

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING

The Stouffer Riviere Hotel
Chicago, Illinois
April 30th May 2, 1993

MINUTES

I. Call to Order

Doctor Rodkey called the meeting to order at 8:03 a.m., Friday, April 30. The following RUC members and alternates were in attendance:

Grant V. Rodkey, MD	Kenneth A. McKusick, MD
Robert K. Anzinger, MD	James M. Moorefield, MD
Timothy D. Costich, MD *	L. Charles Novak, MD
John O. Gage, MD	Eugene S. Ograd II, MD
Timothy Gardner, MD	Bergein F. Overholt, MD
Tracy R. Gordy, MD	Byron Pevehouse, MD
Michael Graham, MD	William Rich, MD *
Kay K. Hanley, MD *	Chester W. Schmidt, Jr., MD
James G. Hoehn, MD	Gregory A. Slachta, MD
George F. Kwass, MD	Ray E. Stowers, DO
Donald T. Lewers, MD	John P. Tooker, MD *
J. Leonard Lichtenfeld, MD *	Richard Tuck, MD
Michael D. Maves, MD	John Tudor, Jr., MD
David L. McCaffree, MD	William L. Winters, Jr., MD

* RUC Alternate

II. Approval of January 29-31 Minutes [Tab 1]

The minutes of the January RUC meeting were approved unanimously and without discussion.

III. Calendar of Meeting Dates [Tab 2]

The RUC discussed dates for future meetings. Dr. Rodkey announced that the June 25-27, 1993, meeting will have extended hours, with the Friday session continuing through Friday evening and the Sunday session continuing until 4:00 p.m. **A motion was made and passed to hold the November 19-21, 1993, meeting in New Orleans.** The February 5-7, 1994, meeting will be in Phoenix. The April 29-May 1, 1994, meeting will be in Chicago. In addition, the Research Subcommittee will meet on Saturday, October 16, in Chicago.

IV. Update on CPT Editorial Panel

Doctor Gordy offered "greetings from the other team" and reported that the CPT Editorial Panel considered a large number of coding requests at its April meeting. He estimated that the Panel had approved 228 new codes, deleted 77 old codes, and revised 178 existing codes. The Editorial Panel also heard 30 presentations in three and a half days. The new and revised codes will be forwarded to the RUC for consideration at its June 25-27 meeting.

V. Research Subcommittee Report [Tab 3]

Doctor Kwass presented a report on the Research Subcommittee's March 6 meeting. The report discusses the composition of Specialty RVS Committees, relative value recommendations for revised CPT codes, a proposal for revisiting recommendations for new technologies, and guidelines for specialty societies that develop comments on other societies' recommendations.

Recommendation 1 concerned the composition of specialty RVS committees. A motion was made to delete the phrase "on a voluntary trial basis only" from Recommendation, but the motion failed for lack of a second. **Motions to approve the first bullet, the second bullet and the remaining bullets of Recommendation 1 all passed.**

Recommendation 2 dealt with developing recommendations for revised CPT codes with existing published values. The committee approved points 1 through 4 of Recommendation 2. Point 5 generated a considerable amount of discussion and some members said the language of the item needed to be clarified. Doctor Rodkey instructed the Research Subcommittee to convene and reconsider the recommendation after the RUC completed its business for the day. He deferred action on point 5 and the remainder of Recommendation 2 until Saturday morning.

On Saturday morning, Doctor Kwass read the revised #5:

5. When a specialty society revalues a key reference or revised code which may serve as a base to a family of new/revised codes, the RUC will evaluate and report the recommended numerical values and the ratio of each new value to the newly assigned value of the key reference/revised base code.*

*Example: In addition to the numerical values for the new/revised codes, the RUC would indicate that, if existing base code C has a value of x, then revised code A should be valued at 50% of x, B at 80% of x, D at 120% of x, and E at 140% of x, and so on based upon the survey results, the society's review process, and the RUC's deliberations.

The committee approved points 5, 6, and 7 of Recommendation 2.

