

**AMA/Specialty RVS Update Committee
September 25-26, 1998**

**Hilton at Walt Disney World Village
Lake Buena Vista, FL**

I. Call to Order:

Doctor Hoehn called the meeting to order at 3:20 p.m. The following RUC members were in attendance:

James Hoehn, MD	Charles D.Mabry, MD*
David Berland, MD	David L. Massanari, MD*
Melvin Britton, MD	John Mayer, MD
Thomas P.Cooper, MD	Clay Molstad, MD
Robert Florin, MD	James Moorefield, MD
John O. Gage, MD	Willard B.Moran, Jr., MD*
William Gee, MD	Thomas G. Olson, MD*
Tracy R. Gordy, MD	William Rich, MD
Kay K. Hanley, MD	Peter Sawchuck, MD*
Alexander Hannenberg, MD	Chester Schmidt, MD
W. Benson Harer, MD	Paul Schnur, MD
James Hayes, MD	Bruce Sigsbee, MD
Richard J. Haynes, MD	Sheldon B. Taubman, MD
Emily Hill, PA-C	Laura Tosi, MD*
David F. Hitzeman, DO	John Tudor, MD
Charles Koopmann Jr., MD	Charles Vanchiere, MD
George F.Kwass, MD	Richard Whitten, MD*
J. Leonard Lichtenfeld, MD	

The following individuals attended and were introduced by Doctor Hoehn: Terry Kay & Thomas Marciniak, MD, Health Care Financing Administration (HCFA); Victoria Albright, Westat, David Peachey, RBRVS Commission of Ontario; and William Mangold, MD, Carrier Medical Director of Arizona and Nevada.

II. Chairman's Report:

Doctor Hoehn announced that this will be Doctor Tudor's last RUC meeting. Doctor Hoehn invited RUC participants to a reception in honor of Doctor Tudor following Fridays activities.

Doctor Hoehn also reported that the September meeting with Doctor Berenson was very positive and anticipates that the RUC will continue to have a very good working relationship with HCFA.

He also reinforced the current policy that the RUC members should continue to be careful when using RUC titles in their other advocacy efforts.

Lastly, Doctor Hoehn talked about the untimely death of Ed Hirshfeld, Legal Counsel for the AMA and that he plans on sending a condolence letter on behalf of the entire RUC.

III. Directors Report:

A Directors Report was presented by Sherry Smith, who asked the RUC members and participants to refer to Tab 2 for 1999 RUC meeting dates and locations. Sherry also announced that one of the goals of the Department of Relative Value Systems is to eventually send all notices and other time sensitive information via E-mail to all RUC members and participants. Therefore, she requested that all e-mail addresses be sent to AMA staff if they have not done so already. In addition, for those individuals that are currently receiving their notices via E-mail but are having difficulty reading the information, a decoder disk is available from AMA staff. Lastly, Sherry reported that the AMA website would be available for viewing on the Intranet by mid-October.

IV. Approval of May 1-May 3,1998 Minutes:

The minutes of the May 1-May 3, 1998 RUC meeting were approved after the following revisions were noted:

- Doctor James Moorefield should be added to the list of RUC member attendees.
- The first sentence of the second paragraph on page 9 under the Ventricular Assist Device (Tab 12) should read “The RUC recommends that the global period on 33975 and 33976 be changed from 90 days to 10 days, thus allowing physicians to report E/M services between the 11th and the 90th postoperative days separately”.
- The first sentence of the third paragraph on page 9 under the Ventricular Assist Device (Tab 12) should read “The work RVUs of 21.60 (CPT 33975) and 29.10 (33976) will be considered interim until adequate survey data are developed and the specialty society presents these codes at the September 1998 RUC meeting”.

The minutes were approved as amended.

V. Calendar of Meeting Dates:

The RUC was informed that the February 5-7, 1999 RUC meeting will be held at the Loews Ventana Canyon Resort, Tucson, Arizona.

VI. CPT Update:

Doctor Tracy Gordy, CPT Representative to the RUC, gave the RUC an update on both the recent CPT Panel meeting as well as the CPT –5 meeting. Doctor Gordy reported that Panel met in August and had a relatively light workload and directed the RUC to Tab 3 for the specific issues addressed. The CPT-5 Workgroups/PAG recently met in

Chicago and discussed the following: structural changes in CPT; whether structural changes should be a Revolutionary vs Evolutionary approach; and concepts of hierarchy, granularity, and nomenclature vs. classification. The next CPT-5 meeting will be held in November and will include a plenary session with presentations by representatives from Snowmed, ICD-10-PCS, HCPCS, and a major third party payor. The Research and Managed Care Workgroups will have presentations by NCQA, AHCPR (Agency for Healthcare Policy and Research), HEDIS, JCAHO, (ORYX system), private funders, and performance measures. Doctor Gordy also reiterated that the participation of each RUC member involved in the workgroups will play a significant role in the CPT-5 project by contributing to each issue from their perspective of the RUC process, and to assist in developing workable solutions to the CPT-5 Project.

