

**AMA/Specialty RVS Update Committee
September 23-25, 1999**

**The Renaissance Madison Hotel
Seattle, Washington**

I. Call to Order:

Doctor James G. Hoehn called the meeting to order on Thursday, September 23, at 8:15 a.m. The following RUC members were in attendance:

James G. Hoehn, MD, Chair	John Mayer Jr., MD
Thomas Cooper, MD*	MD
Lee Eisenberg, MD	David L. McCaffree, MD
Robert Florin, MD	Eugene Ogrod, MD
William Gee, MD	Alan L. Plummer, MD
Kay K. Hanley, MD	David Regan, MD
Alexander Hannenberg, MD	William Rich, MD
W. Benson Harer, MD	Peter Sawchuk, MD*
James Hayes, MD	Chester Schmidt, MD
Richard J. Haynes, MD	Paul Schnur, MD
Rodney Hornbake, MD*	Bruce Sigsbee, MD
David Hitzeman, MD	William Thorwarth Jr., MD*
Dudley Jones, MD	Trexer Topping, MD*
George Kwass, MD*	Laura Tosi, MD*
Charles Koopmann Jr., MD	Charles Vanchiere, MD
Barbara Levy, MD*	Richard Whitten, MD*
J. Leonard Lichtenfeld, MD	Don E. Williamson, OD
Charles Mabry, MD*	William Winters, MD
David L. Massanari, MD	Robert Zwolak, MD
John Mayer,	
<u>MD</u>	

*Alternate RUC Member

Doctor Hoehn introduced the following new members to the RUC:

- Lee D. Eisenberg, MD, AMA CPT Editorial Panel;
- Alan L. Plummer, MD, American Thoracic Society/American College of Chest Physicians;
- David H. Regan, MD, American Society of Clinical Oncology;
- Robert M. Zwolak, MD, The Society for Vascular Surgery/International Society for Cardiovascular Surgery; and
- Don Williamson, OD (RUC HCPAC Review Board).

The following individuals attended as observers and were introduced by Doctor Hoehn: Carolyn Mullen; Thomas Marciniak, MD & Paul Rudolph, MD (via conference call), Health Care Financing Administration (HCFA); and William Mangold, MD, Carrier Medical Director of Arizona and Nevada.

Doctor Hoehn also welcomed two visiting groups to the RUC including the Resource Based Relative Value Schedule (RBRVS) Commission of Ontario and the Alberta Relative Value Commission (Canada). The following individuals were introduced as representing the RBRVS Commission of Ontario: Ron Smuckler, MD, David Peachey, MD, Ted Rumble, Brenda Gluska, and Helen Robson. Mike Grossly and Brian Sponger were introduced as representatives from the Alberta Relative Value Commission (Canada).

II. Chair's Report:

Doctor Hoehn announced that the RUC and workgroups will be exceptionally busy between now and the conclusion of the meeting on Sunday. For this reason, Doctor Hoehn requested that all comments by RUC and workgroup participants should be limited to two minutes assuring everyone will be given an opportunity to comment.

Doctor Hoehn explained that the schedule is organized around six issues including: 1) CPEP Refinement; 2) Practice Expense Methodology; 3) Data collection; 4) Internal Structure; 5) Five-Year Review; and 6) Approving a response to HCFA on the Notice of Proposed Rulemaking (NPRM). Also, Doctor Hoehn explained further that following the impasse on practice expense last April, he and AMA Staff convened a RUC/PEAC planning workgroup in July to discuss practice expense. As a result of this meeting, an additional workgroup on short-term refinement was established. This workgroup on Short-Term Refinement solutions is scheduled to meet this afternoon and all RUC and PEAC members are encouraged to attend. The outcome of this meeting will be reviewed by the RUC on Saturday. Lastly, Doctor Hoehn thanked the AMA staff for the work and effort that went into the staff notes that account for approximately 85% of the agenda book.

Doctor Hoehn reported that the RUC would not receive a Washington Update as scheduled in the agenda, as Ms. McIlrath would not be attending the RUC meeting.

III. Director's Report:

A Director's Report was presented by Sherry Smith, who discussed the RUC's calendar of meeting dates for 2000 as well as some administrative changes within the AMA's Department of Relative Value Systems. The next RUC meeting will be held February 4-6, 2000 in Phoenix, Arizona. The Practice Expense Advisory Committee (PEAC) is also scheduled to meet in Phoenix on February 1-3, 1999. The April/May RUC/PEAC meeting is planning on meeting in Chicago on April 25-30, 2000. The RUC/PEAC will meet again September 27-October 1, 2000 also in Chicago.

Ms. Smith announced that as of October 1, 1999, Patrick Gallagher will be the new Director of the Department of Relative Value Systems. Ms. Smith will remain with the Department of Relative Value Systems in a part time position and will continue her role as the RUC's secretary.