Recommendation 3 dealt with revisiting values of new technologies as they become more commonly done. **The committee approved the recommendation with an editorial revision: the word "technologies" was changed to "services."**

The next section of the report addressed the protocol for societies that submit comments on recommendations developed by other societies. Doctor Kwass said that the subcommittee felt it was unfair for the comments to carry as much weight as a survey. In the subsequent discussion, committee members concurred that societies should not be able to recommend specific competing values unless they had conducted a survey.

On Saturday morning, after approving Recommendation 2, the committee voted to approve the entire report. Doctors Gage and McCaffree asked that the Research Subcommittee report be corrected to show that they had attended the March 6 meeting.

VI. HCFA Update






Sandy Sherman reported that she met with HCFA staff (Jesse Levy, Bart McCann, and Nancy Miller) March 30. They encouraged the RUC to develop work values for services that Medicare currently does not cover or that are priced by the carriers. The RUC discussed non-Medicare payors that are using the Medicare RVS, including some state Medicaid programs, Workmens' Compensation programs, and the CHAMPUS program. **A recommendation was made that a process be developed to allow the RUC to work with the other government payors using the RBRVS.**

At the chair's request, Barry Eisenberg described plans for the May 20-21, 1993, AMA conference titled "RBRVS Physician Payment: Moving Beyond Medicare." He encouraged RUC members either to attend the meeting or send another representative from their organization.

Ms. Sherman continued her report by reminding the RUC that at an earlier meeting with Kathy Buto and Robert Eaton at HCFA, they had asked whether the RUC could deliver its recommendations on a rolling basis as they are developed throughout the year instead of delivering them all at once in July. Responding to that request, the AMA staff were planning to provide HCFA with all of the RUC recommendations developed through the April/May meeting. She asked the RUC to consider the format of these recommendations, and suggested that, in addition to the forms provided by the specialty societies, the minutes of the discussion of each issue be provided. It was suggested that the minutes summarize the committee's deliberations rather than quote individual members. The summaries would be circulated to RUC members for comment before they were sent to HCFA. If the RUC members do not call the RUC staff with any objections, the staff will assume that they approved the summaries.

A third topic discussed at the March 30 meeting was the Research Subcommittee's proposal to review work values for new services as physicians become more familiar with them. **A motion was made and passed for the Research Subcommittee to develop a process for "periodic re-review" of such services.**

Following the report on the March 30 meeting, Doctor Stone provided a report:

-  HCFA is considering a June Notice of Proposed Rulemaking on relative values for services that are carrier-priced, not covered, or restricted in coverage by Medicare.
-  HCFA is considering the issue of severity adjustments and there might be a role for the RUC on this issue.
-  HCFA has been discussing maintaining budget neutrality in the RVS and, where families of codes are revised, it may adjust values to keep the whole family budget neutral or assign the same values to new codes for the same purpose.
-  It was Doctor Stone's impression that the RUC did not want HCFA to restore the 1993 values to what they were before the 2.8% reduction, and he said HCFA did not plan to make such a change. Doctor Rodkey told Doctor Stone that the RUC's view was that the work values should be restored to what they would have been without the reduction and that this point had been made in its formal comments on the November 1992 Rule.
-  HCFA is planning a refinement process similar to the 1992 process to respond to comments it received on the 1993 RVS.

A member of the committee asked that the HCFA updates be in written form for future meetings.

VII. Update on Legal Issues [Tab 4]

The committee discussed whether it needed to adopt "Recommended Guidelines for Compliance with Antitrust Law." Some members said it would be sufficient to "accept" them. Doctor Rodkey said that the word "adoption" implied a firmer commitment. **The committee voted to adopt the guidelines.**

VIII. Review of Potential Cross-Specialty Reference Services

The protocol for rating proposed cross-specialty references was changed in an effort to make it less cumbersome than it was at the January meeting. RUC members were asked to mark their ratings on the same sheet as the proposed reference services. The original list of approximately 600 services was divided into primary and secondary lists. The primary list contained services that were either submitted by multiple specialties or that the Medicare data indicated are provided by multiple specialties, and the RUC was asked to initially rate services on the primary list. This list was rated periodically throughout the meeting.

