

**AMA/Specialty RVS Update Committee
Meeting Minutes
October 5-7, 2006**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, October 5, 2006, at 1:00 pm. The following RUC Members were in attendance:

William Rich, MD (Chair)	Walt Larimore, MD*
Bibb Allen, Jr., MD	M. Douglas Leahy, MD*
James Anthony, MD*	Barbara Levy, MD
Dennis M. Beck, MD*	Brenda Lewis, DO*
Michael D. Bishop, MD	J. Leonard Lichtenfeld, MD
James Blankenship, MD	William J. Mangold, Jr., MD*
Dale Blasier, MD*	Geraldine B. McGinty, MD*
Ronald Burd, MD	Bill Moran, Jr., MD
Manuel D. Cerqueira, MD*	Bernard Pfeifer, MD
Norman A. Cohen, MD	Gregory Przybylski, MD
Bruce Deitchman, MD*	Sandra B. Reed, MD*
James Denny, MD*	David Regan, MD
John Derr, Jr., MD	James B. Regan, MD
Verdi DiSesa, MD*	Chad Rubin, MD*
Thomas A. Felger, MD	Daniel Mark Siegel, MD
Robert C. Fifer, PhD*	J. Baldwin Smith, III, MD
Mary Foto, OTR	Peter Smith, MD
Meghan Gerety, MD	Susan Spires, MD*
Robert S. Gerstle, MD*	Robert J. Stomel, MD*
James Giblin, MD*	Susan M. Strate, MD
David F. Hitzeman, DO	Arthur Traugott, MD
Peter Hollmann, MD	Richard Tuck, MD
Charles F. Koopmann, Jr., MD	George Williams, MD*
Gregory Kwasny, MD	John A. Wilson, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Financial Disclosure Statements must be submitted to AMA staff prior to presenting. If a form is not signed prior to your presentation, you will not be allowed to present.
- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PERC recommendations or PEAC standards. If the society has not accepted PERC recommendations or

PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value or practice expense discussion.

- Doctor Rich welcomed the following new RUC members:
 - Megan Gerety, MD, American Geriatric Society
 - Arthur Traugott, MD, American Medical Association
- Doctor Rich welcomed the CMS Staff attending the meeting, including:
 - Edith Hambrick, MD, CMS Medical Officer
 - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
 - Ken Simon, MD, CMS Medical Officer
 - Pam West, PT, DPT, MPH, Health Insurance Specialist
- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
 - Kevin Hayes, PhD
 - Nancy Ray, MS
 - Ariel Winter, MPP
- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting were:
 - Bill Moran, MD (Chair)
 - James Anthony, MD
 - Katherine Bradley, PhD, RN
 - Joel Brill, MD
 - Neal Cohen, MD
 - Manuel D. Cerqueria, MD
 - Neal H. Cohen, MD
 - Thomas Felger, MD
 - Gregory Kwasny, MD
 - Peter McCreight, MD
 - Tye Ouzounian, MD
 - James Regan, MD
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
 - Charles Haley, MD
- Doctor Rich announced the members of the Facilitation Committees:
 - Facilitation Committee #1
Susan Strate, MD, Chair
Michael D. Bishop, MD
Ronald Burd, MD
Norman Cohen, MD
Mary Foto, OTR

Charles Koopmann, MD
Barbara Levy, MD
Bernard Pfeifer, DC
James Regan, MD
Peter Smith, MD
Arthur Traugott, MD

- Facilitation Committee #2
James Blankenship, MD, Chair
Bibb Allen, MD
Katherine Bradley, PhD, RN
John O. Gage, MD
Meghan Gerety, MD
Gregory Kwasny, MD
J. Leonard Lichtenfeld, MD
William J. Mangold, Jr., MD
Larry Martinelli, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM

- Facilitation Committee #3
Joel Brill, MD, Chair
Sherry Barron-Seabrook, MD
Dale Blasier, MD
John Derr, MD
Thomas Felger, MD
Emily H. Hill, PA-C
David Hitzeman, DO
Willard Moran, MD
Gregory Przybylski, MD
David Regan, MD
J. Baldwin Smith, MD
Richard Tuck, MD

- Doctor Rich welcomed the following individuals as observers at the April 2006 meeting:
 - [Carolyn Baum, PhD, OTRL/L, FAOTA - American Occupational Therapy Association, Inc.](#)
 - [Robert Blaser - Renal Physicians Association](#)
 - [Jayna Bonfini - American Academy of Dermatology](#)
 - [Dawn Brennaman - American Academy of Physical Medicine & Rehabilitation](#)
 - [Mark Campobello - American Urological Association](#)
 - [Scott Collins - American Academy of Dermatology](#)
 - [Noah Cook - American Medical Directors Association](#)

- [Charles A. Crecelius, MD, PhD, CMD - American Medical Directors Association](#)
- [Alan Desmond - American Academy of Audiology](#)
- [Roshunda Drummond-Dye - American Physical Therapy Association](#)
- [Christopher Gallagher - American College of Cardiology](#)
- [Rick Gilbert - American Urological Association](#)
- [Lawrence Green - American Academy Dermatology](#)
- [Dan Han, MD, MS, FACS - Society for Vascular Surgery](#)
- [Debra Henley Lansey, MPA - American Society for Therapeutic Radiology and Oncology](#)
- [Robin Hudson - American Urological Association](#)
- [Beth Kosiak - American Urological Association](#)
- [Stephanie Kutler - The Endocrine Society](#)
- [Gayle Lee - American Physical Therapy Association](#)
- [Tim McNichol - American College of Osteopathic Internist](#)
- [Jennifer Medicus - American Academy of Child and Adolescent Psychiatry](#)
- [Erika Miller - Society of General Internal Medicine](#)
- [James Moser - American College of Radiology](#)
- [Penelope Moyers, EdD, OTR/L, BCMH - American Occupational Therapy Association, Inc.](#)
- [Janemarie Mulvey - College of American Pathologists](#)
- [Nicholas Nickl - American Society for Gastrointestinal Endoscopy](#)
- [Bernard Patashnik - American Academy of Otolaryngic Allergy](#)
- [Randy Patridge - American Academy of Otolaryngic Allergy](#)
- [Wayne Powell - American College of Cardiology](#)
- [Koryn Rubin - American Academy of Ophthalmology](#)
- [James Scroggs - American College of Obstetricians & Gynecologists](#)
- [Mike Sheppard - American Urological Association](#)
- [Matthew J. Sideman - Society for Vascular Surgery](#)
- [Fred Somers - American Occupational Therapy Association, Inc.](#)
- [Kay Sykes - American College of Surgeons](#)
- [Terry Tropin - American College of Obstetricians & Gynecologists](#)
- [Allison Waxler - American College of Cardiology](#)
- [Karen Williams - American Society of Anesthesiologists](#)

- Doctor Rich welcomed the following individuals representing the Korean Medical Association:
 - Hyo Keel Park, MD – KMA – Vice President (Health Insurance)
 - Young-Jae Kim, MD – KMA
 - Sung Chul Shin – KMA
 - Seon Kui Lee, MD – Graduate School of Public Health, Yonsei University
 - Jong Ouck Choi, MD – Korean Medical Practitioners Association

- Young Geon Ji, MD – Pochon CHA University
 - Youm Wook, MD – Soon Chun Hyang University Hospital
 - Bum Yong Lee, MD – Korea Association of Neuropsychiatric Practitioners
 - Change Hwan Han, MD – Korean Neuropsychiatric Association
 - Youn Woo Lee, MD - Yonsei University College of Medicine
 - Sang Ryull Lee, MD - The Korean Association of Anesthesia
 - Hoon Shik Yang, MD - Chung Ang Univ. Hospital, Seoul
 - Soon Hyun Kim, MD – Kon Yang Hospital
 - Min Suk Kim, MD – Korea Cancer Center Hospital, KIRAMS
 - Yeong In Kim, MD - The Catholic University of Korea, Kang-nam St. Mary's Hospital
 - Jon Nam Joh, MD – Korean Association of Obstetricians and Gynecologists
 - Kyoo Duck Lee, MD – Health Insurance Review Agency
 - Ms. Jae Ok Sim – Health Insurance Review Agency
 - Ms. In Sook Jang – Health Insurance Review Agency
- Doctor Rich directed the RUC to review the written apology from the North American Spine Society (NASS) regarding the publication of confidential information and reminded RUC members to maintain confidentiality of RUC information. Representatives from NASS are not in attendance for this single RUC meeting.
 - Doctor Rich delivered a brief personal presentation regarding pay-for-performance issues. The slide presentation is available through AMA staff.

III. Director's Report

Sherry Smith made the following announcements:

- Meeting dates and locations for upcoming RUC meetings are as follows: February 1-4, 2007 at the Omni San Diego Hotel in San Diego, CA; April 26-29, 2007 at the Renaissance Hotel, Chicago, IL; and September 27-30, 2007 at the Swissotel, Chicago, IL.
- The AMA has updated information regarding the RBRVS and the RUC on its web site. Information geared towards the public has been made available on the public portion of the AMA's web site.
- The AMA has also launched a RUC participant only web site containing helpful information for all authorized RUC participants. The site is contained in a "hidden" area, meaning that it cannot be accessed through any search engine or through the AMA main web site. Access will be granted and confidentiality maintained through a direct link distributed only to authorized RUC participants. The new site will not be interactive or replace broadcast emails and other current forms of communication, but

will serve as a continuously updated archival and repository of RUC information.

- The CPT/RBRVS Symposium is scheduled to take place November 16-17, 2006 in Chicago, IL. This is the first year a joint format will be implemented, integrating coding and reimbursement concerns regarding major coding changes in 2007. 1000 attendees are expected. AMA staff expressed appreciation for the RUC members participating as presenters.
- Susan Clark recently conducted a survey of non-Medicare use of the RBRVS, targeting all Medicaid plans, TRI-CARE, private payers, and worker's compensation plans. The data has been collected and is currently under analysis. Some preliminary results and a copy of the survey have been distributed to RUC members. The detailed results will be presented at the Symposium by Doctor Whitten and will be distributed to RUC participants.

IV. Approval of Minutes for the April 27-30, 2006 RUC meeting

Two errors in the minutes were brought to the attention of the RUC. On page 46, the recommendation for code 35884 contains a reference to an inaccurate survey median value. The error is typographical in nature and the recommendation will be corrected in the minutes.

Second, page 69 incorrectly refers to the research subcommittee report as the administrative subcommittee report. The error is typographical in nature and the report will be corrected in the minutes.

The RUC reviewed the minutes and accepted them as amended.

V. CPT Editorial Panel Update

Doctor Peter Hollmann informed the RUC that:

- The CPT Editorial Panel met this past June, beginning the 2008 CPT Editorial Cycle. The Panel will meet October 12-15, 2006 in Washington, DC. for the Annual Meeting of the CPT Advisory Committee and HCPAC Advisory Committee.
- Code proposals considered at the meeting will be primarily Category II, Category III, and laboratory codes. The October meeting will also feature numerous special sessions on use of modifier -51, CPT data models, definition of site of service, and point of care testing.
- Doctor Hollmann noted that CPT code 93325, *Doppler echocardiography color flow velocity mapping* has not yet been reviewed by CPT following the most recent Five-Year Review. The specialty society has indicated to CPT that it has no intention to move forward with a CPT proposal. The RUC agreed to address the issue at this time and briefly reviewed the history of its action. The code was originally referred to the third Five-

Year Review by CMS. The American College of Cardiology (ACC) surveyed the code and made a recommendation to the RUC that the work RVUs be increased. CMS and the RUC indicated an interest in bundling the service with other cardiology services, however, ACC argued that bundling is inappropriate due to the service's varied utilization pattern with a wide variety of other services. ACC asserted that the service does contain physician work and agreed that the coding alternatives suggested by the RUC were inappropriate. The RUC noted that this code was submitted to the Five-Year Review by CMS. Since ACC will not be addressing the concerns in a coding proposal, the RUC will need to examine the code again. **Therefore, the RUC agreed that ACC be asked to bring 93325 to the next RUC meeting for discussion.**

- Doctor Hollmann thanked the RUC for its continued participation during CPT meetings. The RUC representative for the October 2006 CPT meeting is Doctor Moran and the February 2007 meeting is Doctor Cohen.

VI. Contractor Medical Director Update

Doctor Haley thanked the RUC for the opportunity to serve as a representative of Medicare Contractor Medical Directors and noted that there was nothing to report at this time.

VII. Washington Update

Mr. Rich Deem, AMA Senior Vice President of the Advocacy Group provided the Washington Update to the RUC. Mr. Deem began by thanking the RUC and its staff for their efforts to make annual updates to physician work as well as other improvements to the Medicare payment system that are subsequent to the original mandate of the RUC and of great benefit to all of organized medicine.

Mr. Deem provided a complete update of the status of the AMA's advocacy efforts to positively affect the CMS physician payment schedule and avert the projected cuts in 2007. He reviewed the series of proposals that arose in the legislature through September 2006. These proposals from Reps. Bill Thomas, Joe Barton and Nancy Johnson and Sens. Charles Grassley and Debbie Stabenow ranged from one to three years and all would have provided some additional payment for physicians who participated in a quality reporting program. While the AMA made great efforts to encourage Congress to discuss these physician payment issues earlier, it was not addressed until September.

Mr. Deem continued that there are 80 senators and 265 representatives who stated on record that the conversion factor update should be fixed by September but action had not occurred due to adverse economic factors, high costs due to the unfunded fixes enacted for the past five years and political factors. In addition, some Congressional members are not convinced that access to care will not be

reduced if the cuts are enacted. AARP stated that the threat was not access to care, but premium increases. Congress also failed to understand that there are many other cuts taking place at the same time.

Mr. Deem further noted that AMA staff was continuing to work on proposals for the lame duck session beginning on November 13 and would push for enactment of a plan that includes a positive update for all physicians, a fair differential between those who report quality measures and those who do not, and, most importantly, financing that will not drive further cuts in the future. Mr. Deem expressed great gratitude to the AMA's grassroots. This year, medicine has worked together on this issue better than ever before. The message to Congress has been consistent, which is a great concern for any advocacy campaign. However, active physicians must try to get other physicians involved. Currently, the AMA's strongest grassroots efforts come from more than 1.2 million patients that have contacted their legislators this year. Mr. Deem suggested that physicians encourage not only their patients, but also their office staff to become active.

VIII. Relative Value Recommendations for Five-Year Review

Anoscopy and Proctosigmoidoscopy (Tab 4)

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

The facilitation committee met to discuss the Anoscopy Codes (46600-46615) and Proctosigmoidoscopy codes (45300-45327). The facilitation committee felt that the compelling evidence supported the review of these codes. After careful consideration of the specialty society's recommendations, the facilitation committee felt uncomfortable with the specialty society's survey, reference service list and recommended work value for the base code CPT 45300

Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure). The facilitation committee also expressed concern that this effort made by the specialty society would not address CMS' request as these codes were not re-surveyed by the specialty society.

Therefore, the facilitation committee recommends:

- 1.) The issue be divided into two issues: 1.) Anoscopy and 2.) Proctosigmoidoscopy as societies may have different level of interests in these two issues**
- 2.) A new LOI be distributed to the Advisory Committee to solicit all interested societies interested in developing primary recommendations for these codes as well as societies who would like to comment on those recommendations**

3.) The codes be re-surveyed and that an accepted Five Year Review Methodology be used in the development of work recommendations

During the discussion, there was some concern expressed by the facilitation committee that the policy regarding the level of interest process: reporting and response needs to be strengthened. **Therefore, the facilitation committee recommends that the Administrative Subcommittee clarify the RUC's policy when:**

- 1.) AMA staff receives an LOI indicating a specialty society's level one interest and the specialty society decides that they no longer wish to participate in developing primary recommendations**
- 2.) AMA staff receives an LOI indicating a specialty society's level two interest and no comment is received by the specialty society and**
- 3.) AMA staff receives no level of interest from the specialty society.**

IX. Relative Value Recommendations for CPT 2007

Uterine Fibroid Embolization (Tab 5)

Geraldine McGinty, MD, American College of Radiology (ACR), Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR), Jonathan Berlin, MD, American College of Radiology (ACR), Harvey Wiener, DO, Society of Interventional Radiology (SIR)

The CPT Editorial Panel created a new CPT code to provide more specificity to the procedures related to uterine fibroid embolization (UFE). The intent of the Panel was to create a new embolotherapy code that describes UFE separately and distinctly, since it is believed to have reached the point in clinical practice where it is performed with a relatively uniform technique and needed to be specified. The RUC reviewed the physician work and practice expense for this new code over the April and October 2006 meetings.

April 2006

At the April 2006 RUC meeting, specialty provided a detailed description of service, and the intensity and complexity to the RUC for code 37210 *Uterine Fibroid Embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation and intraprocedural roadmapping and imaging guidance necessary to complete the procedure*. The RUC did not accept the survey data for this code, especially the intra-service physician time. The RUC recommended an intra-service time at the 25th percentile of 90 minutes. However, the RUC expressed concern that the

90 minutes of intra-service work remains inconsistent with time mentioned within recent literature.

The code, was compared to code 61623 *Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion* (000 global, Work RVU = 9.95), however the RUC agreed the true value should be lower. The RUC could not support a value equivalent to 9.95 at this time and recommended a value slightly lower, at 9.00, until the specialty present new survey results.

The RUC recommended that code 37210 have a interim value of 9.00 RVUs and asked the specialty society to resurvey and present this code again at the October 2006 RUC meeting. In addition, moderate sedation is inherent within this procedure and this code should be added to the moderate sedation list.

October 2006

In October 2006, specialty presented its results from a new survey. The specialty stated that they had initially requested the new procedure be designated as a 010 day global period code, however CMS had designated the code as a 000 day. The specialty surveyed 750 physicians and received 88 respondents who provided tight statistical data with a median work RVU of 16.97. The respondents believed the intensity and complexity of this new procedure was similar, but not quite equal, to the code they most often selected as a similar service (37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (090 global, Work RVU = 18.71). Understanding the similarities in the two code, the specialty however believed and recommended a much lower work RVU of 10.60, based on the differences in the global period and physician time. The specialty believed that the survey respondents may have misunderstood that the global period for the new code and the work value was then inflated according. In addition, the RUC understood that there was a lack of a good comparison code for the new procedure at the specialty recommended value, and the RUC did believe that the intensity of the reference code could be used as a benchmark for evaluating the intra-service of physician work for the new code.

The RUC believed the reference code 37215 had a higher intra-service work per unit of time (IWPUT) of 0.122, and that the new code had at least 20% less intra-service work. The RUC and the specialty agreed the new code had an IWPUT of approximately 0.095. The RUC then used a building block approach with the IWPUT of 0.095 to establish a physician work value for the new code using the physician time components from the survey.

