

**AMA/Specialty RVS Update Committee  
September 28, 1996**

**Sheraton New Orleans  
New Orleans, Louisiana**

I. Call to Order and Opening Remarks

Doctor Rodkey called the meeting to order at 8:30 am. The following RUC members were in attendance:

Grant V. Rodkey, MD	James G. Hoehn, MD
Robert Berenson, MD*	Dudley D. Jones, MD
Thomas P. Cooper, MD*	J. Leonard Lichtenfeld, MD
Robert Florin, MD	John Mayer, MD*
William Gee, MD	David L. McCaffree, MD
John O. Gage, MD	James M. Moorefield, MD
Timothy Gardner, MD	L. Charles Novak, MD
Megan Gerety, MD*	Frank Opelka, MD*
Tracy R. Gordy, MD	William Rich, MD
Larry Griffin, MD*	Paul Schnur, MD*
Kay K. Hanley, MD	Bruce Sigsbee, MD
Alexander Hannenberg, MD*	John Tudor, MD
W. Benson Harer, Jr., MD	Charles Vanchiere, MD
James Hayes, MD	Richard Whitten, MD
Robert Haynes, MD*	Eugene Wiener, MD*
Emily H. Hill, PA-C	William L. Winters, Jr. MD
David F. Hitzeman, DO	

(\*Indicates alternate member)

Grant Bagley, MD, Health Care Financing Administration (HCFA), and James Alexander, MD, Carrier Medical Director, also attended.

The following facilitation committee was appointed:

Doctors Hitzeman (Chair), Florin, Hannenberg, Koopmann, Opelka, Sigsbee, and Emily Hill, PA-C.

II. Approval of Minutes

The minutes of the April 26-27, 1996 RUC meeting and the June 22, 1996 RUC meeting were approved without revision.

III. Proposed Revisions to Structure and Functions Document

The following revisions to the RUC Structure and Functions Document were approved:

### III. Organization and Structure

The Process will utilize an RVS Committee, ~~three~~two Advisory Committees and appropriate Subcommittees as further described below.

#### A. RVS Update Committee

(2) Composition - The RUC shall be composed of physician representatives from the twenty-~~two~~ three main medical specialties.....The specialties and associated specialty societies to fill these seats will be determined by the RUC in accordance with its normal decision-making processes. The current policies related to eligibility and elections for the rotating seats are included as Appendix - E. The Co-Chairperson of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board will also have one seat and shall be selected by the non-MD/DO representatives on the RUC HCPAC Review Board.

#### (4) Terms of Appointment:

(a) Specialty Society and AOA Representatives and Alternate Representatives: shall hold terms of three (3) years, for their first term. The AMA shall divide the 21 permanent Specialty Societies and the AOA as represented on the RUC into three groups by a random selection process developed by the AMA to select terms for serving the second term on the RUC. The terms of representatives from said groups shall be staggered in the following manner. The representatives from the first group shall serve for three (3) years, the representatives from the second group shall serve for four (4) years and the representatives from the third group shall serve five (5) years. The second term(s) for serving on the RUC as described above shall begin October 1, 1995. After each representative group concludes their respective terms of three (3), four (4), or five (5) years, all successive terms for said representatives shall be three (3) years. Appendix B lists all of the members of the RUC and the year in which their term ends.

(e) ~~After the first two years of existence of the RUC, the RUC shall adopt procedures to stagger the terms of the RUC representatives~~ HCPAC Co-Chair: The RUC HCPAC Review Board representative shall be a representative to the RUC for the same term as their tenure as Co-Chair of the RUC HCPAC Review Board which will be determined by the RUC HCPAC Review Board.

#### (5) Voting:

(a) Representatives from the AMA, the AOA, ~~and~~ each specialty society, and the RUC HCPAC Review Board Co-Chair shall each be entitled to one vote.

(8) Quorum - ~~Fifteen (15)~~ Sixteen (16) representatives to the RUC shall constitute a quorum for the conduct of any business.

#### C. Health Care Professionals Advisory Committee

(6) The RUC HCPAC Review Board is comprised of members of the HCPAC and RUC and also submits work relative value recommendations directly to the Health Care Financing Administration. (See Appendix L for the Health Care Professionals Advisory Committee: Organizational Structure and Process.)