IX. Health Care Professionals Advisory Committee (HCPAC) [Tab 5]

The RUC discussed a proposal to amend the RUC's Structure and Functions document to include the nine organizations that have been named to the HCPAC. Doctor Rodkey accepted an editorial change to delete the word "each." **A motion was made, amended, and adopted to change page 7, Section III.C. of the Structure and Functions document to read as follows:**

(2) Composition The HCPAC shall be composed of representatives of national societies representing relevant health care professionals who are non-MD/DO providers. Representation on the HCPAC shall be on application to and approval by the AMA.

The committee also decided that the members of the HCPAC would be listed in an appendix to the document. There was an extensive discussion of this issue and Doctor Ogrod noted he remained uncomfortable with the proposal. **A motion was made and adopted to refer the issue of what procedures the HCPAC will follow and how it will relate to the RUC to the Research Subcommittee.**

X. Report of Meeting with American Academy of Pediatrics

Doctor Rodkey reported on a meeting held Thursday, April 29 with the American Academy of Pediatrics and several representatives of pediatric subspecialty organizations. **There was a motion for the RUC to develop recommendations for approximately 20 pediatric services that currently have a published value of 0.00 in the Medicare RVS. After noting that these services would not normally be considered by the RUC because they were neither new nor revised, the motion carried unanimously. A second motion was made and adopted to create a small committee of RUC members and CPT Editorial Panel members to facilitate effort to develop appropriate coding changes and relative values for pediatric services.**

XI. Relative Value Recommendations

1. Nail Biopsy [Tab 7]
Tracking number: CC1
Presentation: Lawrence A. Norton, MD
American Academy of Dermatology
American Society of Dermatologic Surgery
Society for Investigative Dermatology

Doctor Norton said the new code was intended to be for both punch and incisional biopsy. He said the three societies sought a coding change because carriers often downcode the procedure to a skin lesion biopsy (11100). Doctor Norton was asked if the work estimate would be different if the vignette had specified nails of the lower extremities. He said that it might be lower because there is more anxiety about possible deformity of nails of the upper extremities. Other questions addressed whether the work levels would change if the physician performed a punch biopsy of the nail bed as compared with a punch biopsy of the matrix and whether a follow-up visit would be necessary. He said that a follow-up visit would be necessary after an incisional biopsy but not a punch biopsy.

The RUC compared this service with the procedure described by code 11750 for excision of nail and nail matrix. Whereas 11750 is used for a partial or complete excision for an ingrown toenail or deformity (RVW 1.70), the RUC raised questions about whether the added work associated with the concern about melanoma would increase the relative work of the new code, making it more equivalent to the 11750, but without the RVW that would be associated with a follow-up visit. The committee voted to approve the specialty's recommendation of 1.34 RVWs.

2. Breast Biopsy [Tab 8]
Tracking number: LL1
Presentation: W. Max Cloud, MD, American College of Radiology

Breast core biopsy (19100) involves the collection of from five to 20 core samples under some form of radiologic guidance, such as ultrasound or stereotactic mammography, from a nonpalpable suspicious breast abnormality. Doctor Gordy said that CPT had rejected an earlier request for a different code; the current revised code represented an editorial change by adding the word "core." Members of the RUC questioned whether ACR had presented compelling evidence that the work value needed to be revised. They also questioned whether it was appropriate for the biopsy code and the guidance code to be listed as separate procedures, because they were always performed together. After the discussion, the RUC rejected the ACR recommendation and the sent the issue back to the specialty society.

The committee also directed specialties to provide comprehensive information to the RUC in the future on billing practices associated with codes, such as when a code is always billed with another code.

3. Gastrointestinal Endoscopic Ultrasound [Tab 9]

Tracking numbers: T1, T2

Presentation: Arnold M. Rosen, MD

American Society for Gastrointestinal Endoscopy
American College of Gastroenterology

The ASGE/ACG recommendation of 6.11 RVW for T1, Gastrointestinal Endoscopic Ultrasound (new CPT code 46XXX) was referred back to the specialty societies, who may submit another recommendation at the RUC meeting in June. Members of the committee noted that 46XXX was an add-on code. They questioned the reliability of the survey data and the rationale for the recommendation, expressing concern about the incremental work compared with the base endoscopy codes. In particular, questions were raised about the range of procedures that might be covered by the new code and whether the survey respondents had included pre- and post-service times in their estimates of the work involved in the add-on code.

