AMA/Specialty RVS Update Committee
November 21, 1998

O'Hare Hilton
Chicago, Illinois

I. Call to Order and Opening Remarks.

Doctor Hoehn called the meeting to order at 10:00 a.m. The following RUC members were in attendance:

James Hoehn, MD
David Berland, MD
Melvin Britton, MD
Robert Florin, MD
John O. Gage, MD
William Gee, MD
Kay K. Hanley, MD
Alexander Hannenberg, MD
W. Benson Harer, MD
Richard J. Haynes, MD
Emily Hill, PA-C
David F. Hitzeman, DO
Charles Koopmann Jr., MD
David L. Massanari, MD
John Mayer, MD
David McCaffree, MD
William Rich, MD
Peter Sawchuck, MD*
Bruce Sigsbee, MD
William Thorwarth, Jr., MD*
Charles Vanchiere, MD
Richard Whitten, MD*
WilliamWinters, MD

*Indicates RUC alternate

II. HCFA Update

Terry Kay and Doctor Marciniak provided an overview of the Final Rule. Due to the short time frame and large number of comments, HCFA decided that it could not effectively respond to all the comments and deferred most decisions until the refinement period. Originally, HCFA intended to respond to code specific comments and make appropriate changes to the data, but due to receiving comments on over 3,000 codes, HCFA officials realized that implementing any changes would redistribute practice expense among specialties in unpredictable ways. Therefore, HCFA's goal was to avoid specific code level changes until the refinement period.

HCFA's approach to the Final Rule was to develop interim solutions for some of the gross discrepancies discussed in letters to HCFA. Some of these changes include adjusting the hours worked for Pathologists and the supplies used by Allergists. Perhaps the largest changes in the Final Rule was the creation of a separate practice expense pool for codes without work RVUs. Since the work RVU is the major driver in the indirect cost allocation, those codes without any physician time are assigned less indirect costs. To lessen the dependence of the indirect cost allocation on physician time data, HCFA created a new pool which contains all codes with no work RVU, regardless of the specialty. The expense dollars for this pool came from the other

specialties that had codes with no work RVUs. If a specialty did not have any codes with zero work RVUs, their practice expense pool was unaffected. HCFA considers this change in methodology an interim solution until the CPEP data for these codes can be validated.

The HCFA officials commented that they did not accept any specialty specific aggregate practice expense survey data regardless of whether the data was from an oversample using the SMS survey or separate specialty practice expense survey. HCFA plans to develop criteria for accepting such surveys during the refinement process but at this time HCFA definitely has concerns regarding using any non SMS survey. The HCFA officials indicated that they would like to work with the AMA to standardize how any additional surveys are incorporated into the practice expense methodology so specialties will have an opportunity to refine their practice expense per hour data.

The HCFA officials stated that during the refinement period they would like to see the RUC and PEAC have a major role in validating physician time data and CPEP input data. HCFA would also be interested in the RUC's comments on many of the methodology issues but it will also be seeking input from many other groups. HCFA plans to select a contractor to develop a technical report which will address the methodology issues, but HCFA has not yet developed a scope of work for this contract.

III. Grouping and Prioritization of Refinement Issues

The RUC divided the refinement issues into the following four categories: See the attached list of issues for a complete description.

1) No RUC involvementother than comment letter to HCFA
2) PEAC review
3) Research Subcommittee review
4) Practice Expense Subcommittee review

The RUC agreed that refining the CPEP data is the highest priority for the PEAC, the refinement of physician time data is the highest priority for the Practice Expense Subcommittee, and working to refine the AMA practice expense per hour data is the highest priority for the Research Subcommittee. All other issues will be examined by the various groups for future refinement.

No RUC involvement other than comment letter to HCFA

Item 1—The use of the top-down approach. The RUC will comment on the overall methodology HCFA used in the Final Rule.

Item 4—Multiple Procedure reductions. The RUC will comment on HCFA's assumptions regarding possible efficiencies achieved when more than one service is performed during a single encounter.

Item 5—Impact of Y2K problems. The RUC agreed that it will include in its comment letter to HCFA that any delays in fee schedule updates due to the Y2K problem may slow down the

refinement process and therefore require a longer period of time for which the values should be interim.

Item 12a—Funding of specialty specific surveys

Item 13—Cross-Walked Specialties. The issues associated with cross-walked specialties are specialty specific issues and should not be addressed by the RUC.

Item 23a—Safety Issues and Item 23b—Incorrect use of CPT codes.
The RUC agreed to only comment on this issue in its comment letter to HCFA on the final rule.

Item 23d—Recognition of the costs of patient acuity and travel. No involvement other than any relationship to CPEP inputs.