Dr. Mark Segal, AMA Vice President of the Group on Coding and Medical Information Systems who discussed the status of the E/M Documentation Guidelines. Dr. Segal reported that discussions on the framework of the new guidelines are ongoing between HCFA and AMA. The AMAs Board of Trustees have discussed this issue extensively and have concluded that the medical profession would be best served if the CPT Editorial Panel resume working on the guidelines. The CPT Editorial Panel plans on holding several workshops at their November meeting to deal with the elements of the guidelines and make any needed comments to HCFA. Dr. Segal also said that HCFA's goal is to develop a set of guidelines that will have some element of quantification but will minimize numeric formulas and "counting" to the extent possible.

VII. Correct Coding Initiative Update:

Doctor Kenneth McKusick, Chair of the Correct Coding Policy Committee (CCPC) gave an overview of the Committee, Phase IV Edits and the Commercial Claims Editing Software. As recommended by the AMA Board of Trustees, the CCPC recently reconvened so that any code edits proposed for implementation in Medicare can be immediately reviewed and corrected as necessary. Because several of the former committee members could no longer participate in the committees activities, current membership of the CCPC and specialty societies were reviewed last August and several new individuals were invited to participate. Doctor McKusick directed the RUC to refer to the handout for the new CCPC composition as well as those individuals who have been invited to participate. The CCPC met in September to discuss several coding issues including: the AMA's response to Phase IV edits; CCPC composition; commercial claims editing software; and CCPC involvement with CPT-5 Workgroup 5. The CCPC plans to meet quarterly and all recommendations and related information regarding its activities will be widely distributed to physicians and specialty society staff.

Phase IV Edits

Doctor McKusick reported that there are a total of 12,754 code pairs and emphasized that the majority of codes relate to the reporting of diagnostic tests and other services on the same day as E & M services. The AMA submitted a comprehensive response to Administar on Wednesday for the most frequently reported codes. The AMA received and compiled approximately forty responses from specialty societies and HCPAC

organizations during this process. A second review of less frequently performed services and set of comments are due to the AMA by October 15th.

Commercial Claims Editing Software

Doctor McKusick reported that the HCFA has completed negotiations with HBOC to implement a limited number of code bundling edits for their ClaimCheck product on October 1st of this year. We recently learned that the contract does include the opportunity for CCPC to review the edits. Unfortunately, the review is required to be confidential. Physicians at HCFA reviewed an initial group of 500 edits and reduced the number to 200 edits. The initial group of 500 edits was found to provide the most cost-savings based on an Iowa pilot test. Medicare is requiring all carriers to separately track savings from these edits. Lastly, the 200 edits are procedure to procedure edits and are not edits that are currently contained in the Correct Coding Initiative.

VIII. HCFA Update:

Terry Kay, Director of the Division of Practitioner and Ambulatory Care provided an update on HCFA's recent activities related to Year 2000 impact, the Ambulatory Surgical Center (ASC) Regulation and also announced that Barb Wynn, Director of the Plan and Purchasing Policy Group will be leaving HCFA. HCFA has a strong interest in the Y2 issue with regards to claims processing. The GAO recently reviewed HCFAs efforts to deal with this issue and was given a grade of F. Mr. Kay said that HCFA will make every effort to avoid any significant delay of claims processing. In addition, HCFA does not have any plan to officially delay publication of the Final Rule for the 2000 Medicare Physician Payment Schedule.

Mr. Kay also reported that the expansion of ASC payment groupings has increased from 8 to 100 and mentioned that the RUC might be interested in looking at this as new CPT codes need to be reviewed and classified into one of the payment groupings.