IV. Approval of the April/May, 1999 Minutes:

The minutes of the April/May, 1999 RUC meeting were approved after the following revisions were noted:

- Page 18, Item K: Replace the listed presenters with the following presenters:

Samuel Hassenbusch, M.D., Ph.D. (AANS)

Bernard Pfeifer, M.D., (NASS)

Michael Ashburn, M.D. (AAPM)

Karl E. Becker, M.D. (ASA)

- Page 11, Item E. Replace current paragraph with the following:
A new CPT code 99173 Screening test of visual acuity, quantitative, bilateral (The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is a diagnostic examination and not a screening test) was established to document a vision test which previously had been included as part of an E/M service. The RUC concluded that assigning work RVUs to this code should be for reporting purposes only. They agreed that this important service should be distinct so it can be used as a quality measure for reporting purposes, but the RUC concluded there is no separate physician work involved in this code.

Work Relative Value Recommendation: The RUC is not submitting a work recommendation for this code, as it should be used for reporting services only.

Practice Expense Recommendation: The RUC examined the practice expense involved in providing this service and agreed that there are clinical labor, supplies, and procedure specific equipment expenses. The RUC recommends that the attached list of direct inputs accurately describes the clinical staff time involved in providing the services as well as the supplies and equipment utilized in this service.

□ Pages 18-21, Item K, Spine Injection Procedures, Review all dummy codes to insure they match with the RUC's recommendations for both work and practice expense recommendations.

The minutes were approved as amended.

A motion was approved by the RUC to file the summary of the July 15 RUC/PEAC Planning Meeting.

V. CPT Update:

Doctor Lee Eisenberg, CPT representative to the RUC, provided a brief update on the volume of codes the Panel will be forwarding to the RUC in February 2000. Doctor Eisenberg directed the RUC to Tab 4 for a listing of new and revised codes that the RUC can expect to review at its February 2000 meeting in Phoenix. In addition, it is anticipated that the RUC will review several issues to be reviewed at the November 1999 CPT Editorial Panel Meeting.

Doctor Vanchiere inquired whether the Panel expects to provide some stability in the series of strep codes for testing as payors continue to deny reimbursement for these codes after so many revisions. Ms. Grace Kotowicz reported that the issues for strep codes for testing have been forwarded and withdrawn by both requestors and specialty societies and the CPT Editorial Panel will review the issues once again this November. It is expected that an accurate assessment of the methods used as well as identification of the codes to report office-based point of care strep tests will be determined at the next CPT meeting.

Doctor McCaffree inquired as to what specific editorial changes were made to CPT Code 88307 *Sentinel Node* (listed in RUC Agenda Tab 4). Doctor Eisenberg reported that the Panel needed to clarify where to place the pathology specimen and the interpretation of the level of work. It was decided that this code would be placed with lymph node biopsy and given the differentiation that it was indeed the sentinel node that was being assessed as opposed to any other lymph node from any other site.

CPT-5

Doctor William Gee provided the RUC with an update on the CPT-5 project. Since the last RUC meeting, there have been two rounds of CPT-5 Workgroup meetings which delivered 34 recommendations to the PAG of which 24 were forwarded to the CPT Editorial Panel. To date, the Panel has adopted a total of 60 recommendations from the CPT-5 Project. Several of the recommendations of interest to the RUC include the following:

- Elimination of “with or without” from code descriptors
- Avoid the use of ambiguous terms in code descriptors except where they are well defined and generally accepted
- Provisional codes for new technology
- Tracking codes for performance measures
- Codes to capture preventive medicine /screening services
- Framework for developing non-physician health professional evaluation services
- Use of Web and Internet communications to decrease timeframe for obtaining a code
- Re-definition of the CPT surgical package.

Doctor Gee explained that the CPT-5 workgroup process is nearly complete. The Structure and Hierarchy and Managed Care Workgroups are scheduled for a one-day fly-in meeting in November and the PAG will meet in February 2000 to complete all remaining business. The next step for the AMA will be to implement the Workgroup/PAG recommendations over the next several years with nearly all changes fully implemented in CPT by 2003.

VI. HCFA Update:

Doctor Thomas Marciniak provided an update from the Health Care Financing Administration (HCFA), including the following pertinent issues:

- HCFA recently hired a new medical officer, Doctor Paul Rudolf. Doctor Rudolf will join the Administrative Subcommittee via speaker phone to provide an update on HCFA’s activities surrounding the five-year review.
- HCFA is Y2K ready and is planning to pay all claims, as previously scheduled on January 17, 2000.
- The comment period on the July 22, 1999 *Proposed Rule* concluded on September 20. HCFA will address the many comments received in the *Final Rule* due out in early November.