PEAC Review of the Issue

Items 19 (including item 25), 22, 23c, 24 a,b,c—CPEP data. These issues are all related to refining and validating the CPEP data. The RUC agreed that the refinement of CPEP data should be the highest priority of the PEAC.

Research Subcommittee

Items 3, 6, 7, 8, 9 (including item 17 and 18), 10, 11, 12b&c, 20, 21 All of the issues related to the SMS survey such as the methodology for calculating physician practice expenses per hour were assigned to the research subcommittee.

Practice Expense Subcommittee

Items 2, 14, 15, 16. These issues relate to the use of physician time data in HCFA's methodology. Also, an examination of alternate methodologies for calculating indirect costs was assigned to the practice expense subcommittee.

IV. Use of Revised RUC Survey

The RUC members discussed how the data from the revised RUC survey should be used for the February RUC meeting. Currently, there are approximately 12 new/revised codes which will be presented at the February RUC meeting. Since this is the first time the practice expense portion of the RUC survey will be used, some RUC members felt that it would be premature for specialties to present their findings to the RUC. Other RUC members stated that the best way to determine the appropriateness of the survey would be to test it and have specialties present their results.

The RUC agreed to proceed with its current plans and have specialties use the current survey for new/revised codes and present their findings at the February meeting. Specialties will have the discretion of asking the RUC to not submit data to HCFA if they determine it is not valid or not representative. The RUC agreed that the current survey should be considered a pilot test and that

any resulting cost data the RUC forwards to HCFA for the development of practice expense RVUs should be included in the refinement process and be eligible for revision. The HCFA officials agreed that this was a reasonable approach.

As previously instructed by HCFA, specialties should only present their direct expense data for the surveyed code. Also a specialty should also select one or two reference codes which are similar in terms of resources necessary to perform the service, however these additional codes should not be surveyed. Specialty societies should not attempt to recommend a practice expense RVU based on the survey data since HCFA will calculate the practice expense RVU based on the direct inputs and also by an allocation of indirect expenses. Also, since the methodology for calculating practice expense RVUs will undergo refinement, it would be impractical for specialties to estimate PE RVUs.

The RUC also discussed the development of a practice expense reference service list by using the practice expense portion of the RUC survey. It was suggested that each specialty choose one or two sentinel codes and survey its members on the direct inputs required to perform the service. While such an approach may be valid there was some concern that developing a reference service with the untested survey instrument would be premature. It was suggested that it might be more appropriate to first test the survey for new/revised codes, adjust the survey if necessary, and then survey sentinel codes. An alternative to surveying sentinel codes would be to have each specialty's relative value committee select a sentinel code and assign the direct inputs for that code. The RUC agreed that if specialties wished to survey a sentinel code at this time they should contact the AMA to obtain a copy of the survey. The AMA will issue a memo notifying specialties of the availability of the survey.

V. February RUC Meeting Agenda

The schedule for the February RUC meeting is as follows:

Wednesday February 3
6:00 to 7:00 PM: HCPAC meeting

Thursday February 4
8:30 to Noon: PEAC
1:00 to 6:00 PM: Research and Practice Expense Subcommittees meet concurrently

Friday February 5
7:00 to 8:30 AM: Administrative Subcommittee
9:00 to 5:00 PM: RUC meeting

Saturday February 6
9:00 to 5:00 PM: RUC meeting

VII. Formation of the PEAC

Dr. Hoehn announced that he has selected Eugene Ogrod, MD, a former RUC member, to chair the PEAC. The PEAC will convene on February 4, 1999 for an organizational meting and is expected to begin its work in late March or early April. A letter from Doctor Anderson will be sent out shortly to all Specialties seeking nominations for the PEAC. Specialties will be asked to forward their nominations to Sherry Smith.

Issues for refinement

The following is a summary of the issues identified in the final rule that will be considered as part of the "refinement" process. Excerpts from the final rule are included in parentheses.