IX. AMA Washington Update:

Sharon McIlrath from the AMA's Washington office reviewed a number of legislative and regulatory initiatives of interest to medicine. On the legislative side, Ms McIlrath discussed the status of the Patients Bill of Rights, and the Lethal Drug Abuse Prevention Act of 1998. The Patients Bill of Rights is dead for this year as neither the House or Senate GOP bill were considered sufficient. Representative Henry Hyde and Senator Don Nickles introduced The Lethal Drug Abuse Prevention Act of 1998, which would prohibit assisted suicide. The bill as proposed would give the federal government the authority to go after physicians who prescribed a controlled substance that led to a patient's death. This bill has concerned both the AMA and the medical profession since the threat of a federal investigation would put a chilling effect on use of aggressive palliative care at the end of life. The Lethal Drug Abuse Prevention Act of 1998 was close to passing but many members had significant doubts after receiving a barrage of phone calls from the AMA, several medical specialty societies and the hospice association. However, the Senate Judiciary Committee did pass a Hatch substitute, which

essentially says that the Attorney General “investigative” authority would not be expanded into these states.

Ms. McIlrath also highlighted some of the regulatory issues on Capitol Hill including the aftermath of the BBA and several other administrative proposals. The so-called MegaReg which provides the rules for implementing Medicare + Choice was supposed to include coordinated care plans, MSAs and fee for service plans. It appears as though the program may not offer many alternatives to the standard risk based HMOs that are already contracting with Medicare as HCFA has received only three applications and deadline was August 31, 1998. In addition, there have been many highly publicized withdrawals from the Medicare business including Prudential. In response to the Mega Reg, the AMA has put together a twenty member team to review several concerns about the regulation which include: The AMA would like HCFA to make it clear to beneficiaries that networks change so there is no guarantee that their personal physician will remain in a particular plan throughout the enrollment period they are signing up for; The AMA does not want HCFA to succumb to pressure to preclude physicians from answering any questions from their patients about which plan to sign up for; and lastly, should a plan terminate a physician, the AMA would like to augment the rules for notifying the patient of the termination.

Ms. McIlrath also highlighted several issues of particular interest including Y2K concerns and commercial off the shelf software system. Although there has been considerable discussion by HCFA of delaying year 2000 payment updates, HCFA now says that it may not have to delay the year 2000 payments. The AMA was also successful in pushing back the deadline for physicians to become y2K compliant from October 1998 to January 1999. The HCFA with tremendous pressure from Congress is in the process of negotiating with GMIS to install a “commercial off the shelf”(COTS) software system in Medicare. HCFA has also contracted with Administar to design the edits in its Correct Coding Initiative, which have totaled over 13,000 edits. Despite the volume and short time frame for review, the AMA and medical specialty societies will make every effort to conduct a thorough review of the edits.

X. Relative Value Recommendations for New or Revised Codes for CPT 1999:

A. Arteriovenous Regional Chemotherapy Perfusion (Tab 5) Tracking Number D1 Presentation: Doctor Charles Mabry, American College of Surgeons

A facilitation committee Doctors Tudor (Chair), Berland, Gee, Harer, Hitzeman, Coldiron, Schmidt, Moran, Zwolak, and Mary Foto, OTR met to consider this issue.

A new code, CPT 36823, was developed to reflect *Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy venotomy sites*. The procedure represents a complex operative procedure frequently performed on patients with extremity lesions.

The procedure involves isolation of the main vascular supply to the arm or leg with cannulation of the artery and vein with this cannulas being used to establish a circuit with a membrane oxygenator perfusion pump (heart-lung machine). A tourniquet is then applied distal to the cannulation sites and the limb perfused with high doses of chemotherapy for a prescribed period (usually one or to hours). After completion of this perfusion period, both the tourniquet and the cannulas are removed and vascular repairs of the vessels are undertaken. The wounds are closed and the patient is taken to the recovery area. This procedure represents a unique combination of a highly invasive surgical procedure with chemotherapy supported by a membrane oxygenator/profusion device. The procedure was initially described in 1954 but has only become more commonly used since oxygenator/profution pumps became available in the 1960's.

The procedure is similar in terms of intensity and work to CPT 35081 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm and associated occlusive disease, abdominal aorta* (work RVU = 28.00). The intraoperative exposure of vessels and cannulation and repair is also similar to the dissection of major vessels in the groin.

The RUC reviewed the original survey results with particular emphasis on the post-operative care and the number of follow-up visits required after the procedure. It was the consensus that the intra-service time should be slightly decreased. The work RVU of 21.00 represented the 25th percentile of the survey. The RUC agreed that this number appropriately valued the new procedure.

Recommendation: The RUC recommends acceptance of 21.00 as the work relative value unit for this new CPT code 36823.