The RUC approved the recommendation of 1.02 RVWs for new code for radiological supervision and interpretation of gastrointestinal endoscopic ultrasound (76XXX). 76XXX is more intensive than 76700 (complete abdominal ultrasound examination) and it is closer to 76805 (complete obstetric ultrasound examination).

4. Psychotherapy [Tab 10]

Tracking number: P1

Presentation: Ronald A. Shellow, MD, American Psychiatric Association

The new code 908XX would be extended to 70 minutes for a psychotherapeutic session when patients reveal suicidal ideation at the conclusion of their usual session. The RUC discussed the relationship between physician work and the time involved in psychotherapy procedures and also compared the work of the service to that of lengthy consultations. It was clear from the discussion that the new code would not only entail the same amount of time as a 90843 (1.12 RVW) and a 90844 (1.76 RVW) service combined, but that the mental and physical effort and stress associated with providing a 75-80 minute psychotherapy service would lead to nearly as much intensity for the new service than that involved in providing two shorter services ($1.12+1.76=2.88$). The RUC adopted the specialty's recommendation of 2.81 RVW.

5. Abdominal Orchiopexy [Tab 11]

Tracking numbers: Y1, Y2

Presentation: Alan R. Bennett, MD, American Urological Association

Arvin I. Philippart, MD, American Pediatric Surgical Association

The revision in the descriptor for code 54640 (Y2) was considered to be editorial only, so no change is recommended from the current RVW of 6.71. Discussion focused on the abdominal approach (Y1), which is considered more complex because it involves extensive abdominal surgery in addition to the orchiopexy. Some questions were raised about the manner in which the two survey results were blended. The survey process involved both pediatric surgeons and urologists, and the recom-

mentation reflects greater weight being assigned to urologist respondents because they were found to do the procedures with much greater frequency than the pediatric surgeons.

6. Hernia Repair (Pediatric) [Tab 12]

Tracking numbers: U3, U1, U2, U4, U21, U22

Presentation: Arvin I. Philippart, MD, American Pediatric Surgical Association

For the revised code 49500 (U3), the APSA recommended the current value of 5.15 be maintained. There was some discussion of code 49680 (U21), which was reduced in HCFA's refinement process. No explanation for this reduction was identified, however, and the RUC agreed with the APSA that current published value, which is only 65% of the value for the same procedure in an adult, is too low. The new hernia repair codes for procedures provided to patients under 6 months of age were surveyed using two different vignettes, one for a term infant and one for a premature infant. The survey values were blended using frequency data on the two classes of patients that was obtained from the survey respondents. Much of the discussion of these recommendations focused on the vignettes and the blending approach. Doctor Philippart noted that, for the premature infants with reducible hernias, surgery would be delayed as long as possible so that they might be older than 6 mos. by the time the operation was done. The RUC adopted all of the APSA recommendations.

7. Hernia Repair (Other Than Pediatric) [Tab 13]

Tracking numbers: U5, U6, U7, U8, U9, U10, U11, U12, U13, U14, U15, U16, U17, U18, U19, U20, U23, U24

Presentation: Paul Collicott, MD, American College of Surgeons

Doctor Collicott said that the hernia codes had been revised to bring the section of the CPT up to date. He said the new codes better describe the differences in work between services, adding that the revision was not an effort by ACS to increase the total number of work values and that these codes had been increased in HCFA's refinement process. The revisions--consisting of deletions, codes that were not changed, combined codes, and codes with increased work values--were expected to be budget-neutral. There was a motion to adopt the ACS recommendations en bloc and forward them to HCFA with the understanding that they would be implemented in a work neutral manner, but the committee determined that a more thorough discussion of each code was required. The RUC's consideration of the new codes in this issue focused on the ratios identified by the survey process between reducible and incarcerated or strangulated hernias and between initial and recurrent hernias.