Issue	Group Responsible for Issue
General Methodology:	
1. **The use of the top-down approach** ("We believe that this methodology list responds to the requirements of the Social Security Act Amendments of 1994 and the BBA."…"A possible weakness of the top-down approach is that it may perpetuate historical inequities in the current charge-based practice expense RVUs. More highly paid physicians would presumably have more revenues that could subsequently be spent on their practices. We believe this issue should be discussed during the refinement process")	**RUC will discuss in comment letter on final rule to HCFA**
2. **Calculation of indirect costs** ("We are making a technical change to the allocation method for indirect costs by using direct costs and the work RVUs scaled using the Medicare conversion factor instead of a factor calculated using the physician time data. Because of questions raised by commenters concerning the time data adjustments, we believe that it is more appropriate to convert the work RVUs into dollars using the Medicare conversion factor (expressed in 1995 dollars, consistent with the AMA SMS survey data). This will give somewhat less weight to work while, at the same time, avoiding a major methodological change until it has been examined further. We intend to work with the medical community during refinement so that we ensure that our allocation methodology is both appropriate and equitable. We allocated indirect expenses to individual CPT codes based on physician work and direct expenses. Some commenters suggest that indirect expenses should be allocated by alternative methods, such as physician time and direct expenses, or just direct expenses. We would welcome your recommendations.")	**Practice Expense Subcommittee**
3. **Errors in HCFA claims data on specialty designation** ("Several surgical specialties urged that we clean the Medicare claims data to eliminate obvious errors, such as data showing a sometimes significant number of nonsurgeons or physician assistants performing complex surgeries that can only be performed by surgical specialties. This misreporting can decrease a specialty's practice expense pool and should either be reassigned or excluded during refinement.")	**Research Subcommittee**
4. **Multiple procedure reductions** ("Although we have not made a specific proposal with respect to multiple procedures thus far, we may do so in the future. We continue to believe there are efficiencies when more than one service is performed during a single encounter.")	**RUC will discuss in comment letter on final rule to HCFA**
5. **Impact of Y2K problems** ("For 1999, we plan to make routine provider payment updates and other BBA changes. These pose minimal risks to contractors' year 2000 (Y2K) efforts and, therefore, can be done. Routine updates between October 1, 1999 and April 1, 2000 may need to be delayed because they would occur during a critical timeframe in late 1999 and early 2000 when final Y2K testing and refinements must be accomplished. We will actively consult with interested professional groups, the Congress and other parties as we develop our plans to achieve Y2K compliance while causing minimum disruption in fee schedule updates.")	**RUC will discuss in comment letter on final rule to HCFA**

Practice Expense Per Hour Data:		
6.	**Use of SMS survey** ("Some specialties are under-represented or not appropriately represented in the SMS data and some are not included at all."…"One of our most important tasks during the immediate refinement period will be to work with the AMA and the medical community to consider possible ways to improve the representativeness of the aggregate specialty-specific data so that sampling error is decreased. As part of the refinement, we will also need to develop strategies to eliminate as many sources of nonresponse and measurement error as possible")	**Research Subcommittee**
7.	**Use of median or mean responses to SMS survey** ("HCFA will calculate the practice expenses per hour by using the mean values for each specialty, at least for the purposes of this final rule.")	**Research Subcommittee**
8.	**Need to audit future survey data** ("Now that it is widely known how these survey data are being used, every specialty has an incentive to ensure that their data are as high as possible in future surveys.")	**Research Subcommittee**
9.	**Inclusion of non-billable hours in the SMS survey of hours of work per year** ("Since pathologists have more Part A reimbursement than any other specialty, we will decrease the number of patient care hours by 6 percent for autopsies and 15 percent for supervision services. However, until we have more information about the appropriate adjustment for "personally performing non-surgical laboratory procedures including reports," the hours for those services cannot be eliminated from our calculations. This point, as well as the general issue of nonbillable hours, should be revisited during refinement.")	**Research Subcommittee**
10.	**Uncompensated Care** ("The amount of patient care hours spent on uncompensated care could be significantly higher for emergency medicine than for any other specialty. These issues require further examination.")	**Research Subcommittee**
11.	**Separately billable supplies and services** ("We do agree that during refinement we need to consider development of a methodology for removing separately billable supplies and services from the SMS data so that the Medicare program avoids making duplicate payments. We also will work with the oncology specialty to ensure that their practice expense per hour for the supply category adequately reflects the actual costs of other oncology supplies.")	**Research Subcommittee**
12.	**Validation of Other PE/Hour Data**:	**RUC will discuss in comment letter on final rule to HCFA**
	A. **Funding of Specialty-Specific Surveys (**"One specialty society commented that we should conduct specialty-specific surveys for all HCFA-designated specialties during the refinement period. The comment stated that it is not reasonable for us to put the burden of oversample costs, which exceed $100,000 on the HCFA-designated specialties that the AMA has chosen not to include in its annual survey sample. Decisions on what surveys are needed, what the criteria should be for those surveys, who should conduct the surveys, and who should fund them will be made as we address these issues during refinement."	
	B. **Revisions of the pe/hour data** ("There is not sufficient time before publication of the final rule to begin to validate either the	**Research Subcommittee**