**B. Laparoscopic Procedures (Adrenalectomy, Splenectomy, Jejuostomy)(Tab 6)
Tracking Numbers E1, P7, P4
Presentation: Doctor Charles Mabry, American College of Surgeons**

CPT code 56321 was established to describe the procedure: *Laparoscopy, surgical: with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal*. Laparoscopy is not a new technology, but the application of this methodology to adrenalectomy is relatively new and was first reported in 1992.

CPT code 60540 *Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure)* (work RVU = 17.03) was used as a comparison code when evaluating the potential work relative value for the new code. CPT 56321 is more technically complex than an open adrenalectomy (CPT 60540). The laparoscopic suturing is made more difficult because of the lack of two-dimensional vision. With an open procedure, the surgeon has both the advantages of tactile information, as well as the ability to view the operative field from more than one restricted view. Similarly, the work need to repair bleeding and suturing of structures is increased due to the more complex and time consuming methods required of laparoscopic suturing.

The RUC evaluated the intensity and complexity measures for the laparoscopic and open adrenalectomy procedures and the differences in intra-operative times. It was the consensus that the work of a laparoscopic adrenalectomy was greater than that for an open procedure. In addition, the RUC reviewed the time intensity/complexity measures and agreed that the work of a laparoscopic adrenalectomy was more closely related to CPT code 43631 *Gastrectomy, partial, distal; with gastroduodenostomy* (work RVU = 19.66). This value is similar to the RVU for a gastrectomy and also represents the additional intra-operative time for a laparoscopic adrenalectomy versus the open adrenalectomy.

Recommendation: The RUC recommends a work relative value of 20.0 for CPT 56321.

A CPT code (56345) *Laparoscopy, surgical; splenectomy* was developed in 1997 and has since that time been carrier priced. In 1998, the RUC reviewed survey data for this procedure code and was able to establish an appropriate work relative unit. CPT code 56345 was developed to adequately reflect new technology and equipment. These components are utilized to reduce postoperative pain and length of hospitalization.

As part of its analysis, the RUC considered existing CPT code 38100 *Splenectomy; total (separate procedure)*(work RVU= 13.01). CPT code 38100 describes an “open” procedure. For CPT code 56345, the intraoperative intra time is longer than that for CPT 38100 due to the maceration and tedious removal process of the spleen through laparoscopic equipment. Laparoscopic suturing is made more difficult due to the lack of two-dimensional vision and visualization of intra-abdominal structures in the left upper quadrant. With an open procedure, surgeons have both the advantage of tactile information, and the ability to view the operative field from more than one restricted view. Similarly, the work performed to stop bleeding and suturing of structures is increased due to the more complex and time consuming methods required for laparoscopic suturing.

Recommendation: The RUC recommends a work relative value unit of 17.00 for CPT code 56345. This value represents the 75th percentile of the survey data. This value takes into count 90 minutes if additional intraoperative time and one less

hospital day for the laparoscopic procedures versus the open procedure (CPT 31800).

Similar to CPT code 56345, *Laparoscopy, surgical: jejunostomy (eg for decompression or feeding)* (CPT 56347) was developed in 1997 and has been valued independently by individual carriers since its inception in 1998. This code also incorporates new equipment and technology which reduce patient pain and length of hospital stay.

CPT code 44300 *Enterostomy or cecostomy, tube (eg for decompression or feeding) (separate procedure)*(work RVU = 8.88) was used as a comparison code in the RUC process. The RUC reviewed survey information and agreed that new CPT code 56347 required more work, technical skill and effort introducing and manipulating the equipment within multiple, separate trocar sites. As with the other two laparoscopic procedures previously detailed, the suturing for the surgical jejunostomy is more difficult due to the lack of two dimensional vision.

Recommendation: The RUC recommends a work relative value unit of 9.78 for CPT code 56347. This value represents the median survey result by physicians.

C. Sentinel Node Biopsy (Tab 7) Tracking Number EE3

Presentation: Doctor Charles Mabry, American College of Surgeons

The RUC evaluated proposed work values for new CPT code 38792 *Injection procedure; for identification of sentinel node*. Increased awareness and better understanding of the natural history of various malignancies and results of treatment have led to new concepts about lymph nodes sampling and staging of malignancies, i.e., breast and melanoma. New procedures, such as sentinel node biopsy, are outgrowths of that enhanced understanding. Current CPT terminology did not effectively describe sentinel node biopsy procedures. The addition of code 38792, along with several editorial changes to other related codes, will allow for an accurate description of the service and will provide for additional outcomes tracking.