The RUC also believed that this 000 day global code was extraordinary, whereas a typical patient would typically require extensive pain management and observation, therefore, the RUC believed post-operatively, a half of a discharge

day management procedure (99238) was appropriate physician work that should be incorporated into its value.

In April 2006 the RUC had expressed reservations about the validity of a 90 minute intra-service physician time. The RUC agreed that the October 2006 survey results of nearly 90 respondents concurred with the specialty's previous recommended time and typical patient scenario. The RUC supported the specialty's survey results and the use of code 37215 as a benchmark for establishing a relative work value in the correct rank order for new code 37210 of 10.60.

The RUC recommends a relative value of 10.60 for code 37210. In addition, moderate sedation is inherent within this procedure and this code should be added to the moderate sedation list.

Note: The CPT Editorial panel has included this code in its conscious sedation list for CPT 2007.

Practice Expense: The practice expense inputs accepted as amended to reflect the change in intra-service work time and corrections from the PERC at the April 2006 meeting.

X. Relative Value Recommendations for CPT 2008

Tumor Debulking (Tab 6)

The American College of Surgeons requested that code 49201 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive* be postponed until February 2007 after review of this service by the CPT Editorial Panel and development of an accurate vignette.

Temporomandibular Joint Manipulation (Tab 7)

Timothy S. Shahabazian, DDS, American Association of Oral and Maxillofacial Surgeons (AAOMS)

The CPT Editorial Panel created a new code category I CPT code, 21XXX, *Manipulation of temporomandibular joint (TMJ), therapeutic, requiring general anesthesia*, to report an existing service for complex manipulation of the temporomandibular joint that has not been adequately codified in CPT.

The RUC reviewed the specialty society's survey results for new CPT code 21XXX and the use of the key reference service code, 21485, *Closed treatment of temporomandibular joint dislocation; complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent* (work RVU = 3.98, total time = 200). Members of the RUC noted that the reference service list included codes with a range of work RVUs of 2.73 - 46.37. It was agreed that a

greater number of lower RVU reference services should have been included. Because of this, the RUC agreed that the survey was positively skewed due to overestimation and subsequent magnitude increases by respondents. The resulting overestimations lead to high pre-service time responses and higher RVU estimations than appropriate. In addition, the RUC noted that the pre-service positioning time is too high for the services being provided. As such, the RUC reduced the pre-service positioning time to 5 minutes, reducing the total pre-service time to 25 minutes. Considering all of the above, the committee believed the 25th percentile survey work RVU (3.80) was appropriate for the service provided.

Additionally, the RUC discussed the post-operative visits and agreed, due to the typical patient as well as the nature of the service, that four follow-up office visits were appropriate. However, the RUC determined that the intensity of the first post-operative visit was too high and recommended that the 99213 visit be reduced to a 99212. The resulting reduction in RVU is 0.47. In summary, correcting for the 25th percentile value (3.80) and subtracting .47 yields a recommended value of 3.33 RVU.

The RUC recommends a relative work value of 3.33 for code 99363 with a pre-service time of 25 minutes.

Practice Expense

The RUC approved the standard 090 day global direct practice expense inputs. Additionally, the RUC reviewed and accepted the amended practice expense inputs.

Non-Implantable Venous Access Device Blood Draws (Tab 8) **John Cox, DO, American Society of Clinical Oncology (ASCO)**

The CPT Editorial Panel agreed that Non-implantable Venous Access Device Blood Draws is a unique new procedure, which involves specialized equipment and intense monitoring and assessment by non-physician health care professionals. This new service differs from existing codes, 36415, *Collection of venous blood by venipuncture* (work RVU = 0.00) and 36540, *Collection of blood specimen from a completely implantable venous access device* (work RVU = 0.00). There are not currently codes to describe blood draw via other routes such as Percutaneous Inserted Central Catheter (PICC) lines and peripheral IVs. To do so, CPT created three new codes, 36592X, *Collection of blood specimen from a completely implantable venous access device*, 36593X, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*, and 36594X, *Dec clotting by thrombolytic agent of implanted vascular access device or catheter*.

The RUC reviewed the non-facility practice expense inputs carefully focusing on the typical patient encounter. The RUC believed, and the specialty agreed, that the clinical labor times initially presented to the RUC were too high for the typical patient encounter. The RUC reduced specific clinical labor activity line items to recommend a total clinical labor time of 19 minutes for code 36592X, 15 minutes for 36593X, and 37 minutes for 36594X. The RUC established a detailed allocation of the clinical labor time in the non-facility setting and no direct practice expense inputs in the facility setting.

XI Research Subcommittee (Tab 9)

Doctor Cohen presented the Research Subcommittee Report to the RUC. Doctor Cohen informed the RUC that new Summary of Recommendation Forms, new Survey Instruments for all Global periods and revised the instruction document were drafted to reflect the RUC's actions from the February and April 2006 RUC Meetings. **The following list summarizes the recommendations approved by the RUC to be incorporated into the survey instruments for the February 2007 RUC Meeting:**

1.) Under the description of Prolonged Services, the following revision will be made to reflect CPT coding language and be consistent with the format of the other post-operative visits mentioned in the surgical survey instruments:

CPT Code	Physician Total Time (Min)	Typical Physician Face to Face Time (Min)	
99354	30-74, <u>Time is total for day</u>	30-74	Performed in the office or other outpatient setting
99355	Each additional 30 min, Use multiples added to 99354, as needed		
99356	30-74, <u>Time is total for day</u>	30-74	Performed in the inpatient setting
99357	Each additional 30 min, Use multiples added to 99356, as needed		

2.) In addition, the following revision will be made to the description of counseling and coordination of care portion of the Evaluation and Management services language in the survey instrument to reflect CPT coding convention:

*****When counseling and/or coordination of care dominates (more than 50%), ~~the time of the face-to-face encounter between the physician and the patient and/or family may be considered the key or controlling factor to qualify for a particular level of E/M service.~~ of the face-to-face physician and patient/family encounter, then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making, whether or not they are family members.**

3.) In addition, a revision will be made to Question 2C to clarify the intent of the language, “The number of visits should include all visits made on the day indicated” to account for CPT coding convention. The recommended language is as follows:

***Immediate post-operative care on day of the procedure, includes “non-skin-to-skin” work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders). Include patient visits on the day of the operative procedure (e.g., in their hospital room or in the ICU) in Question 2c below for 90-day global procedures.**

c) Post-procedure services by day

Post procedure work includes the number, time and type of physician visits from the conclusion of the operation until the end of the Global period for most major surgical procedures. Remember that only one subsequent hospital inpatient service or office visit service may be reported on any calendar day regardless of the number of patient visits. Select the single most appropriate hospital inpatient service code or single office visit code. An appropriate prolonged service code(s) (eg 99354-99357) may be added as indicated. For critical care service exceeding 74 minutes use 99291 and the appropriate number of 99292 services. The number of visits should include all visits made on the day indicated. The type of CPT code used for each visit is listed. These codes are listed on the next page. Use this list on the next page to complete the following two charts. It may also be helpful to think of this exercise as listing the type and frequency of all the evaluation and management codes for which you would submit claims, if there was no global period for the services you are reviewing.

4.) Furthermore, a revision will be made to Question 6 to clarify the list that the survey respondents would be referring to when estimating the work RVU associated with a new or revised code:

Based on your review of all previous questions, please provide your estimated work RVU (to the hundredth decimal point) for the new/revised CPT code:

For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the new or revised code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the new or revised service “relative” to the work RVU of comparable and established reference services. Please keep in mind the range of work

RVUs in the reference service list ~~for the reference codes listed in Question 1 above~~ when providing your estimate.

5.) In addition, a new survey instrument will be created to reflect a new or revised code with a ZZZ global period without any post-operative visits. This non-surgical ZZZ survey instrument will mirror the existing ZZZ survey instrument removing all information pertaining to post-operative visits.

Doctor Cohen informed the RUC that at the April 2006 RUC Meeting, Pathology and Emergency Medicine requested to have their associated XXX descriptions of service be reviewed with further societal input. **The RUC reviewed and approved the specialty society recommended changes to the existing XXX generic descriptions of service for Pathology and Emergency Medicine. These changes are as follows:**

Pathology:

Pre-service period

Review of literature or research and communication with other professionals prior to receipt ~~interpretation~~ of the material.

Intra-service period

Obtaining and reviewing the history and results of other diagnostic studies, including examination of previous/additional slides and/or reports, during the gross and microscopic interpretation of the histologic specimen and/or cellular material; comparison to previous study reports; identification of clinically meaningful findings; consultation with other professionals ~~pathologists~~ regarding the specimen; any review of literature or research during examination of the specimen; any dictation, preparation and finalization of the report.

Post-service period

Written and telephone communications with patients and/or referring physician and arranging for further studies or other services after finalization of report.

Emergency Medicine:

~~For these services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. The work for the total service period may include:~~

- ~~• reviewing records, and interpreting test results or x-rays, and preparing to perform the service~~**
- ~~• performing the service~~**
- ~~• providing immediate post-procedural care before the patient is discharged or admitted to the hospital~~**

- ~~• communicating with the patient, patient's family, and/or other professionals~~
- ~~• completing charts~~

Pre-service period

The pre-service period may include reviewing records, communication with other providers (e.g., primary care physician, EMS personnel), reviewing test results or X-rays, and preparing to perform the service.

Intra-service period

The intra-service period includes performing the service.

Post-service period

The post-service period may include providing immediate post-service care before the patient is discharged or admitted to the hospital, communicating with the patient, patient's family and/or other professionals and completing charts.

Doctor Cohen explained that the Research Subcommittee reviewed the guidelines for specialty societies developing reference service lists and expressed concern that they are not comprehensive and need to be strengthened. After careful consideration of specialty society recommendations, the **RUC approved the following language to be incorporated into the instruction document for specialty societies developing work recommendations for new and revised codes:**

The following is an approved list of guidelines for developing reference service lists. There may be circumstances in which it may not be possible or appropriate to follow one or more guidelines.

The specialty may ask AMA staff and the RUC's Research Subcommittee to evaluate a reference service list in advance of the specialty sending the survey out for completion.

(It should be noted that the term "physician" in this context includes both physician and non-MD/DO providers)

- **Include a broad range of services (i.e. 10-20 services) and their work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.**
- **Include codes that represent Sservices on the list should be those which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed.**

- Include similar or related codes in from the same family or CPT section as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)
- ~~If appropriate, include~~ codes on the MPC list ~~may be included~~.
- Include RUC validated codes.
- Include codes with the same global period as the new/revised code.
- Include several high volume codes typically performed by the specialty.

The RUC requests that the AMA Legal Counsel review these revised guidelines to ensure they protect the RUC from Anti-Trust Law violations.

Doctor Cohen overviewed the specialty society requests reviewed by the Research Subcommittee including:

- The American Medical Directors Association gave a brief presentation of their educational materials for the nursing facility codes that they intend on surveying for the April 2007 RUC Meeting. These materials were approved by the Research Subcommittee
- The American Society of Transplant Surgeons have requested to postpone the Research Subcommittee's review of their survey issues for the standard backbench procedures until February 2007.
- The Joint Council of Allergy, Asthma and Immunology requested the Research Subcommittee review their proposal that they would base their survey on the time, work and complexity for performing a typical battery of tests. **The RUC approved this methodology for surveying these codes and approved that for 95024, the specialty societies have agreed with the RUC's recommendation to base their surveys on 12 tests to be consistent with the PEAC's recommendations. Additionally, the RUC recommends that the specialty when surveying use a battery of 45 tests for CPT code 95027.**

Doctor Cohen explained that on June 21, 2006, the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule indicating various concerns it had with using extant data to develop work RVU recommendations. The Research Subcommittee and the RUC believe that due to this response to the methodology used for several of the RUC's recommendations to CMS, a policy should be developed for how extant data should be used in the RUC process. The Research Subcommittee identified specialty societies' concerns about using extant data including but not limited to:

- Representative Data
- Equal Availability for Database Across Specialties
- Mixing of Methodologies in the RBRVS
- Using Extant Data for a Purpose in Which it was not Designed
- Identifying all Potential Databases

- How the Extant Data Will be Implemented in the RUC Process

A RUC member stressed that the RUC should only consider public databases and that proprietary databases should not be used if the RUC cannot examine or critique this data. He further suggested that a bullet should be added to the aforementioned list - Transparency of the database to address this concern.

As a first step, the Research Subcommittee will form a workgroup to make policy recommendations to the Subcommittee. The Extant Data Workgroup members include: Doctors Hitzeman (Chair), Allen, Derr, Mabry, Manaker, Pfeifer and P. Smith. The first formal meeting of the workgroup will take place at the February 2007 RUC Meeting.

Doctor Cohen described a request made by the American College of Surgeons detailing their concerns that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a “social survey” collecting the specialties’ “wish list.” The RUC determined that the relationship between survey medians and CMS’ final implemented relative values has remained relatively consistent throughout the process and that overall the relationship between the specialty society recommendation and the survey median is approximately 96% and that the relationship between the RUC recommendation and the survey median is approximately 91%.

Doctor Cohen delivered an update on the Modifier -51 Workgroup. The Research Subcommittee reviewed the actions assigned to it from this workgroup and the RUC made the following recommendations:

- 1.) **A question will be added to the Summary of Recommendation Form questioning if the recommended value for the new or revised procedure is based on its Modifier -51 Exempt status.**
- 2.) **The following language will be added to the survey instruments instructions:**
When a code is Modifier -51 Exempt, this procedure is adjunctive to another procedure, therefore only include the additional time/work associated with this code and not included in the time/work for the procedures with which it is commonly billed.
- 3.) **While conducting research on the codes in the Modifier -51 exempt list, it appeared that 7 spine codes on the list had some inaccurate RUC rationales due to changes in legislation. The RUC recommends that the rationale in the RUC database for these codes reflect this legislation. This proposed language will be drafted by AMA staff, reviewed by interested specialty societies and presented at the February 2007 RUC Meeting.**

The RUC approved the Research Subcommittee report and it is attached to these minutes.

XII. Practice Expense Subcommittee (Tab 10)

Doctor Katherine Bradley presented the Practice Expense Subcommittee report and the RUC discussed its three issues: missing physician time, capturing equipment utilization on the multi-specialty practice information survey, and future practice expense refinement processes.

Missing Physician Time

The Subcommittee had first discussed the lack of physician time for four Endoscopic Enteral Stenting codes and one Ocular Photodynamic Therapy code. The RUC agreed with the subcommittee's recommendation and recommends the following regarding these CPT codes:

The RUC recommends that the specialty society research the codes and return to this subcommittee with physician time components and an appropriate rationale based on discussion listed on page 65424 of CMS Federal Register dated June 8, 2001, for codes 43256, 44370, 44379, and 44383 for presentation at the February 2007 meeting.

The RUC agreed with the specialty society recommendation and recommends 3 minutes of intra and total time for add-on code 67225.

Capturing Equipment Utilization

The Subcommittee also discussed the importance and methods of capturing correct equipment utilization rates from the various types specialty practices. The Subcommittee and the RUC reviewed the draft survey question from the multi-specialty practice information survey and the RUC then made the following two recommendations for this issue:

- 1. Question on equipment (18a) on the current draft Multi-Specialty Practice Information should be used to capture specialty practice equipment information. This question will be piloted in the survey this fall and there will be opportunity to modify the question prior to the actual survey that will be performed in the spring of 2007.**
- 2. The equipment question (18a) should encompass equipment items that are below the current proposed \$500,000 threshold to a new threshold of between \$100,000 and \$200,000 to be determined on the number of equipment items (to be resolved by the AMA and CMS staff)**

Practice Expense Refinement Process

The Practice Expense Subcommittee was also asked to discuss whether a more comprehensive review of the direct practice expense inputs for all CPT codes is necessary in the future and how and when it may be performed. Currently, the PERC continues to review the direct inputs of selected existing codes through direct requests from CMS. Specialty societies currently contact CMS and ask for

specific refinements, and if warranted, CMS refers the codes to the PERC for review.

While it was agreed that there is an importance of keeping the direct practice expense inputs current, there was no agreement on how this refinement process would proceed without some understanding of what CMS has in mind regarding a practice expense Five-Year Review time frame and scope. The RUC made the following recommendation:

The RUC continues to express interest in practice expense refinement and plans participate in any refinement process. However, a specific process can not be planned until CMS provides further information on the timeline for the practice expense Five-Year Review.

The RUC approved the Practice Expense Subcommittee report and it is attached to these minutes.

XIII. Practice Expense Subcommittee / Research Subcommittee (Tab 11)

Doctors Bradley and Cohen presented an overview of the joint subcommittee meeting to the RUC. Sherry Smith provided a progress report on the Physician Practice Information Survey. The complete presentation is attached to this report. Some of the key information provided to RUC participants included:

- 48 specialties and health professions have committed to join the effort.
- The AMA will select a survey firm the week of October 9.
- Pilot testing will be funded by the AMA and will be initiated this month.
- The full survey will be launched in April 2007.
- The AMA requested the survey firms to provide proposals to achieve a 50% response rate.
- Based on current CMS precision criteria, it is estimated that 100 respondents per specialty will be needed.
- The sample will be drawn from the AMA Masterfile for all MD/DO specialties.
- CMS has contracted with Lewin to draw samples for the non-MD/DO health professions and to analyze their data. Lewin will be working with the AMA and the survey firm to coordinate this effort to ensure consistency.
- A variety of survey methods (telephone, mail, internet) and incentives (cash, gift certificates, survey reports) will be tested during the pilot phase.
- Data will be available for analysis in the 1st quarter of 2008. Practice expense data will be provided to CMS by March 31, 2008 for consideration in the 2009 MFS rulemaking process.

Ms. Smith indicated that a report of the pilot testing will be provided at the February 2007 RUC meeting.

The Practice Expense Subcommittee / Research Committee report on the Physician Practice Information Survey was filed and is attached to these minutes.

XIV. Practice Expense Review Committee (Tab 12)

The Practice Expense Review Committee met to discuss the refinement of four existing direct practice expense input issues from CMS and two new CPT code issues.

CMS requested the PERC and RUC to review the establishment of non-facility inputs for four code sets and the RUC made the following recommendations:

1. Transcatheter placement of an intravascular stent(s), 37205 and 37206: **The RUC recommends that codes 37205, 37206, and 74960 be referred to the Practice Expense Subcommittee in order to establish guidelines for establishing non-facility direct inputs for codes that have historically been performed predominately in facility settings and currently have relative values only in the facility setting**
2. Renal biopsy, 50200: **The RUC recommends that code 50200, if appropriate, be petitioned by the Society for Interventional Radiology to be included on CPT's conscious sedation list, and their direct input recommendations be cleaned up for any future presentation to the PERC.**
3. Occlusion of fallopian tube(s), 58615: **The RUC recommends the specialty society ask for a new code from CPT that describes the procedure performed by their specialty more accurately.**
4. Arthroscopy 29840 and 29870 – these two codes were withdrawn by the specialty

The PERC and the RUC also reviewed and provided input to the RUC for two new CPT code issues for CPT 2008:

1. Temporomandibular Joint Manipulation (21XXX)
2. Non-implantable Venous Access Device Blood Draws (36592X, 36593X and 36594X)

The RUC approved the Practice Expense Review Committee report and it is attached to these minutes.