- HCFA has sponsored its first meeting with the National Medicare Coverage Advisory Committee last week to discuss coverage of cell transplantation for multiple myeloma. This is in response to an initiative to provide greater input into HCFA's coverage process. The results of this meeting will be posted on the HCFA web page (www.hcfa.gov) in the next few weeks. One outcome of this meeting was that HCFA agreed that the medical community should actively participate in discussions on coverage and ways to improve communication of the coverage policies.
- Doctor Marciniak reiterated that the RUC, and its subcommittees, do not fall under the Federal Advisory Committee Act (FACA) as HCFA is merely an observer at the RUC meetings. Any submission from the RUC to HCFA reflects recommendations that are then internally reviewed by HCFA, prior to any decision or publication.
- Doctor Marciniak emphasized that HCFA has very high hopes for the success of the PEAC and the RUC's activities in the refinement of resource-based practice expense relative values.

VII. Communication Issues

Doctor Hoehn directed the RUC to the staff note in Tab 5 of the RUC agenda book. Doctor Hoehn explained the RUC's policies and procedures regarding communication with the Health Care Financing Administration (HCFA). That is, that only communication directly from the RUC should be considered by HCFA as official recommendations by the RUC. Also, Doctor Hoehn noted that communication to the RUC Subcommittees and RUC should be sent to the AMA RUC staff for distribution.

VIII. Relative Value Recommendations for New & Revised Codes for CPT 2000

A. Breath Test (Tab 6) Tracking Numbers FF1 (78267) and FF2 (78268).

Presentation: Michael Wilson, MD (Society of Nuclear Medicine)

Joel Brill, MD (American Gastroenterological Association)

Work Relative Value Recommendations

New CPT codes were established to report the acquisition for analysis and the analysis of a Urea Breath Test, C-14. The Urea Breath Test, C-14 represents new technology utilized for the detection of *Helicobacter pylori*. Currently, the only other test used to detect *Helicobacter pylori* is the C-13 breath test. The methodology and administration of both the C-13 and C-14 are essentially the same. However, the type and cost of the equipment used for the analysis in both tests are significantly different. The mass spectrometer used for the C-13 breath test can cost between \$50,000-100,000 whereas the liquid scintillator counter used for the C-14 costs between \$10,000-\$30,000. For this reason, a majority of C-13 breath samples are sent to the manufacturer for analysis whereas the C-14 breath samples can be administered and analyzed in a variety of settings.

CPT Code 78267

The RUC agreed that there was no physician work involved in 78267 Urea Breath Test, C-14; acquisition for analysis, as this acquisition service is usually performed by non-physician practitioners. The RUC recommends zero work relative value units for CPT Code 78267.

CPT Code 78268

The RUC compared the median time estimates for the new code 78268 Urea Breath Test, C-14; Analysis (Median Pre-Time 3; Median Intra-time-4; and Median Immediate Post-Service Time-5) to that of the reference procedure CPT Code 78270 *Vit B-12 Absorption Exam* (Median Pre-Time-3; Median Intra-time 5; and Median Immediate Post-service time-5) and work RVW of .20. The RUC also identified several other codes with similar work including 78000 *Thyroid Uptake* (work RVW=.19) and 99211 level 1 *office visit* (work RVW=.17.) The recommendation of .19 also represents the survey median for 78268.

The RUC supports a work relative value of .19 for CPT Code 78268.

Practice Expense Recommendations

The direct inputs for these codes were developed by a survey which estimated clinical staff time, supplies and equipment required to perform both the acquisition for analysis and the analysis for a Urea Breath Test, C-14 in the non-facility setting only.

CLINICAL LABOR

The RUC recommends that the clinical labor inputs for these codes be as follows:

78267	30 minutes	RN/LPN/MA
78268	55 minutes	Nuclear Technologist

The thirty minutes of clinical labor required for the acquisition (78267) represents:

1. Review history to evaluate whether the test is appropriate (ie., patient fasted, is not taking antibiotics or other interfering medication), and explains procedure.
10 minutes
2. Acquisition of the sample. 15 minutes
3. Label and document so specimen can be transported for analysis. 5 minutes

The fifty-five minutes of clinical labor required for the analysis (78268) represents:

1. Identification, labeling, documentation, setting up the procedure. 15 minutes
2. Machine calibration/quality control. 10 minutes
3. Extraction of gas and preparation of scintillation container. 15 minutes
4. Scintillation counting (counter often runs for 120 minutes total). 10 minutes
5. Acquisition of test results, data preparation for physician, documentation, and cleanup. 5 minutes

The RUC agreed with the recommended practice expense clinical labor time presented by specialty societies.