The RUC considered CPT code 11900 *Injection, intralesional; up to and including seven lesions* (work RVU=. 52) when determining an appropriate work value for the new code. It was the consensus that the time and complexity measurements for CPT 38792 were very similar to CPT 11900, and as such, should be valued at a similar rate.

Recommendation: The RUC, therefore, recommends acceptance of .52 as the work relative value unit for CPT code 38792.

D. Ultrasound Bone Densitometry (Tab 8) Tracking Number AA1

Presentation: Doctor William Thorwarth, American College of Radiology

A new CPT code was established to reflect innovative changes in bone densitometry procedures. CPT code 76977 was created to report *Ultrasound bone density measurement and interpretation, peripheral site(s), any method*

In general, bone densitometry is used in conjunction with evaluation and management services to determine whether a patient is at risk for osteoporosis. The services include obtaining a patient history to identify the presence of known risk factors for osteoporosis as well as all medications currently being taken by the patient. Unlike most methods of bone densitometry current in clinical use, ultrasound bone densitometry does not use ionizing radiation. Specifically, the intended use of ultrasound bone densitometry is to perform a quantitative ultrasound measurement of the calcaneus. This measurement can be used in conjunction with other clinical risk factors as an aid to the physicians in the diagnosis of osteoporosis and medical conditions leading to reduced bone density.

For comparison purposes, the RUC referred to CPT code 78890 *Generation of automated data; interactive process involving nuclear physician and or allied health professional personnel; simple manipulations and interpretation not to exceed 30 minutes.* (work RVU = .05). Given the similarity in the areas of time and complexity for physician work, the RUC agreed that the same work relative value unit was appropriate for the new code.

Recommendation: The RUC recommends a work relative value unit of .05 for new CPT code 76977.

**E. Pulmonary Function Procedures (Tab 9) Tracking Numbers WW1-WW7
Presentation: Doctors Alan L.Plummer, American Thoracic Society, Scott Manaker, MD, PhD, American College of Chest Physicians**

CPT code 94620 was revised to read: *Pulmonary stress testing; simple (eg, prolonged exercise test bronchospasm with pre- and post spirometry).* The code descriptor for this procedure was modified by deleting the reference to “complex testing” and placing that procedure in a new code (see below, new code 94621). The change was instituted to ensure that the code would only be used to report “simple” stress testing. Simple and complex stress tests are vastly different in the amount of resources needed to perform them. One code cannot accurately describe two such disparate procedures.

The RUC used CPT code 93015 as a comparison code. CPT code 93015 describes: *Cardiovascular stress testing using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (work RVU = .75). The RUC agreed that the physician work involved in 93015 was greater than that of 94620. It was the consensus that .67, representing 25% percentile, was an appropriate for the physician work being described under the new code.

In conjunction with the revision to CPT code 94620, a new CPT code was created: 94621, *Pulmonary stress testing; complex (including measurements of CO₂ production, O₂ uptake, and electrocardiographic recordings)*.

Complex stress testing measures the integration of cardiac and pulmonary function and the status of physician fitness and includes measuring of CO₂ production, O₂ uptake, and electrocardiographic recordings of the patient's response to the stress. The outputs of this panel of complex metabolic tests are then analyzed and interpreted by the physicians, and a report is generated.

As with revised code, the RUC reviewed CPT codes 93015 and in addition 99215 *Of or other outpatient visits for the evaluation and management of an established patient which requires at least two of these key comments: a comprehensive exam medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided constant with the nature of the problems(s) at the present and or family needs. Usually the representing problem are of moderate to high severity* (work RVU).

When developing a work relative value, The RUC evaluated the survey median of 1.48, and agreed that the physician work was substantially greater than that for CPT code 93015. The RUC accepted the survey median as an appropriate value, and recommends a work relative of unit of 1.48.

Recommendation: The RUC accepts a work rvu of .67 for the new CPT code 94620 and 1.48 for CPT code 94621.

F. Bronchoscopic Procedures (Tab 10) Tracking Numbers BB1-BB3

Presentation: Doctors Alan L. Plummer, American Thoracic Society, Scott Manaker, MD, PhD, and American College of Chest Physicians

A facilitation committee Doctors Schnur (Chair), Britton, Gordy, Hayes, Koopmann, Moorefield, Vanchiere, Cooper and Jerilynn Kaibel, DC met to consider this issue.

CPT code 31622 was revised to describe: *Bronchoscopy: diagnostic, (flexible or rigid), with or without cell washing.*

The code revision included the deletion of the "or brushing" component and was implemented to specifically indicate that "brushing" required more time (e.g. using fluoroscopic guidance) to perform than a bronchoscopy with washings.

