are being discussed by specialty societies.
- Page 6, para. 3 - the budget neutrality section will reflect changes from today's discussion.
- Page 10 - proposed changes should reflect what has been able to be accomplished given the time constraints.
- Interested RUC members can submit other written comments to Mark for inclusion in the revised document.

He also indicated that the staff would make revisions and distribute a newly edited document prior to the next meeting.

Doctor Novak noted that given the extensive amount of work to be done by the next meeting, it might be wise to leave the "Proposed Methodology" as a working document and finalize it in the fall.

Doctor Harer moved to delete item 16b. (page 17), since it pertained to budget neutrality. This motion was seconded and approved.

Doctor McCaffree moved to use the current "Proposed Methodology" as a working document and tie into the "Rules and Procedure" as adopted, then fully revise it at a later date. This motion was seconded and approved.

Doctor Michael Graham then moved to delete items 13c. and 13d. (page 16) which also concerned the budget neutrality concept. This motion was seconded and approved.

Discussion of other revisions was deferred until the revised document could be seen.

VII. Future Meeting Dates

Mark Segal proposed a tentative cycle of three RUC meetings to develop relative value recommendations for coding changes during the 1994 CPT cycle:

• February 1993	August and November actions of CPT
• End of April 1993	February CPT meeting and old business
• End of June 1993	May CPT meeting and any carryover business.

Barry Eisenberg addressed the overall issue of the RUC timetable, emphasizing that the timetable is contingent upon HCFA's schedule. Since HCFA changed their original November date for a Notice of Proposed Rule Making (NPRM) to September, the RUC has two options:

- Talk to HCFA about possible deadline extension, or
- Request that the CPT Editorial Panel move their cutoff back to April or March, rather than May. The disadvantage of this option is that, although they will have more time to develop relative value recommenda tions, specialty societies will have less time to develop coding proposals.

There was discussion of holding another RUC meeting in mid-November to review the August CPT changes. Another suggestion was to attach the meeting to the Interim Meeting of the House of Delegates in December.

Doctor Rodkey will consider another (mid-November) meeting. In the meantime, a decision on specific dates for the RUC cycle was deferred until the upcoming meeting.

VIII. New Business

The following process was used for considering New Business:

1. Brief presentation
   - How the work RVU was obtained
   - Key resources
   - Key clinical comparisons
2. Appropriate recommended relative work value
3. Questions
4. Motions to approve code.

TRANSCERVICAL FALLOPIAN TUBE CANNULIZATION
Tracking Numbers: 9, 12
Presentation: John Graham, MD;
American College of Obstetricians and Gynecologists
Robert L. Vogelzang, MD;
Society of Cardiovascular & Interventional Radiology
Gary S. Dorfman, MD;
Society of Cardiovascular & Interventional Radiology
CPT Advisory Committee

ACOG proposed a relative work value for the new CPT code 583XX (Tracking Number 0009) of 397 RVUs (3.97 x 100). The key reference service they used to obtain this value was code 58992. The ACOG committee also agreed that the work RVUs assigned to a Level III office visit, code 99213, should be included in the recommendation since this new code has a global period of 10 days. SCVIR evaluated the new procedure code (0009) and valued this service at 639 RVUs (6.39 x 100). The evaluation included hysterosalpingography and the cannulizaton of one or two tubes. The key reference services used were codes 35473, 36217, and 35474. SCVIR also offered a recommendation for code 747XX (Tracking Number 0012) of 64 RVUs (.64 x 100), stating that the supervision and interpretation for fallopian tube cannulization should be somewhere in between codes 74485 and 74363.

ACR also submitted recommendations for these two procedures. A value of 565 RVUs (5.65 x 100) was developed for 0009, and 0012 received a value of 70 RVUs (.70 x 100).

Discussion:

After considerable discussion, a general consensus was reached that ACOG and SCVIR/ACR were evaluating two different procedures: the OB/GYN approach is hysteroscopic while the radiology approach is fluoroscopic. In addition, the radiologists included the work of a consultation and sedation of the patient in their recommendation while ACOG did not. Also, SCVIR associates hysterosalpingography with this procedure while ACOG and CPT do not, according to Doctor Gordy.

Doctor Gage recommended that since the RUC was apparently dealing with two different services, the issues should be referred back to the CPT Editorial Panel to consider a separate code for the radiologic approach.

