

**AMA/Specialty RVS Update Committee  
September 27 – September 28, 2002**

**The Swissotel  
Chicago, Illinois**

**I. Welcome and Call to Order**

Doctor James G. Hoehn called the meeting to order on Friday September 27, 2002 at 3:00 p.m. The following RUC members were in attendance.

James G. Hoehn, MD, Chair	J. Leonard Lichtenfeld, MD
James Blankenship, MD	John E. Mayer, Jr., MD
James P. Borgstede, MD	David L. McCaffree, MD
Melvin C. Britton, MD	Bill Moran, Jr., MD
Neil H. Brooks, MD	Bernard Pfeifer, MD
John Derr, Jr., MD	Gregory Przybylski, MD
John O. Gage, MD	Sandra B. Reed, MD*
William F. Gee, MD	William Rich, MD
Meghan Gerety, MD	Peter Sawchuck, MD*
Tracy R. Gordy, MD	Chester W. Schmidt, Jr., MD
Alexander Hannenberg, MD	J. Baldwin Smith, III, MD
James E. Hayes, MD	Sheldon B. Taubman, MD
David F. Hitzeman, DO	Trexler Topping, MD*
Charles F. Koopmann, Jr., MD	Arthur Traugott, MD*
Steven E. Krug, MD*	Richard Whitten, MD
M. Douglas Leahy, MD*	Don E. Williamson, OD
Barbara Levy, MD	

\* Alternate

**II. Chair's Report**

Doctor Hoehn welcomed the RUC members and made the following announcements:

- The following members have been re-appointed:
  - John O. Gage, MD, American College of Surgeons
  - David F. Hitzeman, DO, American Osteopathic Association
  - J. Leonard Lichtenfeld, MD, American College of Physicians/American Society of Internal
  - Charles D. Mabry, MD, American College of Surgeons
- Doctor Sheldon Taubman, RUC representative from the American College of Pathology and Eileen Sullivan-Marx, PhD, RUC HCPAC representative from

the American Nurses Association and Doctor Peter Sawchuck, RUC Alternate representative from the American College of Emergency Physicians announced that they will also end their terms following this meeting.

- The RUC 10-Year Anniversary Dinner will take place in the Edelweiss Room at 6:30 p.m., Saturday evening.
- Doctor Hoehn reminded all RUC meeting attendees that they have agreed to the RUC Confidentiality Notice by their attendance at the meeting.
- Doctor Hoehn announced the members of the two facilitation committees:

**Therapeutic Apheresis  
Facilitation Committee:**

Richard Whitten, MD (Chair)  
Melvin Britton, MD  
Tracy Gordy, MD  
Meghan Gerety, MD  
J. Leonard Lichtenfeld, MD  
John Mayer, MD  
Emil Paganini, MD  
William Rich, MD

**Bone Marrow Facilitation  
Committee:**

James Blakenship, MD (Chair)  
Richard Dickey, MD  
William Gee, MD  
Meghan Gerety, MD  
James, Hayes, MD  
Barbara Levy, MD  
J. Leonard Lichtenfeld, MD  
Holly Stanley, MD  
Paul Wallner, DO  
Richard Whitten, MD  
Don Williamson, OD

- Doctor Hoehn extended his welcome to:
  - Heidi Nadolski, an economist with the National Association of the Statutory Health Insurance Physicians, from Germany; and
  - Tracy R. Gordy, MD, Chair of the CPT Editorial Panel.
- Doctor Hoehn thanked Doctor Rich for representing the RUC on the Centers for Medicare and Medicaid Services Refinement Panel convened in the summer of 2002.
- Doctor Hoehn presented slides from his trip with Sherry Smith to visit the Korean Medical Association and presentation to their 30<sup>th</sup> Annual Congress. Additionally, Doctor Hoehn presented slides from the RUC Outing to Wrigley Field at the April 2002 RUC Meeting.

**III. Director's Report (Tab 1)**

Sherry Smith announced to the RUC that the September RUC meeting schedule is under Tab 1. The next RUC meeting will be held January 30 – February 2, 2003 at the Royal Pacific Resort at Universal Studios, Orlando, Florida.