methodology or findings of the submitted data. Since changes in any specialty's practice expense per hour would have an impact on other specialties, we do not believe it would be equitable to make any sweeping changes without the adequate review that the refinement process can achieve. In addition, we stated in our proposed rule that, for those larger specialties included in the SMS survey, "we are unlikely to make any changes in the final rule" Therefore, we will continue to use the SMS-derived practice expense per hour for these specialties, but will ensure that all of the submitted data will be considered during the refinement process.")	
C. Non-SMS survey data submitted in response to the proposed rule ("During the refinement period we will be working with specialties not represented in the SMS survey to identify the data needed to enable us to determine accurate practice expense RVUs for their services.")	**Research Subcommittee**
13. **Cross-Walked Specialties:** **A. Use of multiple crosswalks for pe/hour data** ("The Society of Gynecologic Oncologists requested that we consider using multiple crosswalks to determine practice expense per hour for specialties that provide interdisciplinary care. The comment stated that the true reflection of practice expense per hour for a gynecologic oncologist is a hybrid of the practice expense per hour for the specialties of obstetrics and gynecology and oncology.") **B. Crosswalks for nursing specialties** ("One commenter made recommendations for revisions or additions to our proposed crosswalks for several nursing subspecialties. Another specialty society commented that under the physician fee schedule we have chosen to pay nonphysician practitioners a percentage of the physician reimbursement, and crosswalking to specialties with higher practice expense per hour rates than general internal medicine or general surgery is not logical or reasonable. Another organization also recommended that data from nurse practitioners and physician assistants be excluded from the practice expense pool calculations. We will further consider appropriate crosswalks for nursing subspecialties during the refinement period.") **C. Transplant surgery as a specialty** ("An organization representing transplant surgeons commented that, as transplant surgery is not a designated specialty in the Medicare claims database, many transplant surgeons designate themselves as general surgeons, who have the lowest practice expense per hour of any surgical specialty. The comment argued that this has led to a significant underestimation of the costs associated with transplant surgery.") **D. Others Commenting on Inappropriate Crosswalk**: Maxillofacial prosthetics Optometry Chiropractors Podiatry	**No RUC involvement. Specialty specific issues.**

	Oncology Oral and Maxillofacial Surgeons Geriatrics Occupational Therapy Audiology	
Physician Time Data:		
14.	**Methodology Utilized in Adjusting Time Data** ("As a matter of consistency and fairness to those services not yet refined by the RUC, we increased the Harvard time data in proportion to the increases for related services. A detailed description of the methodology we employed to make all adjustments to physician time will be placed on the HCFA homepage.")	**Practice Expense Subcommittee**
15.	**Physician time data attributed to each code** ("We believe that ensuring the increased accuracy and consistency of physician time data should be addressed as part of the refinement of the practice expense RVUs. According to our chosen refinement process, requests to adjust the physician time data would be initially referred to the RUC. We believe that the RUC will understand the implications that changes in physician times could have for the work RVUs.") **A. Pediatric surgery** ("The American College of Surgeons commented that physician time for pediatric surgery codes is based on erroneously low physician time data from the original Harvard study, rather than the time data from the special study of pediatric services performed by the same Harvard study team for the American Pediatric Surgical Association in 1992. The latter data were used as the basis for the work RVUs assigned to 48 pediatric surgical services.") **B. Psychotherapy** ("One specialty society, as well as the AMA, pointed out that there are some problems with the accuracy of the physician time data for psychotherapy services. For example, the times assigned to psychotherapy codes that include evaluation and management services are equal to and, in some cases, less than the psychotherapy codes that do not include these services.") **C. Transplant surgery** ("The American Society of Transplant Surgeons identified physician times for several services that it believes are inaccurate and recommended adjusted times for these services.") **D. Radiology** ("We will work with the medical community to develop time estimates for radiology procedures that will make the imputation of time from the work estimates unnecessary.")	**Practice Expense Subcommittee**
16.	**Effect of rounding on high volume services of relatively short duration** ("In our proposed rule, we expressed concern that imprecision in the time estimates for any high volume services that have relatively little time associated with them may potentially bias the practice expense methodology in favor of the specialties that perform these services. We stated at that time that this issue should be examined as part of the refinement of the resource-based PE RVUs.")	**Practice Expense Subcommittee**