SUPPLIES

The RUC recommends that the only supply for 78267 is the Breath Test Kit. A facilitation committee clarified that to perform the C-14 Urea Breath Test (78267), a kit is used by the practitioner performing the acquisition that includes a radioisotope capsule. Therefore the separate reporting for provisions of the radiopharmaceutical is not applicable. This is a departure from nuclear medicine reporting of radiopharmaceuticals. As a result, the committee emphasized additional reporting for radiopharmaceuticals under code HCPCS A4641 or 78990 is unnecessary. The facilitation committee also clarified that the kit used in 78267 includes a “mailer” and therefore the reporting of

Code 99000 is also unwarranted. The RUC recommends that the list of supplies, found below direct input data for 782X2, are appropriate for code 78268.

EQUIPMENT

For 78267, the RUC recommends that the overhead equipment be as follows:

OVERHEAD MEDICAL EQUIPMENT	NO. OF UNITS IN PRACTICE	MINUTES OF USE PER PROCEDURE	HOURS PER WEEK IN USE FOR ALL SERVICES
Dictation System		2	40
Exam Table and Chair		25	40

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•782X1	FF1	Urea Breath Test, C-14; acquisition for analysis	XXX	0.00
•782X2	FF2	analysis	XXX	0.19
□83013	FF3	Helicobacter pylori, breath test for urease activity(<u>mass spectrometry</u>);	XXX	N/A
□83014	FF4	drug administration and sample collection	XXX	N/A

B. Critical Care Services (Tab 7) Tracking Numbers DD1 (99291) and DD2 (99292)

In May 1999, the CPT Editorial Panel approved editorial changes to two critical care codes, 99291 and 99292. The language of these codes was revised to solve longstanding concerns and recurrent problems associated with inconsistent and often incorrect interpretations of the existing CPT language by physicians and third party payors.

The CPT approved revisions to both the introductory language and descriptors for CPT codes 99291 and 99292. These revisions included: 1) the elimination of the word “unstable”; 2) expansion of the definition of critical care to include care provided after the initial intervention; 3) replacing the term “constant attendance” to “constant attention”; 4) inclusion of language that critical care services include treatment and prevention of further deterioration; 5) determination of time for these particular codes should be consistent with CPT instructions for Hospital inpatient E/M codes; and 6)

family discussion time is included as part of the intra-service work not the pre or post work which is consistent with the definition of work for Evaluation and Management services in a hospital setting.

After evaluating these revisions and the attached letter explaining the changes, RUC members agreed that the changes to CPT Codes 99291 and 99292 were editorial only and do not reflect any change in critical care services. The RUC extensively discussed the revisions to these services and reviewed in detail the arguments presented and well articulated in a letter to Doctor Hoehn from Doctor George Sample who represents the Society of Critical Care Medicine, the American College of Chest Physicians, the National Association of Medical Directors of Respiratory Care, the American Association for the Surgery of Trauma, and the American Society of Critical Care Anesthesiologists. The RUC understands that the nomenclature has been updated to clarify the current appropriate use of these codes, and that the language was extracted from HCFA documents (such as the February 1995 Elizabeth Cusick letter which is currently located in the Medicare Carrier Manual). The RUC also extensively discussed the issue of family meeting time in the calculation of intra-service time and work. They agreed that this time should be included in the intra-service period, as it was computed in the Hsaio study. There is also a qualitative difference in this type of family meeting. For example, when a physician must walk a family through the issue of brain death or life support issues, it is an intense experience and very different than informing a patient's family of a particular prognosis, such as the condition is guarded.

The RUC recommends that the current work relative value units currently assigned to the codes be maintained (99291, work RVU=4.00) (99292, work RVU=2.00).

C. Neonatal Intensive Care (Tab 7) Tracking Numbers EE1- EE3 (99295-99297)

The RUC recommends that the changes to the notes in the Neonatal Intensive Care Unit (NICU) section of CPT are editorial and do not reflect any change in neonatal intensive c

IX. HCPAC Report

Don Williamson, OD, Co-Chair provided the RUC with an overview of the HCPAC's discussion of the following; 1) term limits that mirror the RUC; 2) Practice Expense; and 3) the Five- Year Review. Dr. Williamson announced that the HCPAC Review Board agreed that the current three year term limits of its' Board members should be reconsidered because of the possibility that the members could potentially rotate off thus leaving the Review Board without crucial institutional knowledge. After careful consideration, the Review Board approved the following two motions:

The HCPAC Review Board will request each of the associations seated on the HCPAC to consider removal of term limitations. Each association shall submit in writing their approval or disapproval of this change to AMA for consideration at a subsequent HCPAC meeting.

As members leave the RUC HCPAC Review Board, for whatever reason, new three-year terms will start and societies will be encouraged to nominate individuals with experience in the RUC process.