#### D. Third Party Advisory Committee

~~(1) Purpose—The Third party Advisory Committee (TPAC) to advise the RUC Chairperson on the perspectives and relevant data from major third parties. The TPAC shall not be a voting body. Although meetings of its entire membership may be convened by the chairman of the RUC, it is expected that its duties will be carried out through communications between the RUC and the pertinent TPAC members.~~

~~(2) Composition—The TPAC shall be composed of at least four (4) physician representatives and shall include a representative from each of the following: Health Care Financing Administration (HCFA), Medicare Carrier Medical Directors, the Blue Cross and Blue Shield Associations and the Health Insurance Association of American.~~

~~(3) Designation:~~

~~(a) TPAC representatives shall be designated by the representative third party organization.~~

~~(4) Terms of Appointment—TPAC representatives shall hold terms of two (2) years, with maximum tenure of four (4) years.~~

~~(5) Functions—TPAC functions and responsibilities shall include but shall not be limited to:~~

~~a) Advising on the agenda for development of relative values for new or revised codes upon request;~~

~~b) Assisting with the cooperative research agenda;~~

~~e) Providing advice on the update process; and~~

~~d) Serving as liaison with the relevant third parties.~~

#### D. Observers at RUC meetings

A representatives of the Health Care Financing Administration (HCFA) will be invited to attend all RUC meetings as a non-voting observer. Medicare carrier medical directors, representatives from the Physician Payment Review Commission, staff from the Medicaid Bureau, and other governmental representatives may attend RUC meetings as non-voting observers with the approval of the Chair. All observers are bound by the same confidentiality provisions and other RUC Rules and Procedures as other participants in the process.

The following documents will be formally appending to the RUC Structure and Functions document:

- A Rules and Procedures of the RUC
- B List of RUC Members

C	List of Advisory Committee Members
D	List of RUC HCPAC Review Board Members
E	Nominating Subcommittee Report Adopted at the June 22, 1996 RUC Meeting
F	Instructions for Specialty Societies Developing Recommendations
G	RUC Survey Instruments
H	Recommended Guidelines for Compliance with Antitrust Law
I	Standard Methodological Requirements for Specialties
J	Guidelines for Developing Compelling Evidence
K	Guidelines for Specialty Societies Development Written Comments
L	HCPAC Organizational Structure and Processes

During the discussion of the Structure and Functions document revisions, Doctor McCaffree pointed out the inconsistency between the compelling evidence standards in the Instructions to Specialty Societies Developing Recommendations and the Guidelines for Developing Compelling Evidence. The RUC referred the Rules and Procedures document, as well as the other above appendices to staff to review. Proposed revisions will be discussed at the February RUC meeting.

#### IV. Calendar of Meeting Dates

The RUC was informed that the February 7-9, 1997 RUC meeting will be held in Scottsdale, Arizona and the April 24-27, 1997 RUC meeting will be held in Chicago.

#### V. The Future of CPT

T. Reginald Harris, MD, Chairman of the CPT Editorial Panel, presented the RUC with information regarding the future of CPT and potential changes to the structure of both the CPT Editorial Panel and the CPT codes.

Doctor Harris began by congratulating Doctor Rodkey and the RUC on the work that the committee has done over the past several years. He emphasized the importance of communication and feedback between the CPT and RUC processes and discussed his desire to hear any comments or suggestions the RUC has to offer in improving CPT.

In February of 1996, a report was presented to Doctors Todd and Seward regarding the future of CPT. The report was generated from a year long discussion regarding the structure and scope of CPT, for example, the number of codes, specificity, organization of codes, and whether the system should be hierarchical. The report recommended that CPT should be inclusive and used by all health professionals. CPT will also remain a five-digit code, two-digit modifier system. The CPT Editorial Panel will begin to reorganize CPT, but will build on the present system and will use an incremental approach to limit disruption to users. The Panel will also seek to expand CPT for use in Hospital Inpatient coding.

Doctor Harris explained that the AMA is also taking steps to expand the Editorial Panel from 14 to 16 seats. One seat will be added for the CPT HCPAC Review Board Co-Chair and one seat will be filled with a representative from managed care. Beginning in 1997, the Panel meetings will also be more open to interested specialty society representatives. Also, the CPT Clearinghouse has been expanded and will now operate as a subscription service.

Doctor Harris also mentioned other issues that the Editorial Panel will take into consideration in its revisions to improve CPT including: correct coding; complexity of services; biopsy coding; identification of surgical approaches; age populations; and separate procedures.

Doctor Rodkey thanked Doctor Harris for his presentation and applauded the efforts to open the CPT meetings. He emphasized how the openness of the RUC meetings has helped its process. Doctor Novak requested that a summary of Doctor Harris' comments be included in the meeting minutes.