17.	**Standby time** ("A surgical specialty society commented that the physician time does not compensate its members for longer hours and cited examples of nonbillable time, such as standby time for cardiac catheterization and supervision of residents and interns.")	**Research Subcommittee include in item 9**
18.	**Travel time** ("One commenter stated that travel time for home visits is not included in either the work or practice expense RVUs. The commenter suggested that travel time for house calls should be equal to the work equivalent of the lowest office service times 3, for an average of 15 minutes. Further, a modifier should be used to cover instances where travel exceeds the average.")	**Research Subcommittee include in item 9**
CPEP/Direct Expense Data:		
19.	**CPEP data** ("We know that there is much needed improvement in the CPEP data, and the identification and correction of any CPEP errors whether in staff times, supplies, equipment, or pricing will be a major focus of our refinement process." … "Almost 30 specialty societies submitted specific CPT code level changes for the CPEP input data for just under 3,000 codes.."…"We would welcome comments from the RUC/PEAC or any other organization or individual for individual code level data--both for resource inputs and time data. The RUC and PEAC would function as an entity independent from us, much like the current RUC operates for purposes of providing comments on work RVUs. We also recognize the RUC/PEAC may wish to comment on other aspects of the process, such as methodology. We would consider such comments along with those received from others and would likely discuss them as part of the process. However, we wish to emphasize that, as in our dealings with the current RUC, we would retain the ultimate authority and responsibility to establish practice expense RVUs.")	**PEAC**
20.	**Averaging of CPEP inputs for redundant codes, i.e., those reviewed by more than one CPEP** ("As we are making no other changes in the CPEP data for this final rule, we will continue to use straight averaging for the redundant CPEP codes for the purposes of this final rule.")	**Research Subcommittee**
21.	**Use of midlevel practitioners** ("One commenter agreed with our proposal that we address potential bias toward specialties which use more midlevel providers during the refinement period.")	**PEAC/Research Subcommittee include in item 19**

22. **Revisions to pe RVUs for services with zero work** ("Because we are not altering the CPEP at this time, as an interim solution until the CPEP data for these services have been validated, we have created a practice expense pool for all services without work RVUs regardless of the specialty that provides them.".. **"**We are creating a single practice expense pool for all services, such as audiology, that have no work RVUs. This practice expense pool, created by using the average clinical staff time per procedure from the CPEP data and the "All Physicians" practice expense per hour, raises practice expense RVUs for audiology services relative to those previously proposed. However, during the refinement process we will be considering all data submitted on any of these services, including the study submitted with the above comment.")	**PEAC**
23. **Appropriate Site-of-Service Issues:**	
A. **Safety issues** ("The American Urological Association commented that certain codes - 50590, 52234, 52235, 52240, 52276, and 52317 were inappropriately assigned nonfacility PE RVUs, as it is not safe to perform these services in the office. We would need more data to demonstrate that performing these services in the office is not appropriate before we would eliminate the nonfacility RVUs. We are willing to review such information during the refinement process. Such information should be submitted to HCFA, Office of Clinical Standards and Quality".)	**No RUC involvement other than discussion in comment letter to HCFA**
B. **Incorrect use of CPT codes** ("One organization representing psychiatrists noted that CPT codes 90816 through 90829 are restricted to the inpatient hospital and partial hospital and residential care settings, and that CPT code 90870, electroconvulsive therapy, would not generally be performed in an office setting. The commenter recommended that the final rule list RVUs for only the facility setting.")	**No RUC involvement other than discussion in comment letter to HCFA**
C. **Anomalous RVUs with higher values in a facility than an office** ("Another commenter submitted a list of some codes where the facility practice expense RVUs are higher than the in-office values. The instances of higher facility RVUs are an artifact of our indirect methodology and reflect the differing mix of specialties performing a service in each setting.")	**PEAC**
D. **Recognition of the costs of patient acuity and travel** ("The American Speech-Language-Hearing Association commented that the extra costs for patient acuity and travel should be added to the site of service differential.")	**No RUC involvement**

24.	**Supplies:** **A.** **Exclusion of supplies from facility based practice expenses** ("One specialty organization recommended that we confirm that facility-based practice expenses exclude only those practice expenses that are actually provided and paid for by the facility".) **B.** **Payment for supplies used in a SNF** "(Home visits are to be paid using the non-facility RVUs. Therefore, any supplies that would be used are already included in the payment. As for the SNF setting, this is an issue for refinement. We would need more information about the supplies and why the SNF is not responsible for providing them.") **C.** **Recognition of "incident to" supplies** ("One comment argued that incident-to supplies were not counted in the CPEP process, and the other that this separate payment is a preferred method of recognizing added costs to physicians.")	**PEAC**
25.	**Practice expense RVUs for ERSD services** ("We allocated the practice expense pool to ESRD services using the CPEP inputs, as we did for almost all other services. We also believe that the intensity of an average evaluation and management service provides a reasonable estimate of physician time. These issues can be further analyzed during refinement.")	**PEAC include in item 19**