XV. Health Care Professionals Advisory Committee (Tab 13)

Robert C. Fifer, PhD, CCC-A, presented the HCPAC report to the RUC. Dr. Fifer indicated that the HCPAC welcomed the new chair of the HCPAC, Arthur Traugott, MD and William J., Mangold, Jr, MD as the new AMA representative to the HCPAC.

Multi-Specialty Practice Survey Discussion

Dr. Fifer summarized the discussion the HCPAC had on the multi-specialty practice survey for non-physicians. Dr. Fifer indicated that the HCPAC specifically discussed crosswalks of chiropractors with internal medicine and social workers and psychology to crosswalk to psychiatry. The conclusion of the discussion was that chiropractors, social workers and psychologists were highly encouraged to participate in the survey process, rather than crosswalk.

The HCPAC reviewed the non-physician multi-specialty practice survey and briefly discussed the difference between the physician and non-physician surveys, with the focus that chiropractors, optometrists and podiatrists would complete the physician survey form and all the other HCPAC disciplines would complete the non-physician survey.

At the HCPAC meeting additional edits were offered to clarify and make the survey more straightforward for non-physician survey respondents.

HCPAC MPC List

The American Podiatric Medical Association submitted changes to delete and add codes to the HCPAC MPC list. Ms. Foto encouraged that the HCPAC revisit and review the MPC list and to submit any changes to AMA Staff as soon as possible.

Team Conference Codes

The HCPAC had a discussion only on the two non-physician team conference codes that are to be presented in February 2007. CPT codes 9936X2 and 9936X4, performed by non-physicians, will be presented to the HCPAC and codes 9936X1 and 9936X3 will be presented to the RUC. The HCPAC discussed the logistics of coordinating the surveys so that when it is presented to the RUC and the HCPAC the surveys make sense to the surveyees, RUC and HCPAC.

Other Issues

Dr. Fifer indicated that the issue of how to handle an abbreviated procedure for a timed code was brought up at the HCPAC. At this time, the conclusion was that that modifier -52 should be used even though it states discontinued service due to the *discretion of the physician*. Doctor Peter Hollmann indicated he would bring this to the CPT Editorial Panel in October 2006 for clarification.

The Health Care Professionals Advisory Committee report was filed and is attached to these minutes.

XVI. Pre-Time Workgroup (Tab 14)

Doctor Barbara Levy presented the Pre-Service Time Workgroup report and reported that the workgroup concluded its work during this meeting by developing benchmarks which the RUC can use to evaluate the pre-service time for new and revised codes. The Workgroup and the RUC believed the current definition of pre-service time and when the global period starts was misleading and in need of clarification. The following definition for an understanding of the pre-service time period and the following recommended pre-time packages.

After the decision for surgery is made, the global period begins when services are provided which would have been performed at admission the night before scheduled surgery.

The RUC recommended that eight Pre-Service Time packages, six for the facility setting and two for the non-facility setting be adopted and incorporated into the summary of recommendation form. These eight packages are listed with the full minutes following this report and include specific time components and overall time for each pre-service package. The RUC agreed that these packages encompassed most of the patient scenarios. In addition these packages, the RUC recommended the following:

- **The RUC also agreed that for building block IWPUT purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUT should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUT of .0081.**
- **The RUC believed that when a new or revised code goes through the CPT process, the development of the code's vignette is very important in the identification of which pre-service time package should apply. The RUC members recommend that the CPT Editorial Panel is informed of this additional importance.**
- **When a specialty society presents a code it may not be apparent where the dominate site of service will be. The RUC believed there should be some mechanism to review the site of service and make adjustments to the to overall time of the procedure through a change in the code's package number if appropriate.**

- **The RUC believed that the specific package chosen by the specialty needed to be justified at the RUC as well as any additional time above the recommended package time. The RUC believed additional increments of 15 minutes for TEE, invasive monitoring or complex positioning, may be appropriate for some procedures.**

The RUC approved the Pre-Time Workgroup report and it is attached to these minutes.

XVII. Professional Liability Insurance Workgroup (Tab 15)

David Hitzeman, DO, briefed the RUC on the PLI Workgroup discussion. Doctor Hitzeman informed the RUC the status of the PLI premium collection efforts of the Physician Insurers Association of America (PIAA). PIAA provided the PLI premium data for the six pilot states to CMS, however at this time it does not know if and how CMS will use this data. At the PLI Workgroup meeting, Stephen Kamenetzky, MD, stated that Medical Protective (MedPro) also volunteered to submit PLI premium data to CMS (if MedPro received confirmation of confidentiality of data shared), which should ensure sufficient market share data. It is anticipated that CMS will review this data to determine if it meets the appropriate requirements after the release of the November 2006 *Final Rule* and current collection efforts for GPCIs.

Doctor Hitzeman indicated that the PLI Workgroup reviewed the PLI section of the multi-specialty practice survey and suggested some changes to the survey. The PLI Workgroup specifically suggested to define occurrence coverage and claims made coverage. Additional suggestions are outlined in the full PLI Workgroup report attached to these minutes.

The PLI Workgroup also reviewed the PLI implications due the DRA imaging cuts. Doctor Hitzeman indicated that the allocation of PLI RVUs between the technical component (TC) and the professional component (PC) portion is inappropriate. The current PLI RVUs have this relationship reversed, with the higher PLI portion applying to the TC portion and the lower PLI portion applying to the PC portion. The RUC has indicated this to CMS in the past and CMS has acknowledged that the allocation is not correct.

Doctor Hitzeman indicated that when PLI was changed to being based on relative costs, codes which did not have physician work, the technical component of codes, continued to be cost-based under PLI. Doctor Hitzeman stated that nearly \$200 million will be lost from the Medicare Fee Schedule if this allocation is not corrected within the Final Rule publication in November.

The PLI Workgroup discussed what action needed to be taken. The initial thought was to reverse the technical component and professional component allocations.

However, this would cause an excess on the professional component. The recommendation developed was the following:

The RUC recommends that CMS immediately adjust all technical component PLI RVUs to be equivalent to the professional component PLI RVUs for each service. This would result in a redistribution of PLI relative values within the entire Medicare Physician Payment Schedule.

Doctor Hitzeman indicated that the final issue in which the PLI workgroup reviewed was that oral and maxillofacial surgeons have MD, MD/DDS, and DDS classifications for the PLI component. There seemed to be a discrepancy in the PLI determinants by CMS and risk factors for these classifications within oral surgery, maxillofacial surgery and plastic surgery. Malpractice insurance for each classification differs significantly. The PLI workgroup also reviewed a number of low volume codes, which were currently crosswalked to Medicare's classification of category 19-Oral Surgery.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) then withdrew their crosswalk changes until they get further clarification from the CMS Enrollment Division regarding specific provider classifications.

The RUC approved the Professional Liability Insurance Workgroup report and it is attached to these minutes.

XVIII. Administrative Subcommittee (Tab 16)

Doctor Arthur Traugott briefed the RUC on the Administrative Subcommittee discussion. First, the Administrative Subcommittee revised the Structure and Functions document to further clarify the separate roles of RUC Alternates and RUC Advisors. **The RUC approved the changes made to the Structure and Functions document as amended.**

A. RVS Update Committee:

(9) Duty

(a) Specialty Society representatives shall execute independent judgment in their deliberations consistent with membership on the RUC. **RUC representatives should not advocate or present on behalf of their specialty.**

B. Advisory Committee

(3) **Designation** - Specialty Society representatives of the AC shall be designated by each respective Specialty Society. One alternate Specialty Society representative shall also be nominated by each of the Specialty Societies to participate on the AC in the absence of the respective Specialty Society representative. Specialty Society representatives of the AC, to the extent practicable, shall not be the

same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee. **In the rare circumstance that a Specialty Society RUC alternate must serve as a Specialty Society advisor to the RUC during the course of a meeting, (i.e., due to health or emergency issues) that individual shall not serve as a Specialty Society RUC alternate for the remainder of the meeting.** The AMA shall approve all Specialty Society nominations to the AC.

Doctor Traugott indicated that the discussion of possible solutions to alleviate the work load of the RUC members and alternates will be addressed at the 2007 February RUC meeting.

Conflict of Interest

Second, Doctor Traugott indicated that in AMA Legal Counsel's efforts to ensure conflict of interest/financial interests are disclosed for all AMA and AMA-sponsored bodies, Barney Cohen, AMA Senior Division Counsel, prepared a memo to the RUC summarizing the conflict of interests and financial disclosure policies. After review of this memo **the RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations. The RUC also recommends that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society.**

Composition of the RUC

Third, Doctor Traugott indicated that the review of the composition of the RUC began at the April 2006 meeting and will continue at the next meeting as well. Doctor Tuck thoroughly reviewed the agenda materials on the history of the RUC composition. The Administrative Subcommittee then reviewed Medicare charges data (percentage of E/M, percentage of procedures and estimation of global E/M for surgery).

Doctor Traugott reported that Doctor Tuck initiated discussion by asking if the RUC composition provides the expertise to function effectively as a deliberative body. Additionally, Doctor Tuck asked the Subcommittee to review the RUC criteria and reaffirm or revise the five criteria. The Administrative Subcommittee discussed in detail the RUC composition, criteria for participation on the RUC and the addition of a primary care seat or rotating seat on the RUC. Specific discussion items are outlined in the full Administrative Subcommittee report which is attached to these minutes.

The RUC recommended the following actions:

- 1. AMA staff poll all RUC participants (i.e., RUC Members, RUC Alternates and RUC Advisors) on what specific expertise the RUC may be lacking.**

2. **AMA staff collect data with respect to codes brought forward by subspecialties and look at how codes fared when the subspecialty had a rotating seat on the RUC versus when they did not.** All rotating seat subspecialties will be reviewed.

Doctor Traugott indicated that the Administrative Subcommittee did not have enough time to discuss the issue of term limits at this meeting. Term limits will be discussed at the 2007 February RUC meeting.

The RUC approved the Administrative Subcommittee report and it is attached to these minutes.

XIX. Five Year Review Identification Workgroup (Tab 17)

Barbara Levy, MD, Chair of the Five-Year Review Identification Workgroup reported to the RUC the proceedings of the workgroup meeting and presented the workgroup's recommendations for the RUC's consideration.

Doctor Levy first discussed the origin of the workgroup, recounting its mandate and tasks as assigned by the RUC. The workgroup was formed as an outcropping of the Administrative Subcommittee to address issues related to the systematic development of potentially misvalued codes. Its mandate is:

The purpose of the Five Year Review Identification Workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The Workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of "new technology" services.

Doctor Przybylski requested that all reference to misvalued services be referred to in the workgroup's discussions and reports as "potentially misvalued" to maintain its objectivity.

Doctor Levy further stated that the workgroup has been asked to develop objective criteria to identify codes that qualify as new technology; objectively decide whether re-evaluation of new technology codes is warranted; develop objective measures to identify potentially misvalued codes; and recommend a process to review identified potentially misvalued codes.

"New Technology" Identification

The primary indicator for a code to be classified as new technology is at the request of the presenting specialty society. In the case that the specialty does not indicate new technology and the RUC disagrees, the RUC will rely on other supplemental objective measures that must be provided by the specialty. **The RUC will reinstate the question, "How many times have you performed this**

procedure in the past year?” on the survey instrument and that the responses should be included on the summary of recommendation form with and include the distribution of the responses (including the low, 25th percentile, median, 75th percentile, and high responses).

Additionally, the RUC added the following questions to the “checklist for review” form provided in the agenda book and that members consider these questions prior to and during the RUC evaluation of potential “new technology” services:

- Does this service use a newly FDA-approved procedure, technology, or device?
- Is this a new service provided to patients? If no, does this service utilize an existing procedure provided to patients in a new way?
- Did this service originate from a Category III CPT code?

Objective Criteria for Potentially Misvalued Services

Doctor Levy reviewed the workgroup’s suggested criteria for the identification of potentially misvalued codes and provided the workgroup’s preference for prioritization of it. Doctor Levy noted that while there were other suggested criteria discussed, none were rejected by the group, but considered of lesser priority. The RUC agreed with the workgroup on three specific objective measures including:

- Codes that are typically performed in the outpatient setting or doctor’s office but include hospital E/M visits.
- Codes that have relatively high utilization for the specialty, are base codes, and have never been reviewed by the RUC.
- Codes that have a “very high” IWPUT of 0.120 – 0.140 or higher.

The utilization data will be poignant in identifying potentially misvalued services; however, the utilization data available only applies to services provided to the Medicare population. Data from private payers are necessary to more accurately evaluate the services. **The RUC will formally request utilization data for all services from private payers and explore with CMS the possibility of obtaining data for Medicaid. The RUC will formally requests that CMS provide the RUC with data on services that are reported on the same date by the same provider.**

Process for Review of Potentially Misvalued Services

The workgroup considered the venue for reviewing services identified as potentially misvalued. It considered two options, scheduling these codes for review during the regular five-year review process or reviewing potentially misvalued codes on a rolling basis. The RUC agreed that a rolling review place undue stress on specialties and require significant resources to carry out and decided that the five-year review is the appropriate venue for review. However, the RUC did agree that the issue of codes that are typically performed in the outpatient setting or doctor’s office but including hospital E/M visits challenge

the integrity of the RUC process and must be considered separately from the five-year review. **Codes with hospital E/M visits yet typically performed in the outpatient setting or in the physician's office will be considered separately from the potentially misvalued codes and be subject to review prior to the next Five-Year Review. Codes identified and selected for re-evaluation as potentially misvalued will be submitted by the RUC during the CMS comment period (November/December 2009) for inclusion in the next regularly scheduled Five-Year Review.**

The RUC approved the Five-Year Review Identification Workgroup report and it is attached to these minutes.

XX. Multi-Specialty Points of Comparison Workgroup (Tab 18)

John Derr, MD, Chair of the Multi-Specialty Points of Comparison Workgroup reported to the RUC the proceedings of the Workgroup meeting and presented the Workgroup's recommendations for the RUC's consideration.

Evaluation and Management Services

The Workgroup met to discuss a number of issues including the reinstatement of the evaluation and management services to the MPC list. Doctor Derr noted that at the last meeting of the Multi-Specialty Points of Comparison Workgroup in September 2004, the RUC removed all E/M services prior to the third Five-Year Review, as many specialties agreed that the services were mis-valued. The RUC stipulated that all E/M services removed be replaced immediately following the Five-Year Review. The temporarily deleted E/M codes that will automatically be listed again in the MPC list following publication of the final rule are: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99222, 99223, 99232, 99233, 99238, 99242, 99243, 99244, 99245, 99253, 99254, and 99255.

Requested Edits to the MPC List

The Workgroup also discussed the specialty society requests for additions and deletions to the MPC list. The Workgroup received recommendations from 16 specialties requesting more than 90 additions and 20 deletions to the list. Doctor Derr presented these workgroups recommendations for each change to the MPC list. **The RUC made the following edits to the MPC list:**

<u>11044 Add</u>	<u>11443 Add</u>	<u>11606 Add</u>	<u>11641 Add</u>
<u>11420 Add</u>	<u>11444 Add</u>	<u>11620 Add</u>	<u>11643 Add</u>
<u>11421 Add</u>	<u>11446 Add</u>	<u>11621 Add</u>	<u>11644 Add</u>
<u>11422 Add</u>	<u>11600 Add</u>	<u>11622 Add</u>	<u>11646 Add</u>
<u>11423 Add</u>	<u>11601 Add</u>	<u>11623 Add</u>	<u>12052 Add</u>
<u>11424 Add</u>	<u>11602 Add</u>	<u>11624 Add</u>	<u>13102 Add</u>
<u>11440 Add</u>	<u>11603 Add</u>	<u>11626 Add</u>	<u>13121 Add</u>
<u>11442 Add</u>	<u>11604 Add</u>	<u>11640 Add</u>	<u>13122 Add</u>

<u>13133 Add</u>	<u>38571 Add</u>	<u>57155 Add</u>	<u>78478 Add</u>
<u>14040 Add</u>	<u>43268 Remove</u>	<u>60512 Add</u>	<u>78812 Add</u>
<u>15734 Add</u>	<u>43269 Add</u>	<u>61566 Add</u>	<u>78815 Add</u>
<u>19103 Add</u>	<u>43632 Add</u>	<u>61697 Add</u>	<u>79000 Remove</u>
<u>19180 Add</u>	<u>44204 Add</u>	<u>61698 Add</u>	<u>79101 Add</u>
<u>19298 Add</u>	<u>44602 Add</u>	<u>61700 Remove</u>	<u>88180 Remove</u>
<u>19361 Add</u>	<u>45119 Add</u>	<u>62165 Add</u>	<u>88189 Add</u>
<u>20600 Add</u>	<u>45190 Add</u>	<u>63051 Add</u>	<u>88309 Add</u>
<u>20808 Remove</u>	<u>45400 Add</u>	<u>63101 Add</u>	<u>88333 Add</u>
<u>20824 Remove</u>	<u>45820 Remove</u>	<u>63295 Add</u>	<u>93751 Remove</u>
<u>20937 Remove</u>	<u>46260 Remove</u>	<u>63650 Remove</u>	<u>95010 Remove</u>
<u>22525 Add</u>	<u>46934 Add</u>	<u>64449 Add</u>	<u>95015 Remove</u>
<u>22534 Add</u>	<u>49002 Add</u>	<u>64622 Remove</u>	<u>99204 Add</u>
<u>22840 Add</u>	<u>49560 Add</u>	<u>77263 Add</u>	<u>99291 Add</u>
<u>24430 Add</u>	<u>49650 Add</u>	<u>77300 Add</u>	<u>99298 Remove</u>
<u>37215 Add</u>	<u>52000 Add</u>	<u>77301 Add</u>	<u>99299 Add</u>
<u>38100 Add</u>	<u>54150 Add</u>	<u>77334 Add</u>	<u>99311 Remove</u>

Doctor Derr noted that for three codes, 12051, *Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less*; 14041, *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm*; and 20955, *Bone graft with microvascular anastomosis; fibula*, the workgroup denied the specialty's request to delete the code because the workgroup agreed that the codes recommended for deletion were highly utilized base codes that provide a good basis for multi-specialty comparison.