Further discussion was held on the correct coding initiative and the editing software that is required by the Kennedy/Kassenbaum legislation. The RUC was informed that a report from the Correct Coding Policy Committee (CCPC) will be presented to the Editorial Panel in November. At this meeting, the CCPC and the Panel will meet with representatives of these commercial editing software packages. A comment was made that it was burdensome to review the numerous edits created by Administar which were of poor quality. Staff told the RUC that the AMA will not be requesting the Advisors to review this information in the future.

#### VI. Election of Rotating Seats

Doctor Novak presented the Nominating Subcommittee Report which recommended that a representative from each nominated specialty society be permitted to address the RUC prior to the election. The Nominating Subcommittee also recommended the following balloting procedures:

Any specialty society receiving a majority of the votes cast during any round of balloting shall be elected.

##### Internal Medicine Seat - Six nominees - Two or three rounds

Round one: Six eligible - top three advance to round two

Round two: Three eligible - if none receives a majority, top two go to round 3

Round three: Two eligible - majority wins the seat

##### Other Rotating Seat - Twelve nominees - Three or four rounds

Round one: Twelve eligible - top seven advance to round two

Round two: Seven eligible - top three advance to round three

Round three: Three eligible - if none receives a majority, top two go to round 4

Round four: Two eligible - majority wins the seat

After the RUC approved the above election procedures, the following representatives made a brief statement on behalf of their specialty society:

##### Internal Medicine:

Alan Plummer, MD	American College of Chest Physicians
Melvin Britton, MD	American College of Rheumatology
Charles H. Weissman, MD	American Society of Clinical Oncologists
Roy Weiner, MD	Renal Physicians Association
Russell Raully, MD	Society of Critical Care Medicine

##### Other:

John Salvaggio, MD	American Academy of Allergy, Asthma, and Immunology
David Berland, MD	American Academy of Child and Adolescent Psychiatry
Alan Harvey, MD	American Academy of Pain Medicine
Lynda Leedy	American Academy of Physical Medicine & Rehabilitation
Dennis Stone, MD	American Medical Directors Association
Steve Kahler, MD	American Society of Maxillofacial Surgeons
Katherine Honey, MD	American Society for Reproductive Medicine
Robert Vogelzang, MD	Society of Cardiovascular & Interventional Radiology
Robert M. Zwolak, MD	The Society for Vascular Surgery

The American College of Rheumatology was elected to the internal medicine rotating seat. The American Academy of Child and Adolescent Psychiatry was elected to the other rotating seat.

During the election of the internal medicine rotating seat, there was some discussion regarding the number of specialty society members that are internists. This issue will be discussed again prior to the next rotating seat election process.

#### VII. Request from the American Geriatrics Society

The RUC approved the Nominating Subcommittee Report which acknowledged the important contributions made by the American Geriatrics Society but recommended that the RUC not approve its request for a permanent seat for the following reasons:

- Geriatric Medicine is currently represented by the American Society of Internal Medicine, the American College of Physicians, the American Academy of Family Physicians, the American Osteopathic Association, and the American Psychiatric Association. These specialty societies are all represented on the RUC and should serve as the umbrella organization for geriatricians.
- All specialty societies with members on the RUC Advisory Committee are invited to attend and participate at each RUC meeting.
- The RUC has recently initiated a greater role for Advisory Committee members by including representatives on key workgroups and subcommittees. As the AGS letter mentioned, Doctor Megan Gerety is currently on the Research Subcommittee and could continue to participate as an Advisory Committee Members.
- In the creation of the RUC, several criteria were identified for membership on the RUC. The subcommittee reviewed these criteria and found that AGS met only one. Medicare does comprise at least 10% of the specialty's mean practice revenue. All other criteria were not met, including: membership on the American Board of Medical Specialties (ABMS); the specialty must comprise at least 1% of all physicians in practice; the specialty must comprise at least 1% of all Medicare expenditures; and the specialty must not be meaningfully represented by an umbrella organization.

After considerable discussion, the RUC also adopted a motion to request that the Research Subcommittee 1) examine the criteria for a permanent seat on the RUC; and 2) review the current policy of limiting a society to one term on a rotating seat.

## VIII. Report on HCFA Meetings

Sandy Sherman reported on the HCFA Refinement Panel Meetings and review of the RUC recommendations for CPT 1997. She also reported that she and Doctor Rich met with HCFA representatives to discuss the issues that HCFA would like to reviewed prior to the next five-year review, including the issue of open and closed percutaneous services and radiation oncology. The RUC will begin to review these issues as related new and revised codes developed through the CPT process.