A question arose concerning the frequency of the procedure performed by OB/GYN versus radiology. There were no adequate data available. However, Doctor Dorfman stated that the procedure is performed at least as often by radiologists as by OB/GYN's. He objected to adopting only the ACOG definition of this service since this would restrict the procedure to OB/GYN. Doctor Harer agreed, and felt there should be two separate codes.

There was much discussion both for and against Doctor Gage's suggestion. Doctor Gordy presented a compromise: the issue could be taken to the upcoming CPT Executive Committee meeting and put on the agenda for June. An "indent" to the code for the fluoroscopy technique might be arranged.

There was request for an immediate voice vote on division of the code and referral to the CPT panel. The motion was passed.

A second vote was taken to determine whether the recommendations should be accepted in the event that CPT did, in fact, decide to split the codes. Most committee members felt, however, that a decision from the CPT Panel should be made before further evaluation of the codes took place. Thus, this motion did not pass, deferring evaluation of the codes until June, pending acceptance by the CPT Editorial Panel.

The next vote was on code 747XX. Doctor Moorefield moved that the work RVU for code 747XX be set at 65 RVUs (.65 x 100) which is a compromise between SCVIR and ACR. This motion to accept the value of 65 passed.

Summary:

- The recommendation for new code 583XX (Tracking Number 0009) was deferred pending consideration of a code split by the CPT Editorial Panel.

- The relative work value of 65 RVUs (.65 x 100) was accepted for procedure code 747XX (Tracking Number 0012).

NOTE: The presentation materials for these recommendations can be found in TAB E of the May agenda book.

SEVERING ADHESIONS OF ANTERIOR SEGMENT, LASER TECHNIQUE
REPOSITIONING OF INTRAOCULAR LENS PROSTHESIS, WITH INCISION
Tracking Numbers: 10, 11
Presentation: Richard T. Coppoletti, MD;
American Academy of Ophthalmology, Inc.

The AAO submitted recommendations for work RVUs for tracking numbers 0010 and 0011. Procedure 658XX (0010) was described as a relatively infrequent condition where the typical patient is usually post-operative with vitreous to cataract wound. The procedure becomes necessary after a period of time if the condition does not resolve itself. The key reference service used for valuation was CPT code 67031. The recommended value of 355 that was selected was less than the median (375) and than the reference (361).

The second code, 0011, typically involves a cataract patient whose intraocular lens has shifted position and cannot be repositioned without an incision. Doctor Coppoletti stressed that all the risks involved in the procedure are the same as code 65865 only higher. A work RVU of 780 was recommended for this procedure.

Discussion:

Many RUC members questioned the survey technique and expressed concern over the low response rate (29%). Extensive discussion on this issue ensued. However, Doctor Farrell defended the survey method, commenting that the actual number of physicians responding to AOA's survey was equivalent to the numbers responding to the other surveys. Also, a wide range of geographic areas and specialties were represented at the conference where the survey was administered, which was specifically held for individuals involoved in third party reimbursement issues.

There were requests for a list of standard accepted reference services from other specialties for the sake of comparison. Other RUC members argued that this was not the proper focus of the RUC, whose ground rules focused on proper

placement within the work scale for a specialty. **Doctor Rodkey stated that there will be a cross-specialty reference list included in the next meeting's agenda books.**

Some RUC members had difficulty justifying the requested RVU considering the amount of time involved with the procedure, which Doctor Coppoletti indicated was within a range of 4-12 minutes. However, the point was made that time is not the sole component of work.

Doctor Miller moved to accept the ophthalmology recommendations for 0010 and 0011 (separate motions). The AAO recommendation for 0010 was accepted; the recommendation for 0011 was referred back to the committee.

Doctor Rodkey selected a Facilitation Committee to reexamine the recommendation for 0011: Doctor Ogrod, Chairman; Doctor Slachta; and Doctor M. Graham.

The initial voting process was by written ballot. Votes were tallied and a 2/3 majority of favorable votes was needed to pass the recommendation. Considerable discussion followed concerning the voting mechanism. However, **it was ultimately moved, seconded, and approved to keep the written voting process but to adopt a signed ballot providing space for alternative RVU suggestions and key reference services.** The staff developed a ballot form for the following day's proceedings.

Summary:

- The relative work value of 355 (3.55 x 100) RVUs was accepted for tracking code 0010.

- The recommendation for tracking code 0011 was not accepted and a facilitation committee was selected to handle further deliberations. (The Facilitation Committee met Sunday morning; reconsideration of the code is described in section IX.)

NOTE: The presentation materials for these recommendations can be found in TAB F of the May agenda book.