The workgroup also denied a significant number of codes based on the fact that the request came from a specialty that was not the dominant provider of the service. For these codes, the workgroup has requested that staff contact all societies and solicit the concurrence of the dominant specialty. Following notification of concurrence of the dominant specialty, the codes will be re-submitted to the MPC workgroup at its next meeting.

Minimum Utilization Data

The AAFP recommended to the MPC workgroup that it consider establishing a minimum utilization level for inclusion on the MPC. The workgroup concurred in theory, but noted there are a number of exceptions that will affect Medicare utilization data and bar commonly performed codes because they are not performed on the Medicare population. The MPC did agree that utilization data were appropriate to consider when reviewing a code's MPC reference service. Rather than arbitrarily set a "low utilization" number, the RUC may determine relevance on their own, if they are provided with utilization data for referenced MPC codes. **The RUC will include the most recent utilization data for MPC reference codes on the Summary of Recommendation form.**

The RUC approved the Multi-Specialty Points of Comparison Workgroup report and it is attached to these minutes.

XXI. Other Issues

Modifier 51 Exempt Status Indicator Application to the Mohs Surgery Codes (Tab 19)

Peter A. Hollmann, MD, CPT Editorial Panel

The RUC discussed a request from the CPT Editorial Panel to clarify the recommendations of the committee with regard to the Mohs surgery/pathology codes, specifically in relation to the continued application of the modifier 51 exempt status indicator in the CPT codebook and inclusion of the new Mohs surgery/pathology codes 17311 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks* and 17313 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks* in Appendix E.

At the April 2006 meeting of the Relative Update Value Committee (RUC), the recommendations for valuation of the Mohs surgery/pathology codes were considered and implemented. At that time, the RUC requested that the CPT Editorial Panel Executive Committee clarify the inclusion of all aspects of Mohs (i.e., surgery and pathology services) in the descriptor for code 17315. It was also understood by the staff and representatives to the Editorial Panel at the RUC meeting, that the application of the modifier 51 exempt status indicator, and subsequently, the inclusion of this series of codes in Appendix E would not be carried forward with the new series of codes for CPT 2007. At the May 2006 CPT Editorial Panel Executive Committee conference, the Committee accepted the recommendations that the modifier 51 exempt status not be brought forward for application to the new series of codes.

Prior to the June 2006 CPT Editorial Panel Executive Committee meeting, a letter from the American Academy of Dermatology Association was forwarded to AMA staff to request the ability to provide input related to the discussion of the Mohs surgery/pathology codes into the current CPT/RUC Modifier 51 workgroup. Since the Executive Committee had already been taken action to uphold the RUC recommendations, this request was forwarded to the Executive

Committee who voted to reject this request to assign the modifier 51 exempt symbol to codes 173011 and 173013, and reported this decision to the CPT Editorial Panel for discussion. Subsequent to discussion, the CPT Editorial Panel rejected this request and voted to uphold the discussion of the Executive Committee based on recommendation by the Relative Values Update Committee (RUC). It was agreed that it was not the intent of the RUC to value codes 173011 and 173013 as modifier 51 exempt.

The recommendation for exclusion from the list of modifier 51 exempt codes in Appendix E is not apparent in the Mohs Surgery Summary of RUC Recommendations. The absence of this information in the Summary of Recommendations is causing confusion concerning the status of these codes related to the modifier 51 exempt status.

The RUC reviewed this request and received a brief presentation from the American Academy of Dermatology at its October 2006 RUC meeting regarding this issue. **After full committee discussion, consensus was reached that the RUC could not recommend that 17311 and 17313 be -51 modifier exempt or included in Appendix E.**

New Technology Review of Pathology Codes (Tab 20)

Jonathan L. Myles, MD College of American Pathologists (CAP)

The College of American Pathologists requested that the new technology review of CPT codes 88384, *Array-based evaluation of multiple molecular probes; 11 through 50 probes* (work RVU = 0.00), 88385, *Array-based evaluation of multiple molecular probes; 51 through 250 probes* (work RVU = 1.50), and 88386, *Array-based evaluation of multiple molecular probes; 251 through 500 probes* (work RVU = 1.88), be consistent with guidelines approved at the April 2006 RUC meeting for other new technology services. Originally, CAP recommended that the codes be re-evaluated after the service is more widely utilized, with a time-certain re-review in two calendar years. The recently approved process for re-review of all new technology services calls for a review within five years after three years of utilization data are available. The three-year data-gathering phase does not commence until the service appears in CPT. The RUC concurred with the specialty society's request. **CPT codes 88384, 88385 and 88386 will be scheduled for review consistent with all other services included in the "new technology" list.**

The meeting adjourned on Saturday, October 7, 2006 at 3:00 p.m.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee
October 5, 2006**

Members Present: Norman A. Cohen, MD, (Chair), Bibb Allen, MD, John Derr, MD, Charles Koopmann, Jr., MD, David Hitzeman, DO, Scott Manaker, MD, Greg Przybylski, MD, Daniel Mark Siegel, MD, J. Baldwin Smith, MD, Lloyd Smith, DPM, Peter Smith, MD

I. Review of New Summary of Recommendation Forms and Survey Instruments

RUC staff has drafted new Summary of Recommendation Forms, new Survey Instruments for all Global periods and revised the instruction document to reflect the RUC's actions from the February and April 2006 RUC Meetings. These documents were implemented for the October 2006 RUC Meeting. However, AMA staff has received several comments and suggestions for modifying the survey instruments from specialty society staff. Some of these comments were deemed to be editorial in nature and were incorporated into the instruments others were felt to require review by the Research Subcommittee. **The following list summarizes the recommendations approved by the RUC to be incorporated into the survey instruments for the February 2007 RUC Meeting:**

1.) Under the description of Prolonged Services, the following revision will be made to the existing language to reflect CPT coding language and be consistent with the format of the other post-operative visits mentioned in the surgical survey instruments:

CPT Code	Physician Total Time (Min)	Typical Physician Face to Face Time (Min)	
99354	30-74, <u>Time is total for day</u>	30-74	Performed in the office or other outpatient setting
99355	Each additional 30 min, Use multiples added to 99354, as needed		
99356	30-74, <u>Time is total for day</u>	30-74	Performed in the inpatient setting
99357	Each additional 30 min, Use multiples added to 99356, as needed		

2.) In addition, the following revision will be made to the description of counseling and coordination of care portion of the Evaluation and Management services language in the survey instrument to reflect CPT coding convention:

*****When counseling and/or coordination of care dominates (more than 50%), the time of the face-to-face encounter between the physician and the patient and/or family may be considered the key or controlling factor to qualify for a particular level of E/M service. of the face-to-face physician and patient/family encounter, then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making, whether or not they are family members.**

3.) In addition, a revision will be made to Question 2C to clarify the intent of the language, “The number of visits should include all visits made on the day indicated” to account for CPT coding convention. The proposed language is as follows:

***Immediate post-operative care on day of the procedure, includes “non-skin-to-skin” work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders). Include patient visits on the day of the operative procedure (e.g., in their hospital room or in the ICU) in Question 2c below for 90-day global procedures.**

c) Post-procedure services by day

Post procedure work includes the number, time and type of physician visits from the conclusion of the operation until the end of the Global period for most major surgical procedures. Remember that only one subsequent hospital inpatient service or office visit service may be reported on any calendar day regardless of the number of patient visits. Select the single most appropriate hospital inpatient service code or single office visit code. An appropriate prolonged service code(s) (eg 99354-99357) may be added as indicated. For critical care service exceeding 74 minutes use 99291 and the appropriate number of 99292 services. The number of visits should include all visits made on the day indicated. The type of CPT code used for each visit is listed. These codes are listed on the next page. Use this list on the next page to complete the following two charts. It may also be helpful to think of this exercise as listing the type and frequency of all the evaluation and management codes for which you would submit claims, if there was no global period for the services you are reviewing.

4.) Furthermore, a revision will be made to Question 6 to clarify the list that the survey respondents would be referring to when estimating the work RVU associated with a new or revised code:

Based on your review of all previous questions, please provide your estimated work RVU (to the hundredth decimal point) for the new/revised CPT code:

For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the new or revised code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the new or revised service “relative” to the work RVU of comparable and established reference services. Please keep in mind the range of work RVUs in the reference service list ~~for the reference codes listed in Question 1 above~~ when providing your estimate.

5.) In addition, a new survey instrument will be created to reflect a new or revised code with a ZZZ global period without any post-operative visits. This non-surgical ZZZ survey instrument will mirror the existing ZZZ survey instrument removing all information pertaining to post-operative visits.

II. Review of Generic Description of Service for Pathology and Emergency Medicine's Procedures

The Research Subcommittee has developed generic description of service periods for the XXX global procedures including: 1.) Pathology, 2.) Imaging and Diagnostic and 3.) Therapy. These descriptions of service were implemented for the October 2006 RUC Meeting. However, at the April RUC Meeting, Pathology and Emergency Medicine requested to have their associated XXX descriptions of service be reviewed with further societal input. **The RUC reviewed and approved the specialty society recommended changes to the existing XXX generic descriptions of service for Pathology and Emergency Medicine. These changes are as follows:**

Pathology:

Pre-service period

Review of literature or research and communication with other professionals prior to receipt-interpretation of the material.

Intra-service period

Obtaining and reviewing the history and results of other diagnostic studies, including examination of previous/additional slides and/or reports, during the gross and microscopic interpretation of the histologic specimen and/or cellular material; comparison to previous study reports; identification of clinically meaningful findings; consultation with other professionals pathologists regarding the specimen; any review of literature or research during examination of the specimen; any dictation, preparation and finalization of the report.

Post-service period

Written and telephone communications with patients and/or referring physician and arranging for further studies or other services after finalization of report.

Emergency Medicine:

~~For these services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. The work for the total service period may include:~~

- ~~• reviewing records, and interpreting test results or x-rays, and preparing to perform the service~~
- ~~• performing the service~~
- ~~• providing immediate post-procedural care before the patient is discharged or admitted to the hospital~~
- ~~• communicating with the patient, patient's family, and/or other professionals~~
- ~~• completing charts~~

Pre-service period

The pre-service period may include reviewing records, communication with other providers (e.g., primary care physician, EMS personnel), reviewing test results or X-rays, and preparing to perform the service.

Intra-service period

The intra-service period includes performing the service.

Post-service period

The post-service period may include providing immediate post-service care before the patient is discharged or admitted to the hospital, communicating with the patient, patient's family and/or other professionals and completing charts.

III. Reference Service List Policy

The Research Subcommittee reviewed the guidelines for specialty societies developing reference service lists and expressed concern that they are not comprehensive and need to be strengthened. AMA Staff at the request of the Research Subcommittee solicited comments from specialty societies regarding their recommended additions to the existing reference service list guidelines. AMA staff received various comments from specialty societies. After careful consideration of the specialty society recommendations, the RUC approved the following language to be incorporated into the instruction document for specialty societies developing work recommendations for new and revised codes:

The following is an approved list of guidelines for developing reference service lists. There may be circumstances in which it may not be possible or appropriate to follow one or more guidelines.

The specialty may ask AMA staff and the RUC's Research Subcommittee to evaluate a reference service list in advance of the specialty sending the survey out for completion.

(It should be noted that the term "physician" in this context includes both physician and non-MD/DO providers)

- Include a broad range of services (i.e. 10-20 services) and their work RVUs ~~for the specialty~~. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.
- **Include codes that represent Sservices on the list should be those which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed.**
- Include similar or related codes ~~in from~~ the same family or CPT section as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)
- ~~If appropriate, i~~Include codes on the MPC list ~~may be included~~.
- Include RUC validated codes.
- Include codes with the same global period as the new/revised code.
- Include several high volume codes typically performed by the specialty.

Once these comments have been discussed and approved by the RUC, a request will be made to AMA Legal Counsel to review these revised guidelines.

IV. Specialty Society Requests

- The American Medical Directors Association gave a brief presentation of their educational materials for the nursing facility codes that they intend on surveying for the April 2007 RUC Meeting. These materials were approved by the Research Subcommittee
- The American Society of Transplant Surgeons have requested to postpone the Research Subcommittee's review of their survey issues for the standard backbench procedures until February 2007.
- The Joint Council of Allergy, Asthma and Immunology requested the Research Subcommittee review some survey issues for the allergy test interpretation codes. The specialty proposed that they would base their survey on the time, work and complexity for performing a typical battery of tests. The survey respondents would base their estimates on a specified number of tests considered to be typical rather than to provide estimates of time, work, etc., for the number of tests they typically perform in a battery and then divide by that pre-determined number on the survey instrument. The RUC approved this methodology for surveying these codes.

However, the Research Subcommittee identified one issue in their review that the practice expense inputs, as recommended by the PEAC in September 2002, were based on a number of tests in a battery that is different from the proposed number of tests in a battery that have been proposed to be utilized in this review of 95024 *Intracutaneous (intra dermal) tests with allergenic extracts, immediate type reaction, specify number of tests* and 95027 *Intracutaneous (intra dermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, specify number of tests*. The PEAC's recommendations for 95024 were based on 12 tests in a battery while the specialty originally was planning on basing their recommendations on 15 tests in a battery. **For 95024, the specialty societies have agreed with the RUC's recommendation to base their surveys on 12 tests to be consistent with the PEAC's recommendations.**

For 95027, the PEAC's recommendations were based on 12 tests in a battery while the specialty is planning on basing their recommendations on 45 tests. The specialty explained that in 2003 the definition of this code was changed and the phrase "specify number of tests" was added along with other verbiage changes. For years through 2002, accepted practice was to bill based on the number of antigens used. However, code 95027 typically involves testing 12-15 antigens at 3 different strengths. **The RUC accepted this rationale and recommends that the specialty when surveying use a battery of 45 tests for CPT code 95027.**

V. Extant Data Policy

During the Five Year Review Process, the subject of using extant data as an alternative methodology to develop work RVU recommendations was discussed and ultimately was approved in the cases of the NSQIP and the STS database. The RUC felt that these alternative methodologies of developing work RVU recommendations were appropriate tools to be used in the Five Year Review Process. On June 21, 2006, the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule indicating various concerns it had with using this extant data for this purpose. CMS stated that while these

databases are significant tools that can be used to improve the quality of patient care and could be used to validate the results from the RUC survey instrument, there were some concerns about its representativeness, its correlation between time and work as time is only one component in a work RVU, the fact that these databases are not available for all specialties and finally, that the relativity of the fee schedule could be compromised by using such a different method to determine work RVUs of a small number of codes (i.e. codes in the Five Year Review Process) because current work RVUs for other services are not based on this methodology.

The Research Subcommittee feels that due to this response to the methodology used for several of the RUC's recommendations to CMS, a policy should be developed for how extant data should be used in the RUC process. The Research Subcommittee began its discussion by identifying specialty societies' concerns about using extant data. These concerns include but are not limited to:

- Representative Data
- Equal Availability for Database Across Specialties
- Mixing of Methodologies in the RBRVS
- Using Extant Data for a Purpose in Which it was not Designed
- Identifying all Potential Databases
- How the Extant Data Will be Implemented in the RUC Process

A RUC member stressed that the RUC should only consider public databases and that proprietary databases should not be used if the RUC cannot examine or critique this data. He further suggested that a bullet should be added to the aforementioned list - Transparency of the database to address this concern.

As a first step, the Research Subcommittee will form a workgroup to make policy recommendations to the Subcommittee addressing the following issues:

- Determine methods to identify all databases currently available or in stages of development
- Develop inclusion criteria for appropriateness of using extant data
 - Acceptable distribution of site of service
 - Representative
 - Acceptable methods for how time is measured
- Use of the Data
 - A supportive tool to RUC surveys and magnitude estimation
 - A formulaic tool (i.e. IWPUT)

Additionally, AMA staff will query specialty societies about additional issues that the workgroup should address regarding the RUC's use of extant data. The Extant Data Workgroup members include: Doctors Hitzeman (Chair), Allen, Derr, Manaker Pfeifer and P. Smith. The first formal meeting of the workgroup will take place at the February 2007 RUC Meeting. A conference call of this workgroup may be convened to solely establish the agenda for the formal meeting in February. The Research Subcommittee would also like to extend an invitation to CMS to participate in these meetings. AMA

staff will also explore options regarding technical expertise to assist in this discussion.

VI. ACS Request – Historical RUC Recommendation Analysis

During the discussion of the survey instruments, summary of recommendations forms and corresponding instruction document, the American College of Surgeons discussed a letter they had submitted outlining a general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a “social survey” collecting the specialties’ “wish list.” The RUC recommended that as a first step, AMA Staff prepare an analysis of survey medians and CMS’ final implemented relative values to see if the relationship between the survey medians and the final value have changed throughout the process.

This relationship has remained relatively consistent throughout this time period. After reviewing this data at the April 2006 RUC Meeting, the Research Subcommittee recommended as a second step, AMA Staff prepare an analysis of survey medians, specialty society recommendations and RUC recommendations to see if the relationship between these has changed throughout the process. This analysis demonstrated that overall the relationship between the specialty society recommendation and the survey median is approximately 96% and that the relationship between the RUC recommendation and the survey median is approximately 91% and the relationship between the CMS published work RVU and the RUC recommendation is 91%. It also demonstrated that these relationships have remained relatively consistent throughout this time period.

VII. Modifier -51 Exempt Workgroup Update

At the June CPT Panel Meeting, Doctor Hollmann presented the Modifier 51 workgroup minutes (conference call, Wed, May 31, 2006), proposed language for Appendix A & E, Immune Globulin, and Vaccine Toxoid sections and a comprehensive list of all the Modifier 51 exempt codes with associated workgroup recommendations. These documents have been included for the Research Subcommittee’s review. It was agreed that these workgroup products would be sent to advisors for comment and consideration by the Panel for the October 2006 CPT Meeting.

The Research Subcommittee reviewed the actions assigned to it from this workgroup and the RUC made the following recommendations:

- 4.) A question will be added to the Summary of Recommendation Form questioning if the recommended value for the new or revised procedure is based on its Modifier -51 Exempt status.**
- 5.) The following language will be added to the survey instruments instructions:**

When a code is Modifier -51 Exempt, this procedure is adjunctive to another procedure, therefore only include the additional time/work associated with this code and not included in the time/work for the procedures with which it is commonly billed.