The RUC initially adopted the ACS recommendations for U5, U7, U8, U11, U13, U14, U15, U17, U20, U23, and U24. A Facilitation Committee was appointed to consider the remaining codes in the issue. The Facilitation Committee recommended a value of 8.20 for U6 did not feel that there was compelling evidence presented that the values assigned to revised codes (U9, U10, U12, U16, U19) should be increased from their current levels and recommended no change in the RVW. The ACS accepted the Facilitation Committee's recommendation and the RUC adopted them with one exception--it adopted the original ACS recommendation of 9.72 for U19.

There was considerable discussion of the recommendation for U18, an add-on code for implementation of mesh or other prosthesis for incisional hernia repair. This code was referred back to the ACS for reconsideration at the June RUC meeting.

8. Breast Lesion Excision [Tab 14]

Tracking numbers: DD1, DD2

Presentation: Paul Collicott, MD, American College of Surgeons

Doctor Collicott said that the coding changes had been requested to bring breast lesion excision section of CPT up to date. He said the two new codes were needed to describe the extra work that is involved when excising lesions identified by the radiological marker compared with a palpable lesion. The procedure requires the surgeon to spend more time in the operating room because of the need for mammography of the specimen and the need for more dissection than with a palpable mass. The lesion is first localized pre-operatively, the area is biopsied, the biopsy is sent to the radiology laboratory. The patient may require further biopsy before closure or before a "lumpectomy" with reconstruction. Currently, CPT 19120 has an RVW of 4.95. Members of the RUC asked about the "prolonged" preservice time. Doctor Collicott explained that the patients require a lot of counselling.

The RUC adopted the ACS recommendation for DD1. By a wide margin, the RUC rejected the proposed work value for DD2. Doctor Rodkey said that the margin was too wide to be reconciled through a Facilitation Committee. The proposal was referred back to the ACS.

9. Stomach Excisions [Tab 15]

Tracking numbers: K1, K2, K3, K4, K5
Presentation: Paul Collicott, MD, American College of Surgeons

The RUC's discussion of these codes focused both on the relationships of the five codes to one another and to the key reference services, as well as on the appropriateness of the existing, published relative values for these codes. The RUC found the rationale presented by Doctor Collicott for increasing the values from their current levels to be quite compelling. Although codes for these services have been in existence for a long time, advances in endoscopic surgery and medical treatment have decreased the need for open procedures of the stomach while significantly increasing the severity of the conditions requiring such surgery and the physician work involved in them. Multiple surveys were conducted of the work involved in these services, with the result being that the median values forming the basis for these recommendations reflected the views of more than 60 respondents, which is double the number required by the RUC. The RUC approved the specialty society recommendations.

10. Splenectomy [Tab 16]

Tracking number: R3
Presentation: Paul Collicott, MD, American College of Surgeons

Doctor Collicott said the new CPT code reflects the increased intraoperative work required to remove the spleen en bloc when dealing with cancer of the stomach, pancreas, colon, or adrenal gland. This is particularly important when there is an injury to contiguous organs. Patients may have an increased incidence of postoperative sepsis, requiring more postoperative work. The RVW for this code was valued somewhat higher than 50% of RVW for the splenectomy provided as a separate procedure. The ACS recommended no change in the existing RVW for 38100 and 38101 (R1 and R2). The RUC adopted the ACS recommendations.

11. Pelvic Lymph Node Dissection [Tab 17]

Tracking number: Z2, Z3
Presentation: Alan H. Bennett, MD, American Urological Association

The RUC questioned the comparisons made by Doctor Bennett between the total work of the open lymph node dissection and the laparoscopic procedure. The AUA recommendation was referred back for restudy and Doctor Bennett indicated they would request withdrawal of CPT changes for Z2 and Z3.

12. Penile Venous Surgery [Tab 18]

Tracking number: Q1

Presentation: Alan H. Bennett, MD, American Urological Association

The AUA survey found that penile venous occlusive procedure (377XX) was similar in work, time, and effort to the most commonly used reference service (54340). The RUC approved the specialty society recommendation.