Dr. Williamson reported that each HCPAC member was given the opportunity during the HCPAC meeting to comment on Practice Expense and Five-Year Review Issues specific to their specialty. (A complete listing of comments may be found in the HCPAC Review Board minutes, which are attached). Several members of the HCPAC Review Board expressed concern regarding the process for selecting codes for the next Five-Year Review. After a lengthy discussion, the RUC HCPAC Review Board approved the following motion:

The HCPAC requests that an emphasis should be placed on codes with zero work RVWs at the next Five-Year Review for codes of specific HCPAC interest.

The HCPAC Review Board Report is attached to these minutes.

X. General Discussion Regarding Practice Expense Refinement

In the opening session of the RUC meeting, Doctor Hoehn pointed the RUC members to the staff note under Tab 8 regarding impact analysis. Doctor Hoehn expressed his view that the RUC has never made decisions related to the financial impact and would expect that the PEAC operate in the same manner. Doctor Hoehn opened the floor for discussion on this issue, but no further discussion ensued.

Doctor Hoehn also noted the staff note in Tab 8 regarding the list of objectives for this RUC meeting dealing with practice expense refinement.

Doctor William Rich submitted a request to the RUC to reconsider the PEAC recommendations from their April 1999 meeting. **The RUC agreed to reconsider the report and then later in the meeting unanimously voted to approve the report and changes to more than 60 codes.** A few RUC members commented that this PEAC report had not been approved by the RUC in April, because the RUC was concerned that several codes that were not adopted by the PEAC had not been fairly reviewed.

XI. Practice Expense Advisory Committee Report

Doctor Eugene Ogrod presented the report of the Practice Expense Advisory Committee (PEAC). On Thursday, September 23, the PEAC met to consider several procedural issues.

The RUC approved all of the following PEAC recommended procedural issues:

- **The PEAC will establish a facilitation committee process and develop criteria for when such committees should be utilized.**
- **The PEAC will establish a pre-facilitation process and develop criteria for when pre-facilitation committees should be utilized.**
- **The PEAC will implement the RUC's voting requirements (2/3 vote required to approve recommendations).**
- **Specialty societies should be allowed to designate substitute for their PEAC members, on an as needed basis.**
- **Seated representatives at the PEAC will not ordinarily present to the PEAC the practice expense recommendations of their specialty society or organization.**
- **When multiple specialties review a code, specialties are encouraged to present to the PEAC only one set of practice expense data per code that reflect the consensus of the interested specialties.**

The PEAC re-convened on Friday, September 24, to consider the work of the Short-term Refinement Solutions Workgroup. The following PEAC recommendations were approved by the RUC:

- **The Research Subcommittee should consider the issue of the typical service versus the average service in regard to practice expense (in an effort to resolve inequities in practice expense RVUs assigned to services provided to patients of high acuity).**

The approved Practice Expense Advisory Committee report is attached to these minutes.

XII. Workgroup on Short-Term Refinement Solutions Report

Doctor Charles Novak presented the report of the Workgroup on Short-term Refinement Solutions. Doctor Eugene Ograd then presented the Practice Expense Advisory Committee's recommended modifications to the workgroup's report, including:

- Strengthen the workgroups' recommendation regarding the use of templates to require their submission, rather than encouraging specialty societies to submit their recommendations in this manner.
- Specialty societies must be prepared to answer questions regarding the composition of their review panels. The PEAC did not feel that specialties should not be required to meet a specific set of criteria in establishing their committees, or to name specific individuals. However, the PEAC does want the opportunity to ask presenters to address the size and composition of these committees.
- The Research Subcommittee should review the issue of typical versus average service.
- Specialty societies should be able to select the codes for review for the February 2000 meeting. The criteria in the agenda book will be sent to the specialties for information. Specialties will be asked to rank their codes in order of priority.
- Specialty societies should be able to withdraw their codes from the agenda. In addition, the PEAC should be able to refer an issue back to a specialty society to collect further data for review at a future PEAC meeting.

The RUC discussed the recommendations of the Workgroup on Short-term Refinement Solutions and the PEAC's recommended modifications and approved the following issues:

Method of data collection and verification

- **Direct Practice Expense recommendations should be presented to the PEAC based on specialty society committee consensus, with supporting documentation.**
- **As included in the RUC's *Instructions for Specialty Societies Developing Recommendations*, specialty society practice expense committees are encouraged to include the following: both subspecialists and generalists from within the specialty; differing practice circumstances and settings (eg, solo practice, academic settings, large group practice, and HMOs); and a range of relevant**

geographic locations. The specialty society should also consider the expertise of practice managers and/or clinical staff on the committee. The PEAC shall require each specialty society to use a panel (rather than an individual physician) to review CPEP data. The specialty society should provide information on the practice expense committee's composition and demographic information to the PEAC.

The PEAC had recommended that the last sentence be revised to read "The specialty society must be prepared to provide information....." The RUC did not feel that it was onerous to provide the composition of the specialty society panel as part of the materials provided to the PEAC and therefore, approved the workgroup's original recommendation.