- 6.) While conducting research on the codes in the Modifier -51 exempt list, it appeared that 7 spine codes on the list had some interesting valuation history. The RUC had recommended that these procedures (22840, 22842, 22843, 22844, 22845, 22846 and 22847) were originally valued by the RUC through the new and revised process as the global period of these codes were changed from a 000 to a ZZZ. As such the RUC, recommended that the code should no longer be reported with a -51 Modifier and the RVU for these codes should be reduced in some cases by half to reflect this change in global. CMS accepted this recommendation in the Dec 1995 Federal Register. However, the decision was overturned in the Nov 1996 Federal Register due to comments CMS received regarding these codes. The Research Subcommittee discussed this issue and received input from CMS that they would review this issue further. However, at this time **the RUC recommends that the rationale in the RUC database for these codes reflect this history. This proposed language will be drafted by AMA staff, reviewed by interested specialty societies and presented at the February 2007 RUC Meeting.**

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
October 5, 2006**

Doctors Katherine Bradley, PhD, RN, (Chair), James Anthony, MD, Joel Brill, MD, Walt Larimore, MD, J. Leonard Lichtenfeld, MD, William J. Mangold, MD, Bill Moran, MD, David Regan, Charles Rubin, MD, Holly Stanley, MD and Robert Zwolak, MD met and discussed the following three issues:

1. Missing Physician Time – Specific Codes

The following RUC reviewed physician services have been identified by AMA staff as not having any physician time information (Harvard or RUC). CMS uses physician time in its practice expense methodology in order to create its specialty pools and therefore it is in the specialty's best interest to have physician time for all of their codes with physician work. The Practice Expense Subcommittee discussed following two sets of codes and made the following recommendations:

Endoscopic Enteral Stenting codes 43256, 44370, 44379, and 44383

The Practice Expense Subcommittee heard comment from the specialty society that the RUC had rejected the specialty's survey results when they were brought to the RUC in the year 2000 and in 2001. In February 2001 the RUC made recommendations based on a building block methodology without physician time components. The specialty and Practice Expense Subcommittee discussed various methods of establishing physician time components and believed that the specialty would be able to establish physician time components through a crosswalk of existing codes or other means.

The RUC recommends that the specialty society research the codes and return to this subcommittee with physician time components and an appropriate rationale based on discussion listed on page 65424 of CMS Federal Register dated June 8, 2001, for codes 43256, 44370, 44379, and 44383 for presentation at the February 2007 meeting.

Ocular Photodynamic Therapy - 67225

The Practice Expense Subcommittee heard comment from the specialty society that this add-on code was never surveyed and that the work RVU was determined by CMS. The specialty cited code 67221 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* that was recently reviewed at the 3rd Five Year Review (RUC recommended work RVU = 3.45, pre time = 10 minutes, intra time = 15 minutes, immediate post = 5 minutes), and recommended 3 minutes of intra and total time for code 67225. **The RUC agreed with the specialty society recommendation and recommends 3 minutes of intra and total time for add-on code 67225.**

2. Capturing Equipment Utilization Information in the Multi-Specialty Practice Information Survey

CMS had asked earlier in the year, how it should reflect the utilization rate, particularly for high cost equipment. In April 2006, the Practice Expense Subcommittee discussed whether there should be a different rate for all equipment or just for the equipment set by a specific cost thresholds (i.e. equipment priced over \$500,000). Subcommittee members, at that time, indicated that the cost of capital may not have a direct linear relationship with equipment utilization. After much discussion, the RUC made the following recommendation to the RUC in April 2006:

The RUC agreed that the 50% utilization rate is too low and CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographical considerations. (April 2006 RUC)

At this Subcommittee meeting members discussed methods of capturing equipment utilization rates. The subcommittee discussed in detail equipment utilization questions on the draft copy of the Multi-Specialty Physician Practice Information Survey to be piloted this fall by the AMA. The subcommittee believed that this survey would be able to capture some useful information. However, individuals questioned whether this survey effort was the best vehicle to collect data on equipment utilization. A RUC member suggested that the AMA explore over sampling of the types of practices that would typically own this equipment. In addition, going forward it was suggested that the PERC begin requesting utilization rates on new and revised codes that come to the RUC.

The Subcommittee reviewed the draft survey question 18a and questioned whether the list of equipment items should be expanded by using a lower threshold. CMS expressed that a lower threshold would encompass more equipment items and apply to more specialties. The RUC made the following two recommendations for this issue:

- 3. Question on equipment (18a) on the current draft Multi-Specialty Practice Information should be used to capture specialty practice equipment information. This question will be piloted in the survey this fall and there will be opportunity to modify the question prior to the actual survey that will be performed in the spring of 2007. ***
- 4. The equipment question (18a) should encompass equipment items that are below the current proposed \$500,000 threshold to a new threshold of between \$100, 000 and \$200,000 to be determined on the number of equipment items (to be resolved by the AMA and CMS staff)**

** This recommendation was approved by a vote of 5 for and 4 against.*

3. Practice Expense Refinement Process

The now sunset Practice Expense Advisory Committee (PEAC) and the new Practice Expense Review Committee (PERC) essentially reviewed (refined) the direct practice expense inputs for all existing codes on the Medicare Fee Schedule. However, CMS representatives, MedPAC and the RUC have expressed interest in the development of a process of ongoing refinement or maintenance of the direct practice expense inputs. Currently, the PERC continues to review the direct inputs of selected existing codes through direct requests from CMS. Specialty societies currently contact CMS and ask for specific refinements, and if warranted, CMS refers the codes to the PERC for review. The Practice Expense Subcommittee was asked to discuss whether a more comprehensive review is necessary in the future and how and when it may be performed.

The Subcommittee initially discussed the importance of keeping the direct practice expense inputs current, and agreed that the RUC has a great interest in the refinement process. Subcommittee members believed that such a review could be performed similar to the initial PEAC review which was mandatory or it could be specialty driven, based on changes in practice patterns, since many codes may not need any refinement.

CMS representatives reiterated that they are obligated by law to review the values not less than every five years, however they have not yet notified the public as to when the time frame for this obligation would begin.

Understanding that in developing a process for direct practice expense inputs would require more information from CMS about the time frame and scope of future refinement, the Subcommittee believed it would be premature to establish a process of direct practice expense input refinement for existing codes that differs from the current method. The RUC made the following recommendation:

The RUC continues to express interest in practice expense refinement and plans participate in any refinement process. However, a specific process can not be planned until CMS provides further information on the timeline for the practice expense Five-Year Review.

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee/Research Subcommittee
Multi-Specialty Physician Practice Information Survey
Thursday, October 5, 2006**

Practice Expense Subcommittee Members: Katherine Bradley, PhD, RN, (Chair), James Anthony, MD, Joel Brill, MD, Thomas Felger, MD, Chad Rubin, MD, Holly Stanley, MD, J. Leonard Lichtenfeld, MD, William J. Mangold, Jr, MD, Bill Moran, MD, David Regan, MD, and Robert Zwolak, MD.

Research Subcommittee Members: Norman A. Cohen, MD, (Chair), Bibb Allen, MD, John Derr, MD, Charles Koopmann, Jr., MD, David Hitzeman, DO, Scott Manaker, MD, Greg Przybylski, MD, Daniel Mark Siegel, MD, J. Baldwin Smith, DPM, Lloyd Smith, DPM, and Peter Smith, MD

Progress Report on Survey Project – AMA Staff

Sherry Smith provided a progress report on the Physician Practice Information Survey. The complete presentation is attached to this report. Some of the key information provided to RUC participants included:

- 46 specialties and health professions have committed to join the effort.
- The AMA will select a survey firm the week of October 9.
- Pilot testing will be funded by the AMA and will be initiated this month.
- The full survey will be launched in April 2007.
- The AMA requested the survey firms to provide proposals to achieve a 50% response rate.
- Based on current CMS precision criteria, it is estimated that 100 respondents per specialty will be needed.
- The sample will be drawn from the AMA Masterfile for all MD/DO specialties.
- CMS has contracted with Lewin to draw samples for the non-MD/DO health professions and to analyze their data. Lewin will be working with the AMA and the survey firm to coordinate this effort to ensure consistency.
- A variety of survey methods (telephone, mail, internet) and incentives (cash, gift certificates, survey reports) will be tested during the pilot phase.
- Data will be available for analysis in the 1st quarter of 2008. Practice expense data will be provided to CMS by March 31, 2008 for consideration in the 2009 MFS rulemaking process.

Ms. Smith indicated that a report of the pilot testing will be provided at the February 2007 RUC meeting.

Cover Letter for Physician Practice Survey

In contacting physicians to participate in the Physician Practice Information Survey, consistent letter(s) will be distributed by the survey firm. After receiving further input from the selected survey firm, a decision will be made regarding whether a single letter will be sent from both the AMA and the specialty society or whether two separate letters will be sent. On August 18, the AMA distributed a letter with the basic content proposed to be included in this distribution. The

AMA received a few minor edits and incorporated those into a revised version provided to the RUC participants at the RUC meeting.

There was extensive discussion regarding this communication to potential survey respondents. A few individuals argued that this direct communication with the survey respondent should include specific information stating that the data obtained in the survey effort would be utilized in determining practice expense payments from Medicare. The AMA and CMS clarified that this language would not be appropriate as it may lead to a perception of bias.

The Subcommittee members did not offer any revisions to the cover letter as distributed.

Uniform Announcement

The survey effort must be credible, fair, consistent, and transparent. In an effort to provide consistent messaging to specialty society members, the AMA staff drafted a “uniform announcement” that specialties may utilize in their communications. It is envisioned that this two paragraph announcement would be utilized in specialty newsletters, blast e-mails to members, and in response to questions received from members or the press.

The Subcommittee did discuss whether it was appropriate to include the sentence “Data related to professional practice expenses will also be collected and presented to the Centers for Medicare and Medicaid Services.” The Subcommittee agreed that this statement should remain within the announcement.

Subcommittee members asked that the AMA provide specific instructions to specialty societies when this uniform announcement is distributed to participating groups. Members expressed specific concern that expectations regarding acceptable communications be articulated to all specialties. In addition, the AMA and/or the survey firm should develop a frequently asked questions (FAQ) document. The specialties should be able to refer members to the FAQ on a website and have a survey firm directly contact the individuals. The specialty society should refer questions from members to the survey firm and/or AMA staff.

Crosswalk of Medicare Specialty to AMA Masterfile

The Subcommittee members reviewed the proposed linkage between the Medicare Specialty ID and the AMA Masterfile. The Subcommittee recommended the following revisions:

Diabetes should be linked to Endocrinology, rather than Internal Medicine
Hepatology should be linked to Gastroenterology, rather than Internal Medicine
Hematology should be linked to Internal Medicine, rather than Medical Oncology
Facial Plastic Surgery should be linked to Otolaryngology, rather than Plastic Surgery

The AMA will make these revisions as suggested.

The Subcommittees also recommended that the AMA remove all RUC participants (RUC members, alternates, and Advisory Committee members) from the list of individuals within the Masterfile prior to drawing the survey sample.

Crosswalk Requests – Discussion

Practice expense data for a number of specialty societies and health care professions are currently crosswalked from another specialty. In several cases, these specialties have requested a continued crosswalk, rather than direct data collection. The AMA collected these requests and submitted them to CMS staff for review and comment.

In general, CMS staff were supportive that these specialties do not need to collect specific data. However, CMS will decide the actual appropriate crosswalk after the survey process is complete. Specialties should not assume that their crosswalk will remain consistent with the current crosswalk. For example, hematology is currently crosswalked to medical oncology and the more appropriate crosswalk may be internal medicine as hematology will be included within the internal medicine survey sample (see above).

CMS staff did state that clinical psychology and social work may wish to pursue survey data collection, perhaps sharing the expense and collecting a total of 100 respondents for the professions combined. CMS indicated that chiropractors should definitely be surveyed as this profession has its own distinct CPT codes.

Review of List of Questions for Survey

The AMA incorporated many revisions to the draft survey (ie, list of questions) suggested by specialty societies. AMA staff received many helpful comments, particularly from practicing physicians. A few minor revisions and suggestions were made at the meeting and will be incorporated prior to sharing the document with the survey firm for pilot testing (eg, moving the total number of hours to beginning of physician weekly activities section). It is anticipated that the survey firm will also have a number of suggestions and will develop the survey tools to incorporate appropriate responses (N/As, etc) and format. The results of the pilot will also drive additional changes to the survey prior to its launch in April 2007.

The Subcommittee did specifically discuss and provide input on the questions related to nurse practitioners/physician assistants/other independently billing staff to ensure that CMS has the relevant data from the survey results to use in the practice expense methodology. The survey will be revised to incorporate these discussions, as follows:

- 16.** How many of these non-physician personnel are nurse practitioners; physician assistants; and other clinical personnel who can independently bill?
 Full Time Part Time
- 16a.** Do these staff assist you in the hospital?
☐ Yes, total hours per week for all “billing” staff who assist without actually billing.
☐ No
- 17.** How many of these non-physician personnel are RNs, LPNs, physicists, lab technicians, x-ray technicians, medical assistants, and other clinical personnel who can not independently bill?
 Full Time Part Time
- 17a.** Do these staff assist you in the hospital?
☐ Yes, total hours per week for all “non-billing” staff who assist.
☐ No

Carolyn Mullen and Peter Smith, MD are developing language to follow up to 16a and 17a to query further about what these staff are doing while assisting at the hospital.

Non-Physician Payroll Expense:

14. Provide your share of total 2006 non-physician payroll expenses, including fringe benefits.

AMOUNT...\$|_|,|_|_|_|,000

14a. Provide your share of 2006 non-physician payroll expenses, including fringe benefits, that were solely for non-clinical personnel involved primarily in administrative, secretarial or clerical activities, including transcriptionists, medical records personnel, receptionists, schedulers and billing, coding staff, information technology staff, and custodial personnel. AMOUNT...\$|_|,|_|_|_|,000

14b. Provide your share of 2006 non-physician payroll expenses, including fringe benefits, that were solely for nurse practitioners; physician assistants; and other clinical personnel who can independently bill.

AMOUNT...\$|_|,|_|_|_|,000

14b(1) Do these individuals spend 100% of their time as physician extenders/surrogates or as independent billers?

☐ Yes

☐ No ____ %

14c. Provide your share of 2006 non-physician payroll expenses, including fringe benefits, that were solely for other clinical employees, including RNs, LPNs, physicists, lab technicians, x-ray technicians, medical assistants and other clinical personnel who can not independently bill.

AMOUNT...\$|_|,|_|_|_|,000

**AMA/Specialty Society RVS Update Process
Practice Expense Review Committee Report
October 5, 2006**

The following PERC members participated in the discussions: Doctors Moran (Chair), James Anthony, MD, Katherine Bradley, PhD, RN, Joel Brill, MD, Manuel D. Cerqueria, MD, Neal H. Cohen, MD, Thomas A. Felger, MD, Gregory Kwasny, MD, Tye Ouzounian, MD, James Regan, MD, and Anthony Senagore, MD.

Doctor Moran welcomed the group and obtained a unanimous vote to approve the Committee's minutes from the April 2006 meeting.

The following existing code issues were addressed by the PERC as requested by CMS.

1) Transcatheter placement of an intravascular stent(s), 37205 and 37206 (SIR, ACR)

The specialty presented the intravascular stent codes to the PERC for the establishment of non-facility practice expense inputs. In addition to these intravascular stent codes, the society presented a corresponding radiological supervision and interpretation code, 75960 out of the level of interest process, so that it may be refined with these codes. The PERC agreed that the S&I code should be reviewed concurrently, but had other difficulty with the code set brought forward.

The PERC had some difficulty in evaluating the intravascular stent codes presented by SIR and ACR. Doctor Cohen explained that there is no guidelines for having the PERC establish practice expense input recommendations for procedures once performed only in facility. CMS requested the PERC review the non-facility inputs codes, however the PERC did not believe it was in their purview to recommend inputs that may imply that codes are recommended by the group to be safely performed in the physician's office, and subsequently cause a change in practice patterns. In addition, this new ability to perform these in-facility procedures in an office setting, would not allow for any shift of funds from the Part A budget to the Part B budget to compensate for the shift in practice.

CMS representatives agreed there may be some concern for patient safety, as these codes do not appear on the approved ASC listing. The agency has proposed that procedures the ASC may be performed in the ASC when an overnight stay is not typically required when performed in a hospital setting. In addition, it was reiterated that CMS makes the final decision on whether a relative value is published.

The RUC recommends that codes 37205, 37206, and 74960 be referred to the Practice Expense Subcommittee in order to establish guidelines for establishing non-facility direct inputs for codes that have historically been performed predominately in facility settings and currently have relative values only in the facility setting.

2) Renal biopsy, 50200 (SIR, ACR)

The specialty presented this renal biopsy code to the PERC for the establishment of non-facility practice expense inputs. In addition, the society presented four associated imaging, supervision, and interpretation codes (76003, 76942, 76360, and 76393) out of the level of interest process, so that it may be refined with these codes. The PERC agreed that codes billed concurrently should be reviewed concurrently, but had other difficulty with the renal biopsy code.

The specialty indicated in their presentation that the renal biopsy code 50200 was performed with conscious sedation. The PERC believed it was important that the direct inputs associated with conscious sedation be included in the specialty's recommendation if indeed it was deemed appropriately performed with conscious sedation. The RUC database did not contain an indication of the use of conscious sedation in the procedure in the vignette, pre, intra, or post description of physician work.

The RUC recommends that code 50200, if appropriate, be petitioned by the Society for Interventional Radiology to be included on CPT's conscious sedation list, and their direct input recommendations be cleaned up for any future presentation to the PERC.

3) Occlusion of fallopian tube(s), 58615 (SIR, ACOG)

The Society for Interventional Radiology (SIR) presented this occlusion of fallopian tube(s) code to the PERC for the establishment of non-facility practice expense inputs. In addition, the society presented an associated supervision and interpretation codes (74742) out of the level of interest process, so that it may be refined with this codes. The American College of Obstetrics and Gynecology (ACOG) had stated through a letter to AMA staff that "58615 was not the appropriate code for the procedure SIR's members were performing in the non-facility setting. Barb Levy, MD, speaking on behalf of the ACOG stated that the procedure described by SIR for which code 58615 was being used in the non-facility setting, was an inappropriate use of the code. Doctor Levy believes that the code 58615 does not describe the transcervical approach used by SIR. The PERC recommends that the society ask for a new code from CPT that describes the procedure more accurately.

4) Arthroscopy 29840 and 29870 (AAHKS), the specialty withdrew their request for non-facility inputs for these codes.

II. Committee Discussion of New and Revised PE Input Recommendations

The following issues and related practice expense inputs for new and revised CPT codes were reviewed, modified slightly, and are recommended by the PERC:

RUC Tab

Practice Expense Recommendations for *CPT 2008*:

Temporomandibular Joint Manipulation (21XXX) <i>American Association of Oral and Maxillofacial Surgeons</i>	7
Non-implantable Venous Access Device Blood Draws (36592X, 36593X and 36594X) <i>American Society of Clinical Oncology</i>	8

**AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
October 5, 2006**

Members Present:

Arthur Traugott, MD, Chair
Mary Foto, OTR, Co-Chair
Katherine Bradley, PhD, RN
Erik Van Doorne, PT
Thomas Felger, MD
Robert Fifer, PhD
James Georgoulakis, PhD, JD

Anthony Hamm, DC
Emily H. Hill, PA-C
William J. Mangold, Jr., MD
Lloyd Smith, DPM
Doris Tomer, LCSW
Jane White, PhD, RD, FADA
Don Williamson, OD

I. Welcome

Mary Foto, OTR, welcomed the new HCPAC Chair, Arthur Traugott, MD, and the new AMA RUC Representative, William J. Mangold, Jr., MD.