13. Appendico-Vesicostomy [Tab 19]

Tracking number: V1

Presentation: Alan H. Bennett, MD, American Urological Association

The AUA survey found that appendico-vesicostomy (508XX) was similar in work, time, and effort to constructing a bowel bladder (50820). The RUC approved the specialty society recommendation.

14. Urethral Augmentation [Tab 20]

Tracking number: W1

Presentation: Alan H. Bennett, MD, American Urological Association

The AUA survey found that urethral augmentation (517XX) involved more work and time than cystourethroscopy with a steroid injection into a stricture. The RUC compared the service to cystoscopy and treatment, bronchoscopy, and other injections, such as injection of Teflon into the vocal cords. The RUC did not adopt the AUA recommendation and it was referred to a Facilitation Committee. The Facilitation Committee concluded that the work of the service was equivalent to cystoscopy and treatment (52283). The AUA accepted and the RUC adopted the Facilitation Committee recommendation.

15. Renal Endoscopy [Tab 21]

Tracking number: GG1

Presentation: Alan H. Bennett, MD, American Urological Association

The principal comparison for this service was with a TURP. The renal endoscopy involves substantially more intraoperative work and time than the TURP, however, and takes as much as three hours to complete. The RUC approved the AUA recommendation.

16. Dynamic Cavernosometry [Tab 22]

Tracking number: X1

Presentation: Alan H. Bennett, MD, American Urological Association
Robert L. Vogelzang, MD, Society of Cardiovascular and Interventional Radiology

The RUC considered comparisons of this service to angiographic services and to complex cystometrograms and approved the consensus recommendation.

17. Transtracheal Oxygen Administration [Tab 23]

Tracking number: 143
Presentation: Alan L. Plummer, MD, American Thoracic Society
William A. Dasher, MD, American College of Chest Physicians

The two societies asked the RUC to reconsider the recommendation it adopted last year for transtracheal oxygen administration, which was accepted by HCFA. The RUC did not find the specialties' arguments compelling and believed the recommendation to be too high relative to other pulmonary procedures. The RUC voted to reconsider the recommendation but the vote on the new recommendation did not pass.

18. Endoscopic Sinus Surgery [Tab 24]

Tracking numbers: EE1-EE35
Presentation: Charles F. Koopman, MD, American Academy of Otolaryngology & Head and Neck Surgery

The RUC discussed the new and revised endoscopic sinus surgery codes at length. During this discussion, a number of questions were raised about the nature of the changes made by CPT in this section. Doctor Gordy said he would raise the question with the CPT Editorial Panel's Executive Committee. There was also some discussion about whether the specialty society had commented on the RVWs to HCFA during the 1992 comment period. Several RUC members noted that many of the recommendations were above the median from the survey. Citing procedural issues, Doctor Koopman withdrew the whole block of codes, including EE1, which the RUC had initially approved. He said he would bring the whole issue back to the RUC at the June meeting.

XII. Other Issues

During discussion of one of the relative value recommendations, the committee considered ways of preventing "vignette creep." Vignette creep occurs when a specialty society writes a vignette that is more complex than the "typical" service described by the code. As a result, the survey respondents could rate the service higher than it should be. It was suggested that the vignettes could be standardized by preparing the same vignette for both CPT and the RUC. Doctor Gordy said he would discuss the issue with the CPT Executive Committee, but noted that the Editorial Panel was already overwhelmed with material.

Rich Deem, of the AMA Washington Office, gave a summary of pending federal action that would affect Medicare. He predicted that there will be an adjustment for inflation under the MVPS update process. He also reported on the Ways and Means Committee mark-up of the President's budget proposal and predicted physicians would fare better under Rep. Stark's proposal than the President's plan. The converse is true for hospitals. There are also a series of amendments that would restore reimbursement for EKGs, equalize payments for physicians in the first four years of practice, and improve the Geographic Practice Cost Index data.

Doctor Lewers described his meeting with Phil Lee, MD, Assistant Secretary of Health, on CLIA. He briefed Doctor Lee on the current CLIA issues. It was clear from the discussion that the Administration is concerned about reducing the "hassle factor" for physicians. Less clear was how CLIA would be addressed in the forthcoming health system reform plan.

The meeting was adjourned at 11:57 a.m., Sunday, May 2.