**IV. Approval of the Minutes for the April 25-28, 2002 RUC Meeting**

- Doctor McCaffree asked that the minutes reflect his attendance at the April RUC meeting.

- Doctor McCaffree asked for the rationale behind the annual review of the Multi-Specialty Points of Comparison during the September RUC Meeting. Sherry Smith explained that the September RUC Meeting historically has had fewer codes to evaluate in comparison to other RUC meetings and therefore there is more time to consider policy issues such as the Annual MPC Review.
- Doctor Whitten provided editorial grammatical revisions including:
  - Page 14- within the practice expense recommendations for code 2989X, the sentence should read, “These procedures are ~~only~~ performed in the facility setting only.”
  - Page 18- within the Bone Marrow Procedures section the sentences should read,
    - “Thirteen new CPT codes were added and two were deleted to provide greater granularity to code accurately the specific procedures performed for each patient receiving bone marrow or stem cell transplantation.”
    - “The RUC understands that these services are ~~not more~~ commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore a small sample size of 22 is expected.”
  - Page 28- within the recommendations for code 3321X, the sentence should read, “This code is for a right atrial or ventricular lead code only and as such represent a group different from codes 3322X1, 3322X2 and 3322X3.
  - Page 69- Within the Anesthesia Facilitation Committee Report, the sentence should read, “Doctor Gage pointed out that for a family of colon codes in the five-year review, the RUC workgroup did not accept the methodology presented and therefore submitted a recommendation to the RUC of maintaining the current RVUs for the family.”
  - Page 106- The Administrative Subcommittee Members should list Nelda Spyres, LCSW
  - Page 107- within, the Administrative Subcommittee Report, the recommendation should read, “The RUC did not approve the above motions requesting re-examination of the ~~criteria for inclusion on the RUC~~ criteria for permanent seat on the RUC after the original formation.”
- Doctor Hannenberg recommended the following:
  - Page 23- within the recommendations for code 0054X1, the sentence “It is estimated that this service will only be provided to Medicare beneficiaries 100 times a year,” should be deleted. This statement is erroneous because this service frequency data far exceeds this estimation.

**The amended minutes were accepted.**

## V. CPT Update

Doctor Tracy Gordy, Chairman of the CPT Editorial Panel, addressed the RUC about the progress on Evaluation and Management (E/M) coding and documentation guidelines. Chaired by Doctor Doug Wood, the twenty-one member E/M Workgroup includes representation from the RUC, CMS, Carrier Medical Directors, Private Sector Payors, Practicing Physicians Advisory Council (PPAC), HCPAC and CPT. The group met total of six times and during one of the six meetings 26 medical specialties presented their concerns, and perceptions of revisions to the E/M codes and the Documentation Guidelines. In addition, the Workgroup conducted an online call for testimony for which

they received over 60 responses. The Workgroup also surveyed approximately 300 practicing physicians on their use and understanding of the current E/M codes, as well as their coding concerns. The E/M Workgroup in developing recommendations that were initially presented to the Editorial Panel in August used the results of this survey and oral and written testimony. The CPT Editorial Panel accepted the Workgroup's recommendations and forwarded them to the CPT/HCPAC Advisory Committee and to state medical societies for review and comment. The Panel will review all comments and take final action on the proposed revisions to E&M codes at the November CPT meeting. The E/M workgroup proposed the following recommendations:

- 1.) **Maintain five levels of service:** the Panel considered modifying the levels of service to either reduce or increase the number of levels of service. However, it was determined that five levels of service were appropriate. In order to maintain continuity, the numbering for new codes will remain the same as the current codes.
- 2.) **Base E/M codes on total physician work:** total physician work emphasizes the decision-making process of the physician, therefore these codes will continue to be valued through magnitude estimation. Newly recommended E/M codes would not impact the current relative values with which they are associated.

Total physician work includes all work performed before the visit (pre-service), work performed during the visit (intra-service), and work performed after the visit (post-service). Physician work is that work personally performed by the physician and is determined by the amount of time it takes to perform the service, mental effort and judgment, technical skill and physical effort and psychological stress involved whenever there is an adverse outcome. Activities included in the determination of total physician work may include:

- Reviewing test results and pertinent past charts
- Taking a clinically relevant history
- Performing a clinically relevant physical examination
- Making decisions about diagnostic studies and therapeutic interventions,
- Providing patient education and counseling,
- Following up with the patient and other caregivers.