The original code (31622, work RVU = 2.80) has not been surveyed since the Hsiao values were established in the early 1980's. Since that time, the work for that procedure has been increased significantly due to the fact that physicians are using conscious sedation with the bronchoscopy. The recommended work RVU was established at the 25% percentile in order to allow for a range between the diagnostic fiberoptic bronchoscopy (31622) and other bronchoscopy codes.

Given the modifications to the description and the physician work involved, the RUC recommended a slightly discounted value of 2.78. It was the consensus that 2.78 captured 80% of the work involved in the original code.

As a subset to revised code 31622, a new code was created (CPT 31623) to report *Bronchoscopy: with brushing or protected brushings*. This procedure is performed using a brush that is sealed in a catheter. The catheter is then passed through the bronchoscope once it is in place and inserted into an area of a diseased lung, often using fluoroscopic guidance. The brush is then advanced beyond the catheter to obtain uncontaminated material for study and culture.

It was agreed that a physician work rvu of 2.88 was appropriate for this new code.

Newly created code *31624 Bronchoscopy; With bronchial alveolar lavage* describes when a bronchoscope is introduced to perform bronchial alveolar lavage (BAL). Using BAL allows the recovery of cells as well as noncellular components from the epithelial surface of the lower respiratory tract. This differs tremendously from “washings” which refer only to the aspiration of secretions or small amounts of instilled saline from larger airways. This form of therapy affords an effective means to diagnose unusual infections as in patients with immune deficiency diseases and may be used to help guide therapy of chronic inflammatory or fibrotic disorders.

Recommendation: The RUC recommends a work relative unit of 2.88 for 31624.

G. Ventricular Assist Devices (Tab 11)

Presentation: Doctors Sidney Levitsky & Robert Kormos, Society of Thoracic Surgeons

CPT codes 33975 *Implantation of ventricular assist device; single ventricular support* and 33976 *Implantation of ventricular assist; biventricular support* have both undergone significant changes in the amount of physician work required since they were last surveyed in 1993. The technology of VAD implementation has dramatically changed the level of work intensity during intraservice implantation and has also increased the post-operative time since patients are now being managed for months and even years with the device in place. The RUC initially brought the issue to the Health Care Financing Administration in its submission of Recommendations for CPT 1999. At that time, interim values were requested until additional data could be collected. In September 1998, the RUC reexamined survey data regarding proposed changes in work relative value units for these particular codes.

The survey responses and data both confirmed very significant changes in the physician time and work performed for VAD procedures as identified in CPT codes 33975 and 33976. The survey information supports the observations that physicians implanting these devices are spending significantly more time that involves greater work intensity in the operating room completing the intraservice implantation. In addition, they are also performing a tremendous amount of postoperative work that is currently not reflected in

the work relative value units. Furthermore, the technology of VAD implantation has greatly changed and patients are being kept alive longer with newer devices in place.

To reflect these changes, the RUC reviewed again the work relative values for both CPT 33975 and CPT 33976. For CPT code 33975, the RUC accepted the survey median presented and agreed with survey respondents that a new work value of 39.00 accurately reflected the physician work involved in this procedure.

For CPT code 33976, it was the consensus of the RUC that because of the demonstrated increased risk and intra-and postoperative time spent with the patient, an RVU proportional to the relationship of the existing codes, i.e., a 10% increase in work for the biventricular implantation, was appropriate. This calculation results in a proposed work RVU of 43.00.

The RUC recommends acceptance of a revised work RVU of 39.00 for CPT code 33975, and a new work relative value unit of 49.00 for the CPT code 33976.

H. Bypass Grafts (Tab 12) Tracking Number CCI

Presentation: Doctor Robert M.Zwolak, Society for Vascular Surgery

CPT code 35550 was established to reflect *Harvest of upper extremity vein, one segment, for lower extremity bypass procedure (List separately in addition to code for primary procedure)*. CPT 35550 was created as part of a series of codes that included 35682 and 35683. Values for these codes were proposed as part of the RUC's recommendations for CPT 1999.

In determining an appropriate work relative value for CPT 35550, the RUC referenced CPT codes 36821 *Arteriovenous anastomosis, direct, any site (eg Cimino type) (separate procedure)* (work RVU = 8.93) and CPT 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by a leg incision* (work RVU = 9.13) for reference services. However, in surveying for CPT code 35550, respondents noted many differences. CPT 36821 has an equal intraservice time of 60 minutes, but it is a 90 day global service with 30 minutes of pre-service and 48 minutes of post-service time. All intensity comparisons between these two codes listed 35550 as being substantially more intense and complex. Thus, the RVW for CPT 35550 was adjusted downward from the 8.93 rvus assigned to CPT 36821 (based on time), but then increased slightly based on greater intensity. Less urgency of decision making occurs when performing 35550 as compared with that of CPT 34201, but greater skill is required to harvest the vein safely.