II. CMS Update

Edith Hambrick, MD, Carolyn Mullen, and Pam West, PT, DPT, MPH, provided a CMS update, informing the HCPAC that Leslie Norwalk will serve as the acting CMS Administrator since Mark McClellan, MD, has stepped down. Additionally, Herb Kuhn will serve as the acting CMS Deputy Administrator.

Doctor Hambrick indicated that the comment period for the Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System will close on October 10, 2006.

Ms. Mullen confirmed that it will take congressional action for any change to occur to the SGR or moratorium on the therapy cap. Thomas Felger, MD indicated that a united group of physicians, which represented one million health practitioners, visited CMS officials today to encourage that any Five-Year Review budget neutrality adjustment should be applied to the conversion factor, rather than the work relative values. Doctor Felger believed the discussion and suggestions were well received.

III. Multi-Specialty Practice Survey Discussion

Sherry Smith provided an overview of the non-MD/DO practice survey and introduced Doctor Al Dobson from the Lewin Corporation. Lewin has a distinct contract with CMS to draw the samples for these specific surveys and then analyze the resulting data. Lewin will work the AMA and the survey firm to coordinate these activities. The American Association of Oral and Maxillofacial Surgeons, American Chiropractic Association, American Optometric Association and the American Podiatric Medical Association will utilize the “physician” survey tool as this instrument contains language that will be clearer to their members.

CMS staff indicated that it would be important for Chiropractors to participate in the survey effort. CMS also encourages psychology and social work to participate. CMS indicated that the agency would be receptive to a joint survey of psychology and social

work. That is, NASW and APA could potentially share the cost of the survey effort and aim for a total of 100 respondents between the two health professions.

Ms. Smith indicated that each participating specialty society will receive a summary of the results for their society with all confidential information removed. Lewin will work with the AMA to ensure that the data provided to both CMS and the HCPAC organizations is consistent to the data provided by the AMA for the MD/DO specialties. Ms. Smith stated that she will send a letter to the participating specialty societies confirming the arrangements between the AMA, survey firm, Lewin, and CMS to assure their leadership that the AMA will not be specifically involved in the data analysis for these non-MD/DO organizations.. Doctor Dobson also indicated that he will produce a document regarding the arrangement between CMS and Lewin.

Ms. Smith indicated that she will make additional minor revisions to the HCPAC survey to remove language that would not be appropriate (eg, “medical”, etc). Additionally, Ms. Smith answered questions and confirmed:

- Lewin will work with each profession to ensure that only health professionals engaged in clinical work will be included in the survey sample;
- the HCPAC may review the pilot testing results of the “other topic” section in the pilot and then determine whether this section should be included in the full survey;
- the AMA will be selecting the survey firm next week and the pilot testing will begin immediately;
- AMA staff will examine the addition of silent PPOs in the private pay section of the “other topics” section. Ms. Smith will address this specific request with the AMA’s Private Sector Advocacy staff.

IV. HCPAC MPC List Review

The American Podiatric Medical Association submitted changes to delete and add codes to the HCPAC MPC list. Ms. Foto encouraged that the HCPAC revisit and review the MPC list and to submit any changes to AMA Staff as soon as possible.

V. Team Conference Codes – Discussion Only

The HCPAC reviewed the vignette and reference service list for the team conference codes. In February 2007, CPT codes 9936X2 and 9936X4, performed by non-physicians, will be presented to the HCPAC and codes 9936X1 and 9936X3 will be presented to the RUC. Ms. Foto stressed that strong collaboration will need to occur for the societies to develop interrelated recommendations. Robert Fifer, PhD, American Speech-Language-Hearing Association, stated that they will participate in the survey if the *Final Rule* indicates work relative values for the services performed by audiologists and speech language pathologists. Doris Tomer, National Association of Social Workers, indicated that they will participate in the survey process and will indicate so on the upcoming level of interest (LOI) form.

VI. Other Issues

Doctor James Georgoulakis, American Psychological Association, asked the HCPAC how a health care professional should report a service when it had be prematurely ended due to the patient's request or sudden departure. Doctor Peter Hollmann, CPT Editorial Panel, indicated that modifier -52 should be used even though it states discontinued service due to the *discretion of the physician*. Doctor Hollmann indicated he will clarify this with the CPT Editorial Panel next week. Marie Mindeman, CPT Staff, indicated that the *CPT Assistant* November 2001 issue, supports the use of modifier -52 in such a situation.

The meeting adjourned at 6:45 p.m.

**AMA/Specialty Society RVS Update Committee
Pre-Service Time Workgroup Report
Thursday, October 6, 2006**

The following participated in the discussions: Barbara Levy, MD (Chair), Joel Brill, MD, Norman Cohen, MD, Thomas Felger, MD, Emily Hill, PA-C, Klaus Mergener, MD, PhD, MD, Tye Ouzounian, MD, James Regan, MD Gary Seabrook, MD, MD, J. Baldwin Smith, MD, Richard Tuck, MD, and Maurits Wiersma, MD

Doctor Levy began the discussion with an overview of the Workgroup's charge from the RUC: to develop benchmarks which the RUC can use to evaluate the pre-service time for new and revised codes. The workgroup initially discussed the definition of pre-service time and how the global period starts. The Workgroup believed the current definition was misleading and made the following definition for an understanding of the pre-service time period and the following recommended pre-time packages.

After the decision for surgery is made, the global period begins when services are provided which would have been performed at admission the night before scheduled surgery.

The Workgroup then reviewed the 15 summarized pre-service tasks and believed they capture the universe of physician activities in the pre-service time period. The Workgroup made minor changes to a few of the descriptions of pre-service.

The Workgroup then reviewed each of the six pre-service packages and agreed that they encompassed most of the patient scenarios. The Workgroup did however believe that the level of sedation was important enough to add additional levels to packages 1 and 2 in the facility setting to account for sedation. The Workgroup members then developed specific time components and overall time for each pre-service package. **The RUC recommends the times and packages on the second and third page of this report. In addition, the RUC recommends the following:**

- **The RUC also agreed that for building block IWPUR purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUR should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUR of .0081.**
- **The RUC believed that when a new or revised code goes through the CPT process, the development of the code's vignette is very important in the identification of which pre-service time package should apply. The RUC members recommend that the CPT Editorial Panel is informed of this additional importance.**
- **When a specialty society presents a code it may not be apparent where the dominate site of service will be. The RUC believed there should be some mechanism to review the site of service and make adjustments to the overall time of the procedure through a change in the code's package number if appropriate.**

The RUC believed that the specific package chosen by the specialty needed to be justified at the RUC as well as any additional time above the recommended package time. The RUC

believed additional increments of 15 minutes for TEE, invasive monitoring or complex positioning, may be appropriate for some procedures.

**AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
October 6, 2006**

Members Present: Doctors David Hitzeman (Chair), Michael D. Bishop, Stephen Kamenetzky, Brenda Lewis, Scott Manaker, Guy Orangio, Gregory Przybylski, Sandra Reed, David Regan and Peter Smith, Susan Strate and Arthur Traugott.

I. PLI Premium Collection Efforts

Doctor Stephen Kamenetzky informed the RUC that the Physician Insurers Association of America (PIAA) submitted PLI premium data for the six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) to CMS. Doctor Kamenetzky also stated that Medical Protective (MedPro) also volunteered to submit PLI premium data to CMS, which should ensure sufficient market share data. It is anticipated that CMS will review this data to determine if it meets the appropriate requirements after the release of the November 2006 *Final Rule* and current collection efforts for GPCIs.

AMA Staff will contact CMS to ensure that MedPro receives a similar letter as PIAA received to ensure confidentiality of the data shared.

II. PLI Questions on Multi-Specialty Practice Survey

The PLI Workgroup reviewed the PLI section of the multi-specialty practice survey and suggested the following revisions:

1. Define occurrence coverage: covers events that occur while the policy is in force regardless of when the claim is made.
2. Define claims made: covers only events that occur and are reported while the policy is in force.
3. Add a question on the ability or inability for a physician to obtain insurance. A physician may have self-insurance because they do not have a choice.
4. Break out tail coverage from question #12 *Provide your 2006 medical liability insurance premium...*
5. Explore whether to add a question specific to state requirements for minimum limits. This data may be available directly from states.

Sherry Smith answered questions regarding the PLI questions to be included in the “Other Topics” section of the survey and confirmed that in the past, SMS surveys requesting how many malpractice claims have been filed against a physician has had a response rate of 95%. The pilot will determine the response rate on this question and determine if this question should remain on the survey.

III. Deficit Reduction Act (DRA) and PLI Payment Implications

The PLI Workgroup reviewed the significant PLI implications due to the DRA imaging cuts. Doctor Hitzeman indicated that the allocation of PLI RVUs between the technical component (TC) and the professional component (PC) portion is inappropriate. The current PLI RVUs have this relationship reversed, with the higher PLI portion applying to the TC portion and the lower PLI portion applying to the PC portion. This results from the CMS application of resource-based PLI RVUs for the professional component, while retaining charge-based PLI RVUs for the technical component. Doctor Hitzeman stated that nearly \$200 million will be lost from the Medicare Fee Schedule if this allocation is not corrected within the Final Rule publication in November.

In the short time between this meeting and the implementation of the 2007 Medicare Physician Payment Schedule, it may not be feasible to determine an appropriate resource-based methodology for the technical component PLI relative values. However, it is conventional wisdom that the technical component PLI RVUs should not be greater than the resource-based professional component RVUs for the same services. Therefore, it would be logical to modify the technical component PLI RVUs to be equivalent to the professional component PLI RVUs. This would lead to re-distribution of PLI RVUs to other services within the Medicare Physician Payment Schedule.

The RUC recommends that CMS immediately adjust all technical component PLI RVUs to be equivalent to the professional component PLI RVUs for each service.

IV. PLI Crosswalk Query

The American Association of Oral and Maxillofacial Surgeons (AAOMS) initially requested that the PLI Workgroup review the PLI premium crosswalk for oral surgery and the dominant specialty for certain low volume CPT codes. However, after lengthy discussion AAOMS withdrew their crosswalk changes request until they get further clarification from the CMS Enrollment Division regarding specific provider classifications.

**AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
October 6, 2006**

Members Present: Doctors Richard Tuck (Chair), Michael D. Bishop, James Blankenship, Ronald Burd, Mary Foto, OTR, Peter Hollmann, Barbara Levy, Lawrence Martinelli, Bernard Pfeifer, James Regan, Susan Strate and Arthur Traugott.

Doctor Tuck introduced Thomas Healy, AMA Associate General Counsel, who observed the Administrative Subcommittee meeting.

I. RUC Alternate/Advisor Guidelines

The Administrative subcommittee discussed revisions to the Structure and Functions suggested by AMA Legal Counsel to reinforce that RUC Alternates should not present relative value recommendations to the RUC at the same meeting they will be sitting at the RUC table and voting. **The RUC approved the changes made to the Structure and Functions document as amended.**

A. RVS Update Committee:

(9) Duty

(a) Specialty Society representatives shall execute independent judgment in their deliberations consistent with membership on the RUC. **RUC representatives should not advocate or present on behalf of their specialty.**

B. Advisory Committee

(3) Designation - Specialty Society representatives of the AC shall be designated by each respective Specialty Society. One alternate Specialty Society representative shall also be nominated by each of the Specialty Societies to participate on the AC in the absence of the respective Specialty Society representative. Specialty Society representatives of the AC, to the extent practicable, shall not be the same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee. **In the rare circumstance that a Specialty Society RUC alternate must serve as a Specialty Society advisor to the RUC during the course of a meeting, (i.e., due to health or emergency issues) that individual shall not serve as a Specialty Society RUC alternate for the remainder of the meeting.** The AMA shall approve all Specialty Society nominations to the AC.

The discussion of possible solutions to alleviate the work load of the RUC members and alternates will be addressed at the 2007 February RUC meeting.

II. Conflict of Interest

In AMA Legal Counsel's efforts to ensure conflict of interest/financial interests are disclosed for all AMA and AMA-sponsored bodies, Barney Cohen, AMA Senior Division Counsel, prepared a memo to the RUC summarizing the conflict of interests and financial disclosure policies. After review of this memo **the RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations. The RUC also recommends that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society.**

III. **Composition of the RUC**

Doctor Tuck introduced the discussion by stating that any changes or conclusions should sustain and enhance the success of the RUC. Doctor Tuck reviewed the April 2006 Administrative Subcommittee report and the charge to the committee was reiterated. Doctor Tuck thoroughly reviewed the agenda materials on the history of the RUC composition. Doctor Tuck stated that the consistent themes in the historical review of the RUC composition are that the criteria for the permanent seats on the RUC have remained the same. Secondly, that participation in the RUC process (i.e., Subcommittees, Workgroups, etc.) is open to all specialty society advisors.

The Administrative Subcommittee then reviewed Medicare charges data (percentage of E/M, percentage of procedures and estimation of global E/M for surgery). The data indicated that E/M services constitute a significant percentage of services provided by surgical specialists (40-64%).

Doctor Tuck initiated discussion by asking if the RUC composition provides the expertise to function effectively as a deliberative body. Additionally, Doctor Tuck asked the Subcommittee to review the RUC criteria and reaffirm or revise the five criteria. The following discussion items ensued:

RUC Composition

2. The Administrative Subcommittee confirmed that the RUC is a deliberative expert panel, as specified in the Structure and Functions.
3. The RUC must address its creditability/perception to outside entities as well as consider improving the current internal process of reviewing new and revised CPT codes.
4. The RUC should determine its own composition based on specified criteria, as opposed to appointment by the AMA Board of Trustees, as is done for the CPT Editorial Panel.
5. The RUC does not require that RUC members are practicing physicians, AMA members (although encouraged), nor does it preclude physicians employed by carriers.
6. No physician group should feel disenfranchised by the current RUC composition. Participation in the RUC process is open to all specialties through the RUC advisory committee (i.e., subcommittees, workgroups, etc).

7. The RUC with its current composition resolved the third Five-Year Review E/M issues with a fair and united effort.

Criteria

8. Does criteria #1 *The specialty is an American Board of Medical Specialties (ABMS) specialty*, still hold true in 2006 as the best first priority criteria?
9. Is there expertise lacking on the RUC related to its current composition?
10. Does a functional size of the RUC effect the criteria for a permanent seat on the RUC?

Primary Care

11. MedPAC and the American College of Physicians (ACP) have questioned if primary care is adequately represented on the RUC.
12. Should the RUC add a primary care rotating seat, to include an individual who provides primary care services the majority of the time?

The questions above will be addressed at the 2007 February Administrative Subcommittee meeting based on information to be gathered:

The RUC recommends the following actions:

1. **AMA staff poll all RUC participants (i.e., RUC Members, RUC Alternates and RUC Advisors) on what specific expertise the RUC may be lacking.**
2. **AMA staff collect data with respect to codes brought forward by subspecialties and look at how codes fared when the subspecialty had a rotating seat on the RUC versus when they did not. All rotating seat subspecialties will be reviewed.**

The Administrative Subcommittee did not have enough time to discuss the issue of term limits at this meeting. Term limits will be discussed at the 2007 February RUC meeting.

Doctor Tuck and Subcommittee members commended Sherry Smith and Susan Clark for the comprehensive agenda materials compiled for the history of the RUC composition and the Medicare charges data.

**AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup
Friday, October 6, 2006**

Members present: Barbara Levy, MD (Chair), Michael Bishop, MD, James Blankenship, MD, Norm Cohen, MD, Thomas Felger, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Geraldine McGinty, MD, Bernard Pfeifer, MD, J. Baldwin Smith, MD, Maurits Wiersema, MD, Robert Zwolak, MD

I. Review of Workgroup Mandate and Purpose

Doctor Levy thanked the workgroup for their participation and began by reading the workgroup's mandate, noting that the workgroup was formed as an outcropping of the Administrative Subcommittee to address issues related to the systematic development of potentially misvalued codes. The mandate is:

The purpose of the Five Year Review Identification Workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The Workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of "new technology" services.

Doctor Levy further stated that the workgroup has been asked to develop objective criteria to identify codes that qualify as new technology; objectively decide whether re-evaluation of new technology codes is warranted; develop objective measures to identify potentially misvalued codes; and recommend a process to review identified potentially misvalued codes.

In accomplishing this task, the workgroup will face challenges such as the number of codes that may need to be reviewed; making sure that no specialty is singled out; and dealing with the time and cost that the RUC and specialty societies may incur to identify, resurvey, and reevaluate these services.

Staff then provided an overview of the objective measures that had been discussed and suggested prior to the meeting. These include:

- All codes identified on the new technology list
- Codes that have never been valued by the RUC
- Utilization data points including increases in total utilization in a relatively short time period, categories or families of codes that increase in total utilization in a relatively short time period, and codes that increase in total utilization following a CPT editorial change
- Codes with site of service inconsistencies
- Episodes of care by the same provider on the same date that result in multiple service claims - In order to track these codes, the datasets must be run by CMS or the appropriate data to create the sets must be furnished to the AMA by CMS or other payers.

- Codes included on the Multi-Specialty Points of Comparison list
- Codes that increase significantly in the number of specialties performing them or change in the dominant specialty
- Codes that have exceptionally high practice expenses or codes that utilize a technology, equipment, or disposable supplies with few manufacturers or very high costs
- Codes that received a RUC valuation that differs significantly from the specialty society recommendation

The workgroup felt that each of these criteria may help to identify potentially misvalued services. The utilization data may be particularly poignant; however, the utilization data available only applies to services provided to the Medicare population. Data from private payers are necessary to more accurately evaluate the services. **The RUC will formally request utilization data for all services from private payers and explore with CMS the possibility of obtaining data for Medicaid. The Five-Year Review Identification Workgroup recommends that the RUC formally requests that CMS provide the RUC with data on services that are reported on the same date by the same provider.**

II. Identification of Objective Measures to Identify New Technology Codes

Objective Measures to Review New Technology

The workgroup next discussed the need to identify objective criteria for determining whether or not new technology services will be re-evaluated by the RUC. The assumption is that all codes that are identified as new technology will be re-evaluated based on the schedule approved by the Administrative Subcommittee. However, the workgroup may find that not all new technology codes experience a diffusion of that technology. There must be a way to objectively identify the codes that should be re-reviewed. The workgroup agreed that at the time the service is to be re-evaluated, the specialty society be asked the following questions:

- Has the typical patient changed?
- Has the typical procedure changed?
- Has the technology or devices changed in any way?
- Has the utilization (including number of times the code is billed, the dominant specialty, and the site of service) changed?