CHEMOTHERAPY, PLEURAL AND PERITONEAL CAVITIES AND INTO CNS
Tracking Numbers: 18, 19/26, 20
Presentation: Collier Smyth, MD;
American Society of Clinical Oncology
Nelson Richards, MD;
American Academy of Neurology

ASCO assessed relative values for three chemotherapy codes: 96440, 96445, and 96450 (Tracking Numbers 18, 19/26, and 20, respectively). ASCO stated that "assigning work values to these codes was relatively straightforward, since in each case the code encompasses a service for which a relative value is already established". However, they consider the values developed by their society to be more accurate than the existing values. Based on the median values from

the surveys, recommendations for codes 96440, 96445, and 96450 were 250, 231, and 200 RVUs, respectively.

The AAN evaluated code 96450. The Academy stressed that anxiety levels and risk involved with this procedure are extremely high. The iatrogenic stress component of work is greatest, not the physical work. Thus, upon discussion with Doctor Smyth, it was agreed that the RVU for code 96450 should be 200 RVUs, rather than AAN's original recommendation of 154.

Discussion:

For some RUC members, the fact that stress is high for this procedure did not justify the recommended RVU. They stated that every specialty encounters various levels of stress and that physicians go through extensive training to deal with this stress as part of their job.

Some felt that risk of iatrogenic harm should not be basis for the payment system and specific time data was requested. Doctor Smyth estimated that the procedures take approximately 45-60 minutes, plus notes afterwards.

Doctor Smyth pointed out that these three codes are distinct from the other chemotherapy codes which have no work value assigned because these are the only three procedures that the physicians must do themselves from beginning to end.

Doctor Novak moved to accept the recommended relative values for the three codes. All three recommendations were accepted:

- **The recommended RVU for 96440 (# 0018) is 250 (2.50 x 100);**
- **The recommended RVU for 96445 (# 0019/0026) is 231 (2.31 x 100);**
- **The recommended RVU for 96450 (# 0020) is 200 (2.00 x 100).**

NOTE: The presentation materials for these recommendations can be found in TAB G of the May agenda book.

SENSITIVITY SKIN TESTS AND INGESTION CHALLENGE TESTS
Tracking Numbers: 14, 15, 16
Presentation: Donald W. Aaronson, MD;
Joint Council of Allergy and Immunology
Charles F. Koopman, MD;
American Academy of Otolaryngology - Head and Neck Surgery, Inc.

JCAI submitted recommendations for CPT codes 95005, 95014, and 97075 (Tracking Numbers 0014, 0015, and 0016, respectively). None of these codes had been previously assigned a work value. However, JCAI felt it was justified in assigning work RVUs to these particular codes since the procedures are lengthy, complex, and stressful with a high amount of physician involvement. The physician must be present in the area throughout the test period to personally supervise all aspects of the testing. Moreover, an RN or a technician must be trained in the application of the test materials, then regularly supervised. JCAI described how "the tests are done sequentially and

incrementally usually lasting several hours with increasing doses of the test material for each test". Thus, the work RVU recommended was 23 (.23 x 100) per test for codes 95005 and 95014. The key reference services used to obtain this value were codes 99213 and 95017.

The final code, 97075, involves ingestion challenge with multiple types of allergens. Doctor Aaronson stated that there is a real risk of anaphylaxis during this procedure, an incidence of at least 5-8%. The key reference service used was code 91011; the relative value recommendation was twice that of 91011, however, due to the high levels of physician involvement and stress. A recommendation of 305 (3.05 x 100) for code 97075 was presented.

AAO-HNS presented recommendations for only the first two codes because the data obtained for the final code were found to be inadequate. The AAO-HNS recommendation was based on each antigen tested; the JCAI recommendations were for relative values per test. Each antigen could involve as many as 20 tests or as few as one. The AAO-HNS work values recommended for procedural codes 95005 and 95014 were 45 and 60 RVUs (x 100), respectively.

Discussion:

Doctor Aaronson indicated that testing time is approximately 45 minutes, although the physician is with the patient face-to-face for about 5-7 minutes per test. However, he must be present in the testing area for the duration.

Doctor Novak raised two points for consideration:

- Training of personnel is involved in every office and specialty, so it should not be included as part of the physician work component.
- Also, to each in his/her own specialty, there is not unusual stress to do what he/she has been trained to do.

There were a number of questions and concerns regarding the difference between these allergy codes and the E/M codes. Doctor Aaronson noted the difference between the time spent to determine whether a test is positive or negative from the time spent on evaluation. There could be an overlap to E/M, but JCAI has attempted to separate the two. The gathering of the data constitutes the physician work in a testing procedure, not the interpretation which comprises the E/M.