The RUC agreed with the following analysis:

Building Block Analysis

Begin with RVW for CPT 36821 of 8.93.

Subtract pre-service work of scrub, dress, wait (15 min*0.8*0.989*0.0103 = -0.12 rvu

Subtract pre-service eval and positioning (15 min*2.2*0.9898*0.0103) = -0.34 rvu

Subtract discharge management (99238) -1.28 rvu

Subtract one office visit (99213) at discounted rate of 0.65) = -0.65
Final extrapolated RVW for 35550 = 8.93-0.12-0.34-1.28-.065= 6.54

The RUC accepted the rank order analysis compared to CPT codes 35682 and 35683, which were evaluated at the April 1999 RUC meeting. The rationale and comparisons resulted in a relative value unit based on the 25th survey percentile. This value was 6.45

The RUC recommends an acceptance of a work rvu of 6.45 for CPT code 35550.

I. Intravascular Distal Blood Flow Velocity Measurements (Tab 13) Tracking Numbers

Presentation: Doctor Samer Kazziha, American College of Cardiology

The RUC decided that this issue should be addressed at the February RUC meeting and should be considered at a Pre-facilitation meeting.

J. Microsurgery Add-On Codes (Tab 14)

Presentation: Doctor Robert Florin, American Association of Neurological Surgeons

A new code was established, CPT 69990, to report *Use of operating microscope (List separately in addition to code for primary procedure)*. The code was created to reflect circumstances where a surgical microscope is employed for the microsurgical procedure. In addition to the creation of CPT 69990, there were two deletions of existing codes that were previously used to report these surgical circumstances. CPT deleted code 61712 *Skull or spine microsurgery (work RVU 3.49)* along with Code 64830 *Microrepair of nerve (work rvu = 3.10)* were omitted from CPT 1999.

The RUC used a weighted average approach in determining a work relative value for CPT code 69990. The RUC agreed that the weighted average of CPT codes 61712 and 64830 was an appropriate value (3.4670).

The RUC, therefore, recommends a work relative of 3.4670 for CPT code 69990.

XI. Practice Expense Subcommittee Report

On September 25, 1998 the Practice Expense Subcommittee met to discuss the FTC Ruling; Comments to HCFA on the RUC Role in Practice Expense RVU Recommendations, and the Role of the PEAC and the relationship with the RUC. The following members participated in the discussion: Doctors J. Leonard Lichtenfeld, (Chair), William Gee, James E. Hayes, Richard J. Haynes, David F. Hitzman, Charles F. Koopman, John Tudor, Jr., William Thorwarth Jr., Charles Vanchiere, David West, William Winters, and Don Williamson, OD.

Dr. Lichtenfeld reported on the results of the Practice Expense Subcommittee meeting and its discussion regarding the role of the PEAC. Dr. Gee presented a recommendation,

which proposed that the RUC would initially assume the work of the PEAC (with advice as needed). The methodology for assigning practice expense relative values could then either entail conducting detailed CPEP type surveys to collect direct inputs on each new and revised codes or specialty societies could develop practice expense “families” of codes and each specialty RVS committee would “assign” new and revised codes into one of the families. The Research Subcommittee could assist in this process by developing a “cross specialty” practice expense list.

The RUC discussed the merits of a methodology, which assigned codes into families with the same practice expense RVU, and the benefits of assigning responsibility to the RUC of developing practice expense RVUs for new and revised codes. There was some concern that assigning this responsibility to the RUC and not the PEAC would result in the RUC losing the expertise of non MD’s such as practice administrators. The RUC agreed that other groups that would like to provide input could do so by attending the RUC meeting and making comments. The RUC agreed that it should at least begin the process and attempt to develop practice expense RVUs and then gauge the workload. The PEAC would then be assigned responsibility for the refinement process.

The following motion was approved: Beginning with the February 1999 RUC Meeting, the RUC will be responsible for reviewing and making recommendations on practice expense direct inputs for new and revised codes directly, without a prior Practice Expense Advisory Committee (PEAC) review.