Emily Hill, PA-C, reported on the HCFA Refinement Panel meeting to discuss physical medicine and rehabilitation. Results from this meeting and the other refinement panel will be published in the Final Rule due out late this year.

Grant Bagley, MD expressed HCFA's appreciation for the RUC's assistance in the five-year review and told the committee that the efforts will be acknowledged in the Final Rule.

Several RUC members reported on their experiences on at HCFA Refinement Panel meetings and stressed the improved relationship between the RUC and the Carrier Medical Directors since the initial refinement panels. Doctor Lichtenfeld requested specialty societies to provide more complete information with regard to new technology and reporting of multiple codes for one service. Doctor Rodkey thanked everyone involved in these meetings for their representation.

## IX. CPT Update

Tracy Gordy, MD directed the RUC to Tab 8 of the Agenda Book which summarizes the new and revised codes considered by the Editorial Panel to date. He also mentioned that the Panel is reviewing the issue of add-on codes, but will only be considering existing codes in this process. If a specialty society wishes to request a new add-on code, a coding proposal form must be completed.

## X. Relative Value Recommendations for New and Revised Codes

### **Intestinal Sling Procedure (Tab 9), Tracking Number: C1**

#### **Presenter: Frank Opelka, MD, American Society of Colon and Rectal Surgeons**

A new CPT code 4416X was established to report the exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum). Previously, this service would have been reported using an unlisted procedure code.

This service may be performed as the primary service after an abdominal exploration. However, surgeons more commonly perform this procedure at the time of other pelvic operations (eg, abdominoperineal resection for rectal cancer).

The procedure, when performed alone, is more extensive and involves intensive radiotherapy. This procedure is more difficult than exploratory laparotomy. It may be used to determine if pelvic exenteration is necessary.

The RUC accepted a relative value recommendation of 13.00 which was based on a survey median from over 30 colon and rectal surgeons. Key reference services for this new service are codes 44120 *Enterectomy, resection of small intestine; single resection and anastomosis*

(work RVU = 13.15) and 45130 *Excision of Rectal Prolapsed, with anastomosis; perineal approach* (work RVU = 13.03). Pelvic exclusion to treat the underlying malignant condition involves extensive preoperative and postoperative counseling.

The RUC reviewed the relative value recommendations for this new code in comparison to 49568 *Implantation of mesh or other prosthesis for incisional hernia repair (list separately in addition to code for the incisional hernia repair)* (work RVU = 4.89), which is an add-on code with a global period of ZZZ. When performed with other pelvic operations, 4416X would be reported with a -51 modifier and reduced by 50% or 6.50 work RVUs. The RUC agreed that the intra-service work is significantly greater for 4416X because it is a riskier procedure and also requires more time. The intra-service time for 4416X is 120 minutes versus 52 minutes for 49568.

### **Trabeculectomy (Tab 10), Tracking Numbers: B1-B2**

This issue has been withdrawn. The American Academy of Ophthalmology will request reconsideration by the CPT Editorial Panel for these recent coding changes.

### **Coronary Angiography (Tab 11), Tracking Numbers: D1 Presenter: Fortune Dugan, MD, American College of Cardiology**

A new code 935XX *Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization* was added to provide a way to report catheter placement for coronary angiography with left heart catheterization, which requires crossing the aortic valve into the left ventricle with a catheter, is not performed.

The work of 935XX is less than 93510 *Left heart catheterization* (work RVU = 4.33) and, therefore, the survey median of 5.05 was not recommended. The work and risk associated with crossing the aortic valve into the left ventricle with a catheter was determined to be .23. Which is slightly more work than 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = .17) and less work than 93545 *Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)* (work RVU = .29). The RUC recommends that the work RVU for 935XX be equivalent to 93510 less the increment of work of crossing the aortic valve ( $4.33 - .23 = 4.10$ ).

The RUC also reviewed this service with the other codes that will be reported at the same time. A physician will report 935XX (4.10) for the catheter placement; 93545 (0.29) for the injection procedure; and 93555 (0.81) for the imaging supervision, interpretation and report, which will result in a total work RVU of 5.20.

### **Sleep Studies (Tab 12), Tracking Numbers: E1-E4 Presenters: Benjamin Frishberg, MD and Thomas Hobbins, MD American Academy of Neurology and American Sleep Disorders Association**

A new code 9580X was created to report a sleep study unattended by a sleep technologist. This service requires more physician work than the existing code 95807 *Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist* (1.66) because the physician interpretation will more



difficult without the observations and notes of the sleep technologist. The RUC agreed and recommends the survey median of 1.85 for the new code.