- **Surveys of direct practice expense data should remain one option for those that wish to use this methodology, however this will not be a requirement.**
- **The RUC and PEAC should consider extant data provided by specialty societies in reviewing practice expense inputs.**
- **Specialty societies will be encouraged to list other codes to which some or all recommended data could also be applied. For example, "the approved addition of a supply for CPT code XXXXX also be applied these additional 10 CPT codes (XXXX...)." These lists should include the CPT code and full descriptor. The RUC and PEAC will be able to extract codes from this list for discussion. The specialty society should be prepared to answer questions relating to any of these listed codes at the time of their presentation.**

The original workgroup recommendation suggested that specialty societies be "permitted" to list other codes. The RUC altered the recommendation to state that this action be "encouraged" rather than merely permitted.

Ground rules and definitions

- **The PEAC should continue its work utilizing the existing ground rules, however the Research Subcommittee should consider the following issue:**
 - **Specific clinical staff activities for pathology**
 - **That the Research Subcommittee promptly develop specific recommendations that address the issue of services to "typical" versus "average" patients (in an effort to resolve inequities in practice expense RVUs assigned to services provided to patients of high acuity).**

Other Methodological Issues

- **The RUC and PEAC require the use of templates (included in the direct practice expense survey) to identify the time spent on each clinical staff function. Specialties are encouraged to use the written descriptions of specific clinical activities in the pre-, intra-, and post-time periods. These templates and descriptions would be included in the recommendation documents.**

The PEAC recommended that the use of templates be “required” and the RUC agreed with this amendment to the workgroup recommendation.

- **Specialty Society recommendations should be submitted to the PEAC in the same format as required in April. AMA staff will investigate the feasibility of incorporation of a template for itemization of clinical staff time data into the electronic files sent to the specialty societies.**

Code Selection

- **The RUC and PEAC will establish a process to select codes for review, with intent to maximize RUC contribution during the initial refinement period and subsequently complete refinement of all existing CPT codes. A work plan will be developed for remaining codes by the end of the transition to fully resource-based practice expense relative values.**

The PEAC requested that this language be modified to allow the specialty to select the codes for February and not to suggest specific required criteria for this next meeting. The RUC’s discussion concluded that the issue of criteria will be addressed in the coming year. The RUC agreed to replace “establish criteria” with “establish a process.”

- **The RUC recommends that AMA staff request each specialty society to identify ten (10) codes for review at the Winter/Spring 2000 PEAC meeting(s).**
- **The RUC recommends that discussion begin immediately on a process to review E/M services with the goal to conduct a PEAC review, and develop recommendations to the RUC, on this data by at least the April 2000 meeting.**

Doctor Ogrod reported that the ad hoc group that met to discuss the E/M issue recommended that those specialties that have an interest in the E/M codes should get together and come to the PEAC in February 2000 on a recommended approach to review these codes.

The AAO and AOA suggested that their data on code 92012, Eye Exam, might be helpful in reviewing the E/M services. These societies will be presenting the data for the eye exam codes in February 2000 for the PEAC’s review.

A motion was made to mandate that the CPT Code 99213 be reviewed by the PEAC, with a report to the RUC by the April 2000 meeting. This motion was extensively discussed, with some RUC members stressing the need to review E/M services before moving forward with the review of codes with global surgical periods. Other RUC members argued that the review of the E/M codes need to be conducted in a deliberate manner in order to obtain accurate direct practice expense inputs for these services and that this process should not be rushed. It was also pointed out that the workgroup recommendation reflected a compromise between those that wanted the E/M codes reviewed at the February 2000 PEAC meeting and those that felt a specific timeframe should not be mandated at this time. The motion failed and the RUC subsequently, adopted the workgroup recommendation.

- **Specialty societies shall select those codes with the greatest need for the specialty and specialties should rank order their selections so that if a large number of codes are submitted, the number of codes may be decreased across the board (ie, review top 3 instead of top 5 at the first meeting).**

This recommendation on rank order was recommended by the PEAC.

- **The PEAC should review other criteria for selection of codes for other meetings.**

Doctor McCaffree noted that a discussion should take place regarding the five tables of criteria. It was noted that the PEAC will develop criteria at a future meeting and this issue will be included in their report to the RUC for final approval.

- **Specialty societies may withdraw practice expense recommendations at any time during the review process.**

Several RUC members expressed disagreement with this recommendation of the PEAC, while others felt that specialty societies should have the opportunity to withdraw codes from the PEAC's agenda.

The approved report of the workgroup on Short-term refinement solutions is attached to these minutes.

XIII. Research Subcommittee Report

Doctor Florin summarized the Research Subcommittee's discussions regarding the RUC practice expense survey instrument, SMS activities and an alternative methodology for calculating PLI and PE RVUs.