The PEAC will be responsible for reviewing existing practice expense data during the refinement process and will potentially meet for a ½ day organizational meeting during the RUC February 1999 meeting. Doctor Hoehn will make a final decision on the implementation of the PEAC after HCFA publishes its Final Rule in November. At that time, the AMA will solicit specialty societies for nominations for membership on the PEAC.

The Practice Expense Subcommittee Report was approved as amended. The final report is attached to these minutes.

XII. Research Subcommittee Report

On September 25, 1998 the Research Subcommittee met to review the following: a RUC Survey to Collect Practice Expense Direct Inputs; Summary of Recommendation forms, Customizing the RUC Survey by Specialty Societies, and the MPC. The following members participated in the discussion: Doctors Robert Florin (Chair), David I. Berland, John O. Gage, W.Benson Harer, John E.Mayer, Alan L.Plummer, Chester W. Schmidt, Paul Schnur, Bruce Sigsbee, George Kwass, and Eileen Sullivan-Marx, PhD and Emily Hill, PA-C.

Dr. Florin briefed the RUC on the results from the Research Subcommittee meetings. While the research subcommittee attempted to establish the ground rules for collecting

practice expense direct inputs, the subcommittee concluded that additional meetings would be needed before a draft survey instrument could be used by specialty societies.

The RUC discussed in detail the merits of the Research subcommittees' proposal to begin developing a survey which specialty societies could use to collect aggregate practice expense data. Since this activity is currently conducted by the SMS, several RUC members questioned the appropriateness of expending the RUC's limited resources on such an activity that would be in direct competition with the SMS. Also, it was suggested that the research subcommittee clearly defines its intended outcome and anticipated values added before it embark upon such a complex and resource intensive project. While some RUC members supported activities which pursued different methods for collecting aggregate practice expense data, others felt that since HCFA has already accepted the SMS methodology, and due to the large volume of work facing the RUC in the future, the development of a separate survey should not be a priority for the RUC. The RUC members agreed that while there were shortcomings to the SMS data, they preferred to work with the SMS staff to overcome any survey shortcomings.

The RUC approved the following motion: The Research Subcommittee will prepare a draft survey by mid-November which specialty societies can use to collect work and practice expense data for new and revised codes scheduled for the February RUC meeting.

The approved Research Subcommittee Report is attached to these minutes.

XIII. Administrative Subcommittee Report

On September 25, 1998, the Administrative Subcommittee met to discuss the composition of the PEAC, RUC Representation related to ACP/ASIM and the preliminary scope of the next Five-Year Review. The following members participated in the discussion: Doctors William Rich (Chair), Melvin Britton, Tracy Gordy, Alexander Hannenberg, Clay Molstad, James Moorefield, Laura Lowe Tosi, Richard Whitten and Mary Foto, OTR. Doctor Brett Coldiron substituted for Doctor David McCaffree.

Doctor Rich opened the discussion by reviewing the Administrative Subcommittee's recommendations for the composition of the Practice Expense Advisory Committee (PEAC). After a lengthy discussion, the RUC approved the following recommendations with editorial changes:

The Practice Expense Advisory Committee (PEAC) will initially be composed of individuals from the organizations detailed on Page 9 of the August 19, 1998 letter to Nancy Ann Min-DeParle. At a later date, the PEAC will decide what organizations to add as appropriate.

The two rotating seats (one internal medicine, one any other) on the PEAC will be open to all RUC Advisory Committee members and will not necessarily be consistent with the rotating seats on the RUC. The PEAC shall elect the representatives to the rotating seats.

The RUC also commented on the Administrative Subcommittee's recommendation related to RUC seats for the American College of Physicians/American Society of Internal Medicine. In July 1998, a merger between the ACP/ASIM was implemented. Currently both organizations hold separate, permanent seats on the RUC.

After a considerable discussion, it was the consensus that the RUC should table these recommendations for discussion at the February 1999 meeting in Tucson, Arizona. Both the RUC and the Administrative Subcommittee will reevaluate the following recommendations at the February 1999 meeting:

- The ACP and ASIM seats should both be retained by current incumbents until the First Term expires in May 1999.
- At that time, ACP/ASIM will be asked to designate a single RUC member and alternate to initiate a new three-year term, representing ACP-ASIM.
- A new RUC seat will be established (thereby keeping total seats the same) designated as an internal medicine rotating seat. The eligible societies are listed on Appendix E, Page 2 of the RUC's Structure and Function document.

The Administrative Subcommittee report was accepted as amended. The approved Administrative Report is attached to these minutes.

XIV. Other Issues

The meeting adjourned at 7:30 p.m.