Based on the specialty's response to these questions and the data available to the AMA, the workgroup may make an objective determination of the need to re-evaluate. If the technology has not diffused, then the code will remain on the new technology list for another cycle. If at that time, the technology is still not diffuse, the code will be removed from the new technology list.

The workgroup raised the question regarding the necessity of a full survey for codes that are to be re-evaluated. The workgroup was in favor of looking into alternate methodologies.

Objective Measures to Identify New Technology

The workgroup discussed the criteria presented and identified the most likely criteria to indicate that a new service is new technology. The primary indicator for a code to be classified as new technology is at the request of the presenting specialty society. In the case that the specialty does not indicate new technology and the RUC disagrees, the RUC will rely on other supplemental objective measures that must be provided by the specialty. **The RUC will reinstate the question, “How many times have you performed this procedure in the past year?” on the survey instrument and that the responses should be included on the summary of recommendation form with and include the distribution of the responses (including the low, 25th percentile, median, 75th percentile, and high responses).**

Additionally, the workgroup requests that the RUC add the following questions to the “checklist for review” form provided in the agenda book and that members consider these questions prior to and during the RUC evaluation of potential “new technology” services:

- **Does this service use a newly FDA-approved procedure, technology, or device?**
- **Is this a new service provided to patients? If no, does this service utilize an existing procedure provided to patients in a new way?**
- **Did this service originate from a Category III CPT code?**

Other Issues

The question was raised of whether CMS would consider new technology codes as codes that are not subject to work neutrality. The workgroup agreed that the commonalities in the terms may cause some confusion and suggestions for a change in the name of the list will be presented at the next meeting.

III. Identification of Objective Measures to Identify Potentially Misvalued Codes

The workgroup reviewed the suggested criteria for the identification of potentially misvalued codes and recommended that the workgroup prioritize the criteria and select the most significant criteria. During the discussion, the workgroup identified two other objective measures that may identify potentially misvalued codes. The first are codes that have very high IWPUTs. The workgroup agreed that “very high” may be established as 0.120 – 0.140 and up. The second objective measure is codes that have had changes in the CMS coverage criteria that affect valuation after the RUC has already evaluated the service. All other suggested criteria were presented discussed and none were rejected. However, the workgroup was able to prioritize those criteria that it believed would most easily and effectively identify potentially misvalued codes. The workgroup agreed on three specific objective measures including:

- Codes that are typically performed in the outpatient setting or doctor’s office but include hospital E/M visits.
- Codes that have relatively high utilization for the specialty, are base codes, and have never been reviewed by the RUC.
- Codes that have a “very high” IWPUT of 0.120 – 0.140 or higher.

The workgroup asked that AMA staff assemble a list of codes that meet each of these criteria and present the total number of codes at the next meeting.

IV. Procedures for Review of Potentially Misvalued Codes

The workgroup considered the venue for reviewing codes that are identified and selected as potentially misvalued. It considered two options, scheduling these codes for review during the regular five-year review process or reviewing potentially misvalued codes on a rolling basis. The workgroup agreed that a rolling review place undue stress on specialties and require significant resources to carry out. The workgroup felt that the five-year review is the appropriate venue for review. However, the workgroup did agree that the issue of codes that are typically performed in the outpatient setting or doctor's office but including hospital E/M visits challenge the integrity of the RUC and must be considered separately from the five-year review. AMA staff was asked to compile these codes for consideration by the workgroup at its next meeting. **The RUC recommends that the codes with hospital E/M visits yet typically performed in the outpatient setting or in the physician's office be considered separately from the potentially misvalued codes and be subject to review prior to the next Five-Year Review.**

The workgroup asked that prior to the next meeting, staff identify the codes that fall into the category and review and support the accuracy of the data on which the codes were based. **The RUC recommends that the codes identified and selected for re-evaluation as potentially misvalued be submitted by the RUC during the CMS comment period (November/December 2008) for inclusion in the next regularly scheduled Five-Year Review.**

**AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup
Saturday, October 7, 2006**

Members present: John Derr, MD (Chair), James Blankenship, MD, Ron Burd, MD, Robert Fifer, PhD, CCC-A, Charles Koopmann, MD, Robert Kossmann, MD, Walt Larimore, MD, J. Leonard Lichtenfeld, MD, Daniel Mark Siegel, MD

Reinstatement of Evaluation and Management Services to the MPC

Doctor Derr welcomed the MPC workgroup and began the meeting by noting that at the last meeting of the Multi-Specialty Points of Comparison Workgroup in September 2004, the workgroup made a recommendation to remove all evaluation and management codes prior to the third Five-Year Review, as many specialties agreed that the services were mis-valued. The workgroup concurred with this recommendation and removed all evaluation and management services from the MPC list with the stipulation that they be replaced following the Five-Year Review. The temporarily deleted E/M codes that will automatically be listed again in the MPC list following publication of the final rule are: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99222, 99223, 99232, 99233, 99238, 99242, 99243, 99244, 99245, 99253, 99254, and 99255.

Specialty Society Requests to Update the MPC

AMA staff commented that in addition to MPC edits, some specialties have made other recommendations to the MPC. The American Academy of Pediatrics has requested that its acronym be corrected for codes 99436 and 99440. The acronym in the MPC is currently incorrect. Staff has made this correction to the list. Numerous other specialties have requested that MPC codes reviewed in the third Five-Year Review have their status (A, B, or C) corrected in the MPC based on that review. Following publication of the CMS Final Rule, staff will make the necessary changes to the list.

The workgroup then reviewed each individual specialty society request to add to or delete from the MPC list. A summary of the workgroup's actions is provided below:

CPT Code	SS Recommendation	Specialty Society	MPC Action	Additional Rationale
11044	Add	ASCRS	Add	
11420	Add	AAD	Add	
11421	Add	AAD	Add	
11422	Add	AAD	Add	
11423	Add	ASPS/AAD	Add	
11424	Add	AAD	Add	
11440	Add	AAD	Add	
11442	Add	ASPS/AAD	Add	
11443	Add	AAD	Add	
11444	Add	AAD	Add	
11446	Add	AAD	Add	
11600	Add	AAD	Add	

11601	Add	AAD	Add	
11602	Add	AAD	Add	
11603	Add	AAD	Add	
11604	Add	AAD	Add	
11606	Add	AAD	Add	
11620	Add	AAD	Add	
11621	Add	AAD	Add	
11622	Add	AAD	Add	
11623	Add	AAD	Add	
11624	Add	ASSH/AAD	Add	
11626	Add	AAD	Add	
11640	Add	AAD	Add	
11641	Add	AAD	Add	
11643	Add	ASPS/AAD	Add	
11644	Add	AAD	Add	
11646	Add	AAD	Add	
12051	Remove	ASPS	Denied	
12052	Add	AAD	Add	Pending Final Rule
13102	Add	ACS	Add	
13121	Add	AAD	Add	
13122	Add	ASSH	Add	
13133	Add	ASCRS	Add	
14040	Add	AAD	Add	
14041	Remove	ASPS	Denied	
15734	Add	ASPS	Add	Pending Final Rule
19103	Add	ACS	Add	
19180	Add	ACS	Add	
19298	Add	ASTRO	Add	Pending Final Rule
19361	Add	ASPS	Add	
20600	Add	ASSH	Add	
20808	Remove	AAFP/ASSH	Remove	
20824	Remove	AAFP/ASSH	Remove	
20937	Remove	ASSH	Remove	
20955	Remove	ASSH	Denied	
20973	Remove	ASSH	Denied	Request concurrence of dominant specialty
22525	Add	AANS	Add	
22534	Add	AANS	Add	
22840	Add	AANS	Add	
22842	Remove	AANS	Denied	Request concurrence of dominant specialty
23395	Remove	ASSH	Denied	Request concurrence of dominant specialty
24430	Add	ASSH	Add	
29075	Add	ASSH	Denied	Request concurrence of

				dominant specialty
29848	Remove	ASSH	Denied	Request concurrence of dominant specialty
37215	Add	AANS	Add	
38100	Add	ACS	Add	
38571	Add	ACS	Add	
43239	Remove	AGA	Denied	MPC agrees it is a relevant base code
43268	Remove	AGA	Remove	
43269	Add	AGA	Add	
43632	Add	ACS	Add	
44150	Add	ASCRS	Denied	Not an "A" code
44160	Remove	ASCRS	Denied	Request concurrence of dominant specialty
44202	Remove	ASCRS	Denied	Request concurrence of dominant specialty
44204	Add	ASCRS	Add	
44602	Add	ASCRS	Add	
45119	Add	ASCRS	Add	
45190	Add	ASCRS	Add	
45331	Remove	AGA	Denied	MPC agrees it is a relevant base code
45380	Remove	AGA	Denied	MPC agrees it is a relevant base code
45400	Add	ASCRS	Add	
45820	Remove	ACS	Remove	
46260	Remove	ASCRS	Remove	
46934	Add	ASCRS/ACS	Add	
49002	Add	ACS	Add	
49560	Add	ACS	Add	
49650	Add	ACS	Add	
52000	Add	AUA	Add	Pending Final Rule
54150	Add	AAP	Add	
57155	Add	ASTRO	Add	
59400	Remove	AAFP	Denied	Request concurrence of dominant specialty
60512	Add	ACS	Add	
61566	Add	AANS	Add	
61586	Remove	AANS	Denied	MPC agrees it is a relevant base code
61697	Add	AANS	Add	Pending Final Rule
61698	Add	AANS	Add	Pending Final Rule
61700	Remove	AANS	Remove	
62165	Add	AANS	Add	
63051	Add	AANS	Add	

63101	Add	AANS	Add	
63295	Add	AANS	Add	
63650	Remove	ASA	Remove	
64449	Add	ASA	Add	
64622	Remove	ASA	Remove	
77263	Add	ASTRO	Add	Pending Final Rule
77300	Add	ASTRO	Add	Pending Final Rule
77301	Add	ASTRO	Add	
77334	Add	ASTRO	Add	Pending Final Rule
78315	Add	SNM	Denied	Request concurrence of dominant specialty
78478	Add	SNM	Add	Pending Final Rule
78812	Add	SNM	Add	
78815	Add	SNM	Add	
79000	Remove	AAFP	Remove	
79101	Add	SNM	Add	
88180	Remove	CAP	Remove	
88189	Add	CAP	Add	
88309	Add	CAP	Add	Pending Final Rule
88333	Add	CAP	Add	
93751	Remove	AAFP	Remove	
95010	Remove	JCAAI/AAOA	Remove	
95015	Remove	JCAAI/AAOA	Remove	
99204	Add	ACP	Add	
99291	Add	ACP	Add	
99298	Remove	AAP	Remove	
99299	Add	AAP	Add	
99311	Remove	AAFP	Remove	

For three codes, the workgroup denied the specialty's request to delete the code because the workgroup agreed that the codes recommended for deletion were highly utilized base codes that provide a good basis for multi-specialty comparison.

The workgroup also denied a significant number of codes based on the fact that the request came from a specialty that was not the dominant provider of the service. For these codes, the workgroup has requested that staff contact all societies and solicit the concurrence of the dominant specialty. Following notification of concurrence of the dominant specialty, the codes will be re-submitted to the MPC workgroup at its next meeting.

Other Business

Deletion of C Codes

There are 31 C codes currently listed on the MPC. AAFP proposed that all C codes be deleted from the list. There was significant discussion on the issue, noting that C codes sometimes serve as the base for comparison and Harvard values are still assumed to be correct. The MPC workgroup agreed that deleting C codes at this juncture is premature and arbitrary. Rather, the workgroup asked that AMA staff contact all specialty societies with remaining C codes and inform them that the workgroup is considering removing all C codes and ask that if they have any objection to removing the codes. If there is an objection, specialties will be asked to state their rationale for continued inclusion.

Guidelines

The MPC workgroup was concerned that there are no clear guidelines provided to specialties describing the suggested requirements for adding or deleting codes to the MPC. Additionally, there are no instructions for use of the MPC. The MPC workgroup requests that staff assemble a short history and user guide to the MPC for the workgroup's consideration and present it at the next meeting.

Minimum Utilization Data

The AAFP recommended to the MPC workgroup that it consider establishing a minimum utilization level for inclusion on the MPC. The workgroup concurred in theory, but noted there are a number of exceptions that will affect Medicare utilization data and bar commonly performed codes because they are not performed on the Medicare population. The MPC was able to agree that utilization data were appropriate to consider when reviewing a code's MPC reference service. Rather than arbitrarily set a "low utilization" number, the RUC may determine relevance on their own, if they are provided with utilization data for referenced MPC codes. **The MPC Workgroup requests that the RUC include the most recent utilization data for MPC reference codes on the Summary of Recommendation form.**

October 2006 RUC Physician Time File																			
CPT Code	Pre Evaluation Time	Pre Positioning Time	Pre Service Scrub Dress Wait Time	Median Intra Service Time	Immediate Post Service Time	9 9 2 9 1	9 9 2 9 2	9 9 2 3 1	9 9 2 3 3	9 9 2 3 8		9 9 2 1 1	9 9 2 1 2	9 9 2 1 3	9 9 2 1 4	9 9 2 1 5	9 9 2 9 6	Unadjusted Total Time	
37210	20	10	10	90	30													160	
21XXX	10	10	5	20	20								3	1				136	



Multi-Specialty Physician Practice Information Survey

RUC Meeting – October 5, 2006





AMA Internal Team

- Jill Blim, Director, Planning
- Sara Brotherton, Director, Data Acquisition Services
- David Emmons, PhD, Director, Economic and Health Policy Research*
- Amanda Ervin, Director, Health Information Technology
- Jon Fanning, Senior Policy Analyst, Private Sector Advocacy
- Kurt Gillis, PhD, Senior Economist, Economic and Health Policy Research*





AMA Internal Team



- Carol Kane, PhD, Principal Economist, Economic and Health Policy Research
- Todd Klemp, RBRVS Data and Methods Manager*
- Sandy Marks, Assistant Director, Federal Affairs*
- Sharon McIlrath, Assistant Director, Federal Affairs *
- Mindy Schneiderman, PhD, Director, Market Research and Analysis*





AMA Internal Team

- Paul Rockey, MD, MPH, Director, Undergraduate and Graduate Medical Education
- Joanne Schwartzberg, MD, Director, Aging and Community Health
- Sherry Smith, Director, Physician Payment Policy and Systems*
- Sara Thran, Market Research Manager, Market Research and Analysis (lead SMS survey effort 1984-1999)*
- Marylou White, Director, Editorial Operations (lead SMS survey effort 1982-1990)





Specialty Participation = 100%

- 46 specialties and health professions have committed to join the effort.
- Participation from every specialty where data, either from SMS or supplemental surveys, is used to determine practice expense costs.
- In addition, several specialties are now participating whose costs have historically been crosswalked from other specialties.
- CMS has reviewed the crosswalk requests and agrees to continue crosswalks for these specialties. However, CMS has urged the chiropractors to participate in the survey process.



CMS Participation

- CMS has not yet formally responded to the AMA August 18 written request for a formal commitment to purchase data from the survey.
- CMS staff have been engaged in the review of the survey.
- We need CMS commitment prior to launching the survey. We are confident that this will be achieved as CMS has expressed strong support for this survey effort.





Timeline



- October-December 2006
- Early 2007
- February 2007

Pilot Testing

Analysis of Pilot

RUC Meeting: Report on Pilot



- April 2007
- December 2007
- March 2008

Launch Survey

Complete Survey

Data Analysis Complete

Data Provided to CMS



- Spring 2008
- November 2008
- January 1, 2009

CMS Proposed Rule

CMS Final Rule

CMS Implementation





Survey Scope



- The survey will be comprehensive
- We were responsive to comments to eliminate questions that would not add beneficial information to the physician community
- CMS prefers a broader in scope than practice expense only.
- The AMA and all participating societies will benefit from data that can be utilized for a wide range of advocacy campaigns





Survey Length

- The AMA is committed to a scientific survey with a target 50% response rate.
- We will ensure that the length of the survey will not impair the response rate.
- Survey firms recommend that the physician component of the survey be 15-20 minutes in length.
- Results of the pilot testing will determine if we have the appropriate number of questions.



Incentives



- We will explore a number of incentives during the pilot study, including:



- cash payment/gift certificates to physician and/or practice administrator



- sharing summary reports with survey respondents





Survey Sample



- MD/DO sample will be drawn randomly from the AMA Masterfile.
- We will retain the expertise of an outside survey firm to ensure that the sample is representative of the physician community.
- Over-samples will be drawn to ensure 100 respondents per specialty





Survey Sample



- CMS has retained Lewin to assist in special sampling concerns (e.g., Pain Medicine)
- As utilized in the supplemental surveys, weighting is also possible in the data analysis phase to address concerns raised by some specialties regarding typical practice setting.





AMA Masterfile

- The AMA Masterfile includes all physicians in the United States, both members and non-members.
- The address information in the AMA Masterfile is reliable. 97% of the mailing addresses are deliverable. Major survey firms also have tracing capabilities.
- The sample will be drawn from active, non-federal physicians in patient care.





Non-MD/DO Surveys



- Lewin will work with CMS and the survey firm to develop a similar sampling method for non-MD/DO health professionals.
- Lewin will receive the survey data for these health professionals at the conclusion of the survey. Lewin will work with the AMA to prepare similar files and PE/Hour calculation for the non-MD/DO providers.





Survey Budget

- The final cost of the survey will not be known until after the pilot study is complete.
- The AMA will contribute significant resources to this important effort, including staff resources, funding the pilot study, funding the sampling design, providing a large contribution to the survey itself, and analyzing the results.
- The AMA appreciates the serious commitment made by specialties and other health care professionals. This combined commitment of \$1 million will help make this survey a reality.





Survey Method



- We will pilot test various survey methods (e.g., telephone, mail, etc)
- The physician will be the initial point of contact
- We will strongly encourage the physician to request the practice administrator to complete the financial component of the survey.





Data to Specialties



- The AMA will analyze the data in the 1st quarter of 2008.
- PE/Hour data will be provided to CMS by March 31, 2008
- Data files will be provided to each participating specialty.
- Identification information will be removed to meet confidentiality requirements.





Survey Firm Selection

- The AMA solicited and received bids from 7 survey firms:
 - Doanne (utilized by many specialties conducting supplemental surveys)
 - Gallup
 - Harris
 - National Organization for Research at the University of Chicago (NORC)
 - Pipal Research
 - RAND Corporation
 - Research Triangle Institute (RTI)



Specialty Communication



- Uniform Announcement
- Survey Cover Letter
- All contact with the survey respondents will be with the survey firm. Specialties should not attempt to contact individual respondents.