Doctor Miller spoke in support of the recommendation. He believes that the risk described by Doctor Aaronson is justified because it is an invasive procedure that takes a healthy person and puts them at risk.

A major point of contention was whether the .23 work RVU requested was on a per test (i.e., per prick) basis. This would average approximately 7-8 tests in a 2-3 hour period, with venom testing totaling about 20 tests. The rationale of having a value assigned for each test rather than each antigen tested was questioned. Doctor Aaronson explained that the amount of time and effort will vary from test to test. They should not be compensated for a group of 15 tests if only one test is needed. Many were not comfortable

converting to a per test basis. The CPT Panel's interpretation of this issue was also unclear.

Since the values for all other skin tests are zero, some members inquired about the likelihood that HCFA might assign zero to this code as well. Doctor Aaronson replied that the descriptor was changed by the CPT Panel. JCAI is not requesting work values for all skin tests (patch tests, etc.). For these particular sensitivity tests, however, there is clearly physician work involved that should be acknowledged.

A few members questioned whether addition of the terms "sequential and incremental" to the codes might be a means of unbundling the testing services. They also questioned the change from a 0.00 work effort value to one where they would receive .23 for each test.

The ingestion challenge test code presented many of the same issues as the two previous codes; namely, E/M and stress.

The new ballots were used to vote on the three codes. Committee members were instructed to consider either eventuality; per test or per antigen since the CPT viewpoint was an issue that could not be resolved that day. A definitive answer is expected from the CPT Editorial Panel in June.
[Note: The CPT Editorial Panel has indicated that codes 14 and 15 were per test (i.e., per prick)].

Results: None of the three relative value recommendations were accepted. The following Facilitation Committee was appointed: Doctor Novak, Chairman; Doctor Anzinger; Doctor Berenson; and Doctor Gordy.

NOTE: The presentation materials for these recommendations can be found in TAB H of the May agenda book.

For the future, Mark noted that the RUC methodology encourages communication between the specialties, so that a joint recommendation may be presented to the Committee.

IX. Ophthalmology Facilitation Committee Report

After a Sunday morning meeting, the Facilitation Committee felt it appropriate that the ophthalmology recommendation be reconsidered.

Doctor Farrell reiterated that the repositioning procedure (0011) was a secondary procedure, performed relatively infrequently. The value being requested was less than for the initial procedure, even though it has the potential to be more dangerous.

No revised work value recommendations were offered. Doctor Farrell felt the values presented accurately reflected what members felt were the correct values. Doctor Ogrod stated that the Facilitation Committee was not recommending a change in the relative work values presented, since they did not regard this as their role.

A lengthy discussion followed concerning the purpose of RUC and whether the Committee should attempt to crosslink between specialties or accept the existing cross specialty RVS based on the Harvard study. Doctor Rodkey focused the discussion by stating that the RUC's purpose is to objectively develop an RVS with cohesive determination of the work components across the range of specialties.

Doctor Rodkey moved that the business of this committee is to establish an RVS which encompasses work, time, risk, skill, and input of resources throughout the range of physician services with internal validity across all specialties. After the motion was seconded by Doctor Gage, considerable discussion ensued:

> Some spoke against the motion supporting the view that internal consistency must be preserved within each individual specialty. Doctor Hoehn pointed out that the motion as stated was actually a "statement of purpose", a mission statement, and perhaps it should have a tighter focus. Doctor Slachta spoke against the motion stating that the issue of cross-walks was a Herculean task which, if attempted, may paralyze RUC to lack of accomplishment.

The Chair felt that to pass the motion at this stage would not be productive. Thus, the motion was withdrawn. However, Doctor Rodkey stated that the Committee agrees that it should have the responsibility for interspecialty cross-links. He asked the Research Subcommittee to develop parameters and a report for the November meeting concerning cross-linking.

A vote was then taken on the ophthalmology recommendation for 0011. However, the recommendation was, again, not accepted.

X. Conclusion

Speaking on behalf of the AMA, Doctor Lewers concluded the meeting by commending all RUC members and staff. The objectivity and cooperation shown throughout the proceedings was most impressive and encouraging. Working together, the RUC can achieve a goal that is of the utmost importance to medicine. Doctor Rodkey echoed Doctor Lewer's sentiments and emphasized the importance of the RUC's mission for both the profession and the public.