The Subcommittee discussed various aspects of the practice expense survey instrument, including the collection of specific data elements and the relationship between the survey and HCFA's overall methodology. The subcommittee stressed the need for HCFA to

provide more specific information on several areas such as the criteria for differentiating between procedure specific and overhead equipment as well as the process employed to calculate the clinical staff wage data.

For example, although HCFA recently proposed to eliminate service time attributed to clinical staff in the facility setting from its CPEP database, the Research Subcommittee agreed that there is a need to continue to collect this information. To further the discussion on this issue, the RUC agreed to encourage specialties to collect data on the extent of clinical staff time spent in a facility setting. The Subcommittee also discussed the merits of removing overhead equipment from the direct cost category and will formally request HCFA to examine this issue and provide an impact analysis by the next RUC meeting.

The RUC approved the following recommendations:

- **The RUC approved the practice expense survey.**
- **The RUC will continue to collect the clinical staff time spent during the service period in the facility setting via the current RUC practice expense survey.**
- **Encourage specialties to use a standard survey based on the questions contained in the 1996 SMS survey, and Specialties can offer additional reliable data on the extent of clinical staff time spent in a facility based on methodology approved by the research subcommittee.**
- **HCFA should examine and revise the wage data to clarify the list and provide an explanation on the calculations used in the wage data.**
- **Specialties are allowed to develop new staff types for any of their codes.**
- **The RUC practice expense survey will continue to collect overhead equipment on a code by code basis and the RUC requests that HCFA provide an impact analysis on the removal of overhead equipment from the direct cost category by the next RUC meeting.**

Doctor Florin briefly explained to the RUC an alternative methodology that is applicable to calculating both PLI and PE RVUs. Several RUC members expressed an interest in pursuing this methodology and encouraged Doctor Florin to further develop his analysis. Doctor Florin stressed that if this methodology were used, the CPEP data would not be needed and the refinement process would be greatly simplified.

The Research Subcommittee Report was approved and is attached to these minutes

XIV. Practice Expense Subcommittee Report

Doctor Lichtenfeld presented the results of the Practice Expense Subcommittee meeting. The Subcommittee reviewed previous adjustments made to Harvard time data, physician time for existing codes, physician time for new and revised codes, and the formulation of the RUC Comment Letter on HCFA's Notice of Proposed Rulemaking. The RUC accepted the following recommendations:

Continued Discussion Regarding Adjustments Made to Harvard Time

- The RUC will continue to monitor adjustments to physician time but offers no recommendation on the issue at this time.

RUC Review of Physician Time for Existing Codes

A Pre-Facilitation Committee was organized, which then reviewed and modified the data submissions of CPT codes that were lacking post service office visits and levels. All post service time levels reviewed and modified by the Physician Time Pre-Facilitation Committee were approved by the RUC as a group to be forwarded to HCFA. **The minutes of the Pre-Facilitation Committee are attached to these minutes.**

RUC Review of Physician Time for New and Revised Codes

- The RUC should explicitly evaluate the physician time when it recommends a work RVU. If the RUC does not approve the specific time, the RUC may make revisions to this time or refer back the issue to the specialty society.
- Where multiple specialty societies present different physician time data for the same codes, the specialty societies should also develop a joint time recommendation that will be then submitted to HCFA in accordance with RUC policy and procedures. The time data from each society should still be provided to the RUC to assist the RUC in its analysis and deliberations.

Formulation of RUC Comment Letter on HCFA's Notice of Proposed Rulemaking

The Subcommittee reviewed a draft comment letter on the July 22, 1999 Notice of Proposed Rulemaking (NPRM) and suggested revisions.

Other Issues

RUC expects that HCFA will publish relative values for immunization codes, consistent with the other non-covered Medicare services.

The Practice Expense Subcommittee report was approved and is attached to these minutes.

XIV. Administrative Subcommittee Report

On September 25, 1999 in Doctor William Rich's (Chair) absence, Doctor Alexander Hannenberg presented the Administrative Subcommittee Report to the RUC. The

Subcommittee discussed the upcoming Five-Year Review, several issues surrounding the election of rotating seats, and the terms of subcommittee members. After careful consideration, the RUC approved the Administrative Subcommittee's recommendations with a minor revisions.

Doctor Hannenberg gave an overview of the upcoming Five-Year Review and a brief synopsis of an informational presentation of the Five-Year Review given by Doctor Paul Rudolf from the Health Care Financing Administration. Doctor Hannenberg told the RUC that upon completion of Doctor Rudolph's presentation, the Administrative Subcommittee expressed concern over the potential large volume of codes that would have to be reviewed in a relatively short period of time. Doctor Hannenberg further explained that the Chair, Doctor Rich assured the Administrative Subcommittee members that this fall the AMA staff would facilitate numerous conference calls to establish a process for the Five-Year Review.