Practicing Physician Input



- We ask the RUC to provide advice on the following issues at this meeting:
 - PLI Section of the Survey – PLI WG
 - Equipment Utilization Issue – PE Sub.
 - Independently Billing vs. Incident-to Services Provided by Same Clinical Staff: how to address this issue – Joint PE/Research Subcommittee





February 2007 RUC Meeting



- Will provide report on pilot survey
- Will seek additional input prior to launching survey in April 2007



CMS Requests Status Report

Request for Review	CPT Codes	Rationale for Review	Status of Presentation
Partial Mastectomy	19301	CMS request review as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Proctosigmoidoscopy	45300, 45303, 45305, 45307, 45308, 45309, 45315, 45317, 45321, 45327	CMS request as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Anoscopy	46600, 46604, 46606, 46608, 46610, 46611, 46612, 46614, 46615	CMS request as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Computer-Aided Detection (CAD)	77051, 77052	CMS request to review direct PE inputs	To be presented at the February 2007 RUC Meeting
Dual-Energy X-Ray Absorptiometry	77080, 77081, 77082	CMS request to review direct PE inputs	To be presented at the February 2007 RUC Meeting
Proton Beam Treatment Delivery	77520, 77522, 77523, 77525	CMS request to review four codes to assign practice expense inputs for the non-facility setting	To be Presented at the April 2007 RUC Meeting
Remote Afterloading High Intensity Brachytherapy	77781, 77782, 77783, 77784	CMS request to review four codes due to a change in global period from 90 day to XXX, which will permit separate payment each time services are provided	Referred to CPT for Review
Eye Exams	92002-92014	CMS request as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Cardiac Catheterization	93501-93572	CMS request to develop direct cost inputs for these services	To be presented at the February 2007 RUC Meeting
Nursing Facility Care	99304-99318	CMS request review as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Domiciliary Care	99326-99337	CMS request review as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting
Home Care	99343-99350	CMS request review as part of the Five Year Review Process	To be presented at the February 2007 RUC Meeting

Gynecologic Oncology		CMS request to review supplies that should be included in the standard global package, if the specialty believes inputs are currently missing	To be presented at the February 2007 RUC Meeting
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December 21, 2006

Leslie Norwalk, Esq.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS-1321 FC and CMS-1317 F: Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B.

Dear Ms. Norwalk,

The American Medical Association/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to provide comments on the Final Rule for the 2007 Medicare Physician Payment Schedule, published in the December 1, 2006 *Federal Register*. On November 3, 2006, the RUC submitted its initial comments on this Rule. We continue to support these comments and have attached them to this letter for your review. At this time, we would like to provide additional comments regarding this Rule.

Five Year Review - 2005

The Centers for Medicare and Medicaid Services (CMS) announced that the agency had reviewed all of the RUC's recommendations and accepted 95 percent of the RUC recommended values. We are particularly pleased that CMS has accepted the RUC's recommendations for the Evaluation and Management procedures. Furthermore, the RUC recommended and CMS accepted that the full increase of the E/M be incorporated into the surgical global periods for each CPT code with a global of 010 and 090. As you are aware, the RUC and its participants put a great deal of time and effort into developing recommendations that were equitable across all specialties. This arduous task could not have been accomplished without great support of the RUC members, specialty society staff and the input from CMS representatives. We appreciate CMS' validation of these efforts.

Unfortunately, there were several codes which the RUC recommendations were not accepted by CMS. These codes include the following:

22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique) - CMS proposes 21.79 work RVUs for this code, rather than accept the RUC recommendation of 22.00 work RVUs.

31360 Laryngectomy; total, without radical neck dissection - CMS proposes 26.22 work RVUs for this code, rather than accept the RUC recommendation of 28.00 work RVUs

31365 *Laryngectomy; total, with radical neck dissection* - CMS proposes 35.00 work RVUs for this code, rather than accept the RUC recommendation of 37.00 work RVUs

31367 *Laryngectomy; subtotal supraglottic, without radical neck dissection* - CMS proposes 27.00 work RVUs for this code, rather than accept the RUC recommendation of 27.36 work RVUs

31368 *Laryngectomy; subtotal supraglottic, with radical neck dissection* - CMS proposes 30.50 work RVUs for this code, rather than accept the RUC recommendation of 36.00 work RVUs

31390 *Pharyngolaryngectomy, with radical neck dissection; without reconstruction* - CMS proposes 38.33 work RVUs for this code, rather than accept the RUC recommendation of 40.00 work RVUs

31395 *Pharyngolaryngectomy, with radical neck dissection; with reconstruction* - CMS proposes 39.50 work RVUs for this code, rather than accept the RUC recommendation of 44.00 work RVUs

34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision* - CMS proposes 17.94 work RVUs for this code, rather than accept the RUC recommendation of 18.31 work RVUs

35102 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)* - CMS proposes 34.00 work RVUs for this code, rather than accept the RUC recommendation of 36.28 work RVUs

35556 *Bypass graft, with vein; femoral-popliteal* - CMS proposes 25.00 work RVUs for this code, rather than accept the RUC recommendation of 27.25 work RVUs

35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels* - CMS proposes 30.00 work RVUs for this code, rather than accept the RUC recommendation of 32.00 work RVUs

35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery* - CMS proposes 30.00 work RVUs for this code, rather than accept the RUC recommendation of 32.00 work RVUs

42845 *Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap* - CMS proposes 29.00 work RVUs for this code, rather than accept the RUC recommendation of 32.00 work RVUs

44120 *Enterectomy, resection of small intestine; single resection and anastomosis* - CMS proposes 18.00 work RVUs for this code, rather than accept the RUC recommendation of 20.11 work RVUs

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44130 *Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)* – CMS proposes 20.00 RVUs for this code, rather than accept the RUC recommendation of 20.87 work RVUs

47600 *Cholecystectomy*; – CMS proposes 15.85 work RVUs for this code, rather than accept the RUC recommendation of 15.88 work RVUs

63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* – CMS proposes 3.47 work RVUs for this code, rather than accept the RUC recommendation of 3.55 work RVUs

95872 *Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied* – CMS proposes 2.88 work RVUs for this code, rather than accept the RUC recommendation of 3.00 work RVUs

The RUC supports its recommendations for these procedures and requests that CMS further reconsider these issues. We urge you to accept all RUC recommendations.

In preparation for the fourth Five Year Review, which CMS will call for comments November 1, 2009, the RUC formed the *Five-Year Review Identification Workgroup* to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The need for objective review of potential misvaluation has been a priority of the RUC, CMS and MedPAC in recent years.

The RUC will rely on the recommendations of this Workgroup, based on established objective criteria, to identify codes that will be considered for reevaluation in the upcoming Five-Year Review. The Five-Year Review Identification Workgroup develops and maintains processes associated with the identification of services that meet various objective and data-derived criteria that may indicate potential misvaluation. These criteria include, but are not limited to services that have evolved in primary site of service since their inception and original valuation, services that may or may not be appropriately bundled, and services utilizing “new technology.” Already, CMS has provided very valuable data that the Workgroup will rely on for portions of its review. We appreciate the cooperation of CMS and hope to continue to work collaboratively with the Agency to ensure the efficacy of the Five Year Review Process as well as the integrity and relativity of the entire RBRVS.

New and Revised Process: CPT 2007

The Centers for Medicare and Medicaid Services (CMS) announced that the agency had reviewed all of the RUC recommendations and accepted 98 percent of the RUC recommended values. The RUC sincerely appreciates the confidence that CMS has displayed in our process. We also acknowledge the valuable contribution of your staff in attending and observing our meetings.

However, there are four codes which the RUC recommendations were not accepted by CMS. These codes include:

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94005 Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more – The RUC recommended value is 1.50 RVUs

96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family – The RUC recommended only practice expense inputs for this procedure

99363 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements) - The RUC recommended value is 1.65 RVUs

99364 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of three INR measurements) - The RUC recommended value is 0.63 RVUs

CMS determined that these four codes should be bundled into the evaluation and management services and offered no rationale for this decision. The RUC respectfully disagrees with this determination and strongly believes that each of these procedures is a separate and distinct service not adequately described in the evaluation and management services.

Specifically, the anti-coagulant management codes were created to address a concern from 2001 when the Centers for Medicare and Medicaid Services (CMS) stated that the standard of care for anticoagulant services was suboptimal and the current payment policy requires the physician to have the beneficiary make an office visit to discuss prothrombin time tests results and necessary adjustments to receive separate payment. Although it is clinically optimal for a physician to discuss results with a patient and make an adjustment during a face-to-face encounter under some circumstances, physicians often engage in these activities outside of a face-to-face encounter with the patient. The CPT Editorial Panel agreed with the specialty that bundling this post service time into the payment for the visit is unfair when physicians are managing patients on long-term anticoagulants. In addition, the Panel believed that CMS policy provides inadequate avenues for physicians to be paid for managing patients on long term anticoagulant may contribute to the problem of underutilization of anticoagulant drugs that has adverse effects on the health of patients. Failure to receive anticoagulant drugs when indicated can increase patient risk of thrombosis and embolism, and under- or over-anticoagulation can increase patient risk of bleeding. The CPT Editorial Panel discussed the issue at its February 2006 meeting and created two new codes to allow the reporting of anticoagulant management services. To ensure appropriate utilization of these codes, the Panel added minimum International Normalized Ratio (INR) measurements, eight for the initial anticoagulant management and three for subsequent therapy, and stated that this service cannot also be reported with another Evaluation and Management (E/M) code. The RUC strongly urges CMS to change the status indicator for all of the aforementioned codes to "active" and accept the associated RUC recommendations.

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Moderate Sedation (99143-99150)

In the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) comment letter regarding the NPRM from August 22, 2006, we urged CMS publish RVU recommendations for all services whether or not they are covered. The RUC identified 31 services that have been reviewed by the RUC, yet were not included in the Medicare Physician Payment Schedule. In the Final Rule, CMS indicated that it had accepted the RUC's recommendation to publish the RVUs for these services regardless of coverage determination. Thank you for accommodating our request.

The moderate sedation codes continue to be included on the fee schedule as Status Indicator "C" (Carrier Priced), with no published RVUs. Given CMS' direct involvement in the development of these codes, it disappoints us that the Status Indicator for the codes is "C." We urge you to accept the April 2005 RUC recommendations for these services. If CMS, would like further RUC review of this issue, the RUC would be able to accommodate such request at its April 2007 RUC Meeting.

In its November 21, 2005 *Federal Register* 2006 Medicare Physician Fee Schedule comments, CMS stated that it was "uncertain whether the RUC assigned values are appropriate and has carrier priced these codes in order to gather information for utilization and proper pricing." While we appreciate CMS' reconsideration of paying for sedation services not previously covered and understand this is an interim position, we request that CMS consider the following arguments in revising its position.

These CPT codes (99143-99150) were surveyed by several specialty societies in order to provide the RUC with data necessary to appropriately value the service. Codes were developed to simplify reporting these services into age-specific categories. The RUC-recommended values for these six codes were based on valid surveys and carefully vetted through the RUC process. We are confident in the accuracy of the values assigned. While CMS has assigned these codes to Status Indicator "C," the RUC believes that they should be listed with Status Indicator "A" (Active) and their RUC-recommended RVUs published.

Providing moderate sedation to patients undergoing certain outpatient procedures requires an enhanced level of provider skill and training and incurs additional medical-legal liability. Compared to patients not receiving sedation care, it is also associated with greater patient satisfaction and possibly improved outcomes. Additionally, moderate sedation often produces cost savings over similar procedures provided with anesthesia care in an operating room. Furthermore, the far-reaching shortage of pediatric anesthesiologists at children's hospitals has created the need for moderate sedation services provided by other hospital-based physicians. In most metropolitan areas of the United States, these children's hospitals form the safety net for subspecialty care provided to children in the Medicaid program. This critical service is directly supported by the publication of relative values of these codes.

Appendix G ("Summary of CPT Codes That Include Moderate Sedation") in the CPT manual was developed to identify services where sedation is an inherent part of the procedure. We firmly believe that any service performed that is *not* listed in Appendix G should be appropriately paid

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when reported with a moderate sedation code. There is significant additional cognitive skill required and this is reflected in JCAHO mandates addressing specific credentialing criteria for individuals providing moderate sedation. The work involved in providing sedation is *not* included in the RVUs for any procedure not included in Appendix G and the RUC believes that physicians should be adequately compensated for providing such services.

For these reasons, the RUC respectfully requests that CMS reconsider its decision to list the moderate sedation codes as carrier-priced. We urge CMS to publish the RUC-approved RVUs and assign these codes as Status Indicator "A" (Active) codes.

CMS Requests

CMS has made requests in its *Proposed Rules* published on June 29 and August 22, 2006 and its *Final Rule* published November 1, 2006 to have several procedures reviewed for various reasons. The RUC upon receiving these requests initiated a level of interest process to determine which specialty societies had an interest in developing recommendations for these procedures. These procedures are to be presented at either the February or April 2007 RUC Meetings. These requests, CPT code numbers, rationale for request and status of presentation have been summarized in the attached table.

Carrier Priced Codes - Table 17

In the *Final Rule*, CMS states, "We are carrier-pricing the global and TC for the codes listed in Table 17. The TC is not paid in the facility setting under the PFS and the RUC did not forward recommendations in the non-facility setting because these services are performed infrequently, if at all in the non-facility setting. Work RVUs will continue to be used to establish payment for the PC." To clarify the RUC has reviewed each of these codes in this table. For the vast majority of these services, the RUC recommended that the relative values of these codes should be NA in the non-facility setting. However, we understand that the American College of Cardiology has responded to your request to review practice expense inputs for the cardiac catheterization codes and will present their recommendations at the February 2007 RUC Meeting. The RUC would also note that there are codes included in Table 17 that appear to be listed in this table in error, for example, 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes*. We urge CMS to issue a technical correction notice addressing this issue.

The RUC appreciates the opportunity to offer these comments to CMS. We look forward to our continued relationship to further improve the RBRVS.

Sincerely,



William L. Rich, III, MD, FACS

cc: RUC Participants



November 3, 2006

Leslie Norwalk, Esq.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-FC
Mail Stop C5-11-24
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS-1321 FC and CMS-1317 F: Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B.

Dear Ms. Norwalk

Thank you for the opportunity to provide initial comments regarding the November 1, 2006 Final Rule on the Medicare Physician Payment Schedule. We have identified a number of issues that we hope to see addressed in a technical correction of the final rule. These issues include corrections to the revised practice expense (PE) methodology, publication of non-covered services, and acceptance of one previous work RVU recommendation.

Revised Practice Expense Methodology

CMS has announced a new practice expense methodology, which is in summary, a blend between a "bottom up" approach and a "top down" approach. CMS will calculate direct practice expense RVUs using data refined by the RUC and its Practice Expense Review Committee. The indirect practice expenses, making up 60-70% of total payment depending upon specialty, is still based on a "top down" approach, allocating specialty level data from surveys to individual services using work RVUs and direct expenses. In the June 29, 2006 Proposed Rule's description of the methodology for calculating indirect cost PE RVUs, CMS indicates in Step 8 that the work RVU used in the allocation of indirect expenses included the separate work budget neutrality adjustment from the Five-Year Review of the work RVUs. The RUC and many other commenters objected to using budget-neutralized work relative values in the computation of practice expenses. In the Final Rule, CMS acknowledged these comments and changed the methodology, as follows:

Comment: *Many commenters recommended that we not use the budget-neutralized work RVUs in the indirect PE allocation, but rather use the unadjusted work RVUs.*

Response: *As discussed in section III.D.3. of this final rule with comment period, the BN adjustment necessitated by the 5-Year Review of work RVUs will be accomplished through the use of a separate, BN adjustor applied to the work RVUs. However, as recommended by the commenters, we will not use the budget-neutralized work RVUs to calculate indirect PE.*

However, Addendum B In this final rule reflects practice expense relative values that were computed using adjusted work RVUs. The application of budget neutrality to the work relative values has been applied and utilized in the indirect practice expense allocation, despite CMS clear written statement that this would not occur **We urge CMS to immediately correct this error and use the unadjusted work RVUS as the appropriate allocator in the methodology. We anticipate that a technical correction would be published with a revised Addendum B.**

Publishing Relative Value Units (RVUs) for Non-covered Services

In the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) comment letter regarding the NPRM from August 22, 2006, we urged CMS publish RVU recommendations for all services whether or not they are covered. The RUC identified 31 services that have been reviewed by the RUC, yet were not included in the Medicare Physician Payment Schedule. In the Final Rule, CMS indicated that it had accepted the RUC's recommendation to publish the RVUs for these services regardless of coverage determination. Thank you for accommodating our request.

However, for nine services, 38207-38215 Bone Marrow and Stem Cell Harvesting, RUC staff forwarded the incorrect RVU recommendations rather than the more recent RUC recommendation. We apologize for this error. Shortly after the submission of our comments, we located this error and made efforts to provide the correct recommendations to CMS staff on October 19, 2006. CMS staff indicated that the Final Rule was in production and the original submission of the incorrect recommendations would appear in the Rule. We understand this constraint. At this time, we ask that you publish the appropriate RUC recommended RVUs for these nine services. The RUC recommendations are attached to this comment letter.

Ventricular Restoration

In the November 1, 2006 Final Rule, CMS published the interim RVU rather than the final RUC recommended RVU for CPT code 33548, *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)*. This interim recommendation was forwarded to CMS in April 2005 and the

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final recommendation was forwarded in September 2005. The RUC has periodically followed an interim recommendation with a final recommendation following our September meetings. This is the case with this single code. We ask that CMS replace the interim RVU with the final RUC reviewed RVU for this service. The RUC recommendation is attached.

Other Issues

In addition to these comments, we are disappointed by the Agency's decision to apply a separate budget neutrality factor to all work RVUs rather than to the conversion factor. The RUC reaffirms its position that applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and strongly urges CMS to instead apply any necessary adjustments to the conversion factor.

The RUC strongly objects to using work relative values as a mechanism to preserve budget neutrality. These adjustments to the work relative values cause confusion among the many non-Medicare payers, as well as physician practices, that adopt the RBRVS payment system. According to a recent survey conducted by the AMA, 77% of all public and private insurance payers rely on the RBRVS. We believe that this adjustment should have been transparent and continue to advocate that any budget neutrality adjustments be made to the conversion factor, rather than the work relative values.

Thank you for the opportunity to provide these early comments regarding the Final Rule. We appreciate your attention to these errors and look forward to the technical correction.

Sincerely,

A handwritten signature in cursive script, appearing to read "William L. Rich, III, MD".

William L. Rich, III, MD

cc: RUC Participants

attachments