The Editorial Panel also added a new code 958XX *Polysomnography; sleep staging with 4 or more additional parameters of sleep with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist*. The specialty societies recommended a work RVU of 3.80, which is .27 more work than 95810, the equivalent service without the CPAP therapy. The RUC referred this issue to a facilitation committee to review all of the codes in this family (95808, 95810, and 958XX). The facilitation committee (Doctors Hitzeman (Chair), Florin, Hannenberg, Koopmann, Opelka, and Sigsbee and Emily Hill, PA-C) will meet at the February RUC meeting.

#### XI. Joint Report of Research Subcommittee & Workgroup on Global Surgical Packages

A joint meeting of the Research Subcommittee and the Workgroup on Global Surgical Packages was held on September 27. The RUC has adopted the following recommendations made by the Research Subcommittee and Workgroup on Global Surgical Packages which met on September 27, 1996 to review the issue of physician work involved in the evaluation and management component of the global surgical packages:

1. There is an evaluation and management component of the global service package.
2. The RUC accepted Dan Dunn's report for informational purposes.
3. The RUC adopted the principle that evaluation and management services have equivalent work values across all physician specialties.
4. The RUC requests that HCFA adjust global service relative values to incorporate changes in the evaluation and management service relative values as published in the May 3 Federal Register.

The RUC acknowledges that the additional analysis by the Workgroup of the survey already completed, the Harvard data, and potential additional surveys may be needed in order to develop a more specific proposal about how the E/M changes should be incorporated into the global services.

#### **The full report of the Research Subcommittee and Workgroup on Global Surgical Packages is attached.**

Doctor Tudor presented the Informational Report from the Intensity Workgroup, which includes himself and Doctors Robert Florin, Megan Gerety, and Matthew Liang. The workgroup agreed that although intensity is an important component of physician work and more attention must be directed toward it, neither the workgroup nor the RUC have the expertise or resources to develop and validate a new tool for measuring intensity;. The workgroup suggested that HCFA may be interested in undertaking such a study.

Doctor Bagley agreed that HCFA is interested in the issue of intensity, but pointed out that it is not realistic for HCFA to fund any new studies.

The RUC requested that AMA staff contact a consultant to review the issue. The RUC may be able to refine the intensity questions that are already being asked in the questionnaire and reported to the RUC.

#### XII. Practice Cost Subcommittee

The RUC received a report of the Practice Cost Subcommittee, which met on Friday, September 27 with Grant Bagley, MD, Health Care Financing Administration; Dan Dunn, PhD, Cambridge Health Economics Group; and Russell Burge, PhD, Health Economics Research. The Practice Cost Subcommittee was presented with a status report on the Clinical Practice Expert Panels (CPEP) and the decision to cancel the survey for direct costs. A review of the other HCFA-funded studies, which rely on existing data on time and work, was met with several questions and concern by the subcommittee. Doctor Bagley also explained that it will become more important to look at the relationship between physician work and practice costs and HCFA may look to the RUC to be involved in the refinement process for the resource-based practice expense values.

**The Report of the Practice Cost Subcommittee is attached.**

**XIII. RUC Database**

Sandy Sherman informed the RUC that AMA staff is completing a database which includes information that the RUC has collected during its review of relative value recommendation. This database is currently being edited for accuracy and will be available to the RUC at the next meeting.

Paul Markowski, Director of CPT Intellectual Services, told the RUC that the AMA has received a favorable ruling from the Federal Trade Commission (FTC) regarding the distribution of this information. He also indicated that the AMA will be exploring options for distributing the information and would welcome any suggestions from RUC members or specialty societies. Mr. Markowski will provide an update at the February RUC meeting.

Several members of the RUC agreed that this information will be useful in their future deliberations for relative value recommendations for new and revised codes. Members also asked about the possibility of including the RUC recommendations that are previously published in the Federal Register. The RUC requested that the FTC opinion be distributed to the committee.

**XIV. Other Issues**

Information on Medicare Data was included in the RUC agenda book for informational purposes. A question arose about the available data on services provided to beneficiaries of Medicare HMOS. The RUC requested staff to explore what other data may be available for use in the RUC process.

Doctor Rodkey recognized each of the RUC members who were departing after this meeting, including: Eugene Wiener, MD, American Pediatric Surgical Association; Timothy Gardner, MD, Society of Thoracic Surgeons; L. Charles Novak, MD, American Society of Anesthesiologists; and James Fanale, MD, American Geriatrics Society. Doctor Rodkey expressed his appreciation for the leadership and accomplishments of all members of the RUC.