Election of Rotating Seats

During the rotating seat election last Spring, it was unclear to the majority of RUC members whether they were electing the specialty society or the candidate representing the specialty society. The RUC also agreed that the subcommittees needed to establish whether it was appropriate for the candidates to be present and available for a brief presentation at the RUC meeting during the election process. The RUC unanimously agreed with the Administrative Subcommittees recommendation to deal with these issues.

Recommendation #1

The RUC shall elect the specialty society rather than an individual. Candidates representing these specialty societies will be invited to briefly present before the RUC. The Administrative Subcommittee also noted that all eligible specialty societies should be notified that they should attend the RUC meeting to make their presentation.

The election of the rotating seats last spring raised several additional issues including: 1) whether or not the RUC needed to establish a formal balloting process for the balloting process when electing multiple candidates and 2) whether the RUC should consider staggering the rotating seats so all three seats do not turnover at the same time.

Doctor Hannenberg explained that the Administrative Subcommittee found that no motion was necessary in response to the Balloting Process for multiple candidates in the future. The Administrative Subcommittee clarified that RUC meetings are conducted according to Sturgis, Standard Code of Parliamentary Procedure, and that Preferential voting was used in the April meeting and is included in Sturgis. The Administrative Subcommittee reinforced this method as policy and the RUC recognized this as clarification and agreed meetings will continue to be conducted according to Sturgis, Standard Code of Parliamentary Procedure. At this time, several RUC members suggested including Sturgis into the Bylaws of the RUC.

The RUC also agreed to a lottery process which will be initiated in the April 2001 meeting for newly elected rotating seat members to establish the process for staggering the three seats to ensure that they do not end on the same date. The RUC concluded that the Administrative Subcommittee will need to determine whether the first member rotated off can be re-appointed to the same subcommittee in the first year of the lottery process. The Administrative Subcommittee proposed and the RUC approved the following motion to deal with these two issues:

Recommendation #2

The RUC shall continue to refer to its Rules and Procedures Document for preferential balloting found in Sturgis and the RUC should initiate a lottery process at the April 2001 meeting that will determine the corresponding terms for newly elected rotating seat members.

Terms of Subcommittee Members

Doctor Hannenberg explained that the Administrative Subcommittee carefully considered the length of both the Subcommittee chair and members. This issue was addressed as several RUC members expressed concern that as soon as the chair and subcommittee members become knowledgeable on a subcommittee's issues, the seats rotate. Furthermore, the rotation of the Chair and subcommittee members at the same time creates further disruption due to the loss of all institutional knowledge within a subcommittee. Therefore the subcommittee proposed the following motions that were approved with minor revisions as the RUC argued that terms should be the same for all members including the Chair.

Recommendation #3

To ensure institutional memory, the Chair of the RUC shall appoint the chair of each subcommittee to a ~~three-year~~ two-year term or for the remainder of his/her RUC Term (if less than two years).

The Chair of the RUC shall appoint subcommittee members for two-year terms.

Upon completion of the review of the Administrative Subcommittee's Report several RUC members discussed the following issues of concern for future meetings of the Administrative Subcommittee:

1. Request was made to have the names of the PEAC and HCPAC members who are willing to serve on subcommittees be given in thirty days to Doctor Ograd.
2. The Administrative Subcommittee in February 2000 must evaluate the issue of adding PEAC members to subcommittees.

The Administrative Subcommittee report was approved with modifications by the RUC and is attached to these minutes.

XV. Other Issues

At the conclusion of the RUC meeting, several RUC members expressed their concern and frustration in establishing a process to refine the resource-based practice expense relative values. Of utmost concern was the time and financial commitments required by physicians and their respective specialty societies to appropriately refine all of the existing CPEP data. Those speaking were also concerned that HCFA does not fully appreciate the work and personal sacrifice that goes into the RUC process. They also stated that they were cautiously awaiting HCFA's decision on the practice expense recommendations forwarded at both the April and September RUC meetings. In addition, some RUC members questioned the ability to make significant contributions to the resource-based PE RVUs by merely focusing on the direct practice expense inputs. Individual members presented significant concerns about the intellectual and scientific validity of the current practice expense methodology.

Others on the RUC argued that although the sense of frustration was understandable, the RUC had no choice but to work on behalf of the medical community to ensure that the underlying data to calculate PE RVUs were valid and reasonable. One RUC member pointed out that if the medical community comes to consensus on the underlying data, then it will be feasible to illustrate the percentage of practice expense that Medicare is actually paying. This information could then be a powerful lobbying tool. The consensus of the committee was that the cost-benefit issues surrounding the PEAC and RUC's involvement in the refinement of direct practice expense data deserve further discussion at future meetings, but that it was necessary that the RUC move forward in its work.

The meeting adjourned at 5:50 p.m.