Because the amount of each activity performed varies for each visit, physicians should choose a level of service based on total work rather than on one or more specific activities performed during the visit.

Previous versions of CPT Evaluation and Management codes described the concept of total physician work, in terms of the key components of history, physical examination and medical decision making, as well as the contributory factors of counseling, coordination of care and the nature of the presenting problem. Physicians selected a code based on the extent to which each of the three key components was performed. The new E/M code structure asks physicians to select a code based on the total physician work performed without breaking it down into key components or individual activities.

- 3.) **Generate Clinical Examples:** clinical examples created for reference services third and fifth level of service for outpatient visits and for the second level of service for inpatient visits will serve as a reference for physicians to determine the magnitude of work performed.

To initiate the clinical example review process, and to determine whether the development of clinical examples is a reasonable approach, E/M Workgroup members conducted a feasibility study in which the various specialties on the Workgroup developed clinical examples for five medical conditions. These medical conditions were decided upon by the entire workgroup and they include headache, low back pain, chest pain, abdominal pain and painful urination. Once these clinical examples are reviewed, the workgroup plans to present these models to the CPT Editorial Panel in November 2002. Eventually, the Workgroup will request the creation of clinical examples from all medical specialties for the selected levels of service. Doctor Gordy stated that the E/M Workgroup would like to have all of these clinical examples by February 2003, so that they will be published during the CPT 2004 cycle. Additionally, Doctor Gordy indicated that it would be helpful for the RUC to review the work equivalency of these clinical examples.

The RUC responded to Doctor Gordy's presentation with several questions including:

- **Time Frame Issues:** Several RUC members expressed concern that the time allotted to develop and review new E/M clinical examples in the spring of 2003 for publishing in the CPT 2004 coding cycle seemed unrealistic. Doctor Rudolf of CMS agreed with these RUC members that the time frame might not be reasonable considering the amount of review required.
- **CMS Acceptance of Final Recommendation:** The RUC asked for clarification on the level of commitment CMS had made to this process and expressed that CMS should not have the sole responsibility to approve the final E/M recommendations. The RUC recommends that the approval of a final recommendation be the result of a collaborative effort by the E/M workgroup, the CPT Panel, and the RUC.
- **The RUC's Role:** The RUC members discussed their potential role in this E/M clinical examples review process and decided that a clear methodology and work plan needs to be designed by the RUC prior to actual review.
- **Peer Review Process:** The RUC members expressed their support for a peer review process and Doctor Gordy confirmed that this was a part of the workgroup's proposal.
- **Non-Medicare Payers:** Several RUC members expressed concern that non-Medicare payers' would reject new payment policies established by recommendations from the E/M workgroup, the CPT Panel and the RUC. The RUC stressed that these groups should work with non-Medicare payers and providers to ensure that the coding and documentation requirements would be accepted.
- **Diagnosis:** Several RUC members expressed concern that by basing coding decisions on diagnosis, physicians may code services based on differential diagnosis and/or severity of diagnosis. Doctor Gordy acknowledged these concerns and will present this issue for consideration to the workgroup.
- **Specialty Specific E/M Codes:** Doctor Mayer questioned whether the workgroup was moving in the direction of specialty-specific E/M codes. It was noted that specialty specific payment differentials for the performance of the same service are

not authorized under the current statute. Although this idea was discussed, the E/M workgroup opted for a different method of improving E/M codes and documentation guidelines.

- **Resources Required to Conduct Review:** A number of RUC members expressed concern that this project would be expensive, requiring additional meetings. Several members also stressed that RUC members, advisors and others would have to volunteer their time in order to complete the project and that the AMA should thoroughly evaluate the projected costs and resource requirements.

**A motion was made to include the RUC in the E/M Clinical Example Project. This motion was accepted by the RUC.**

#### **VI. CMS Update**

Doctor Paul Rudolf announced that CMS is in the process of writing the Final Rule. He stressed that the conversion factor update is a congressional issue, and it will be addressed in detail during the Washington Update.

- Doctor Sawchuck asked CMS to elaborate on the proposed changes to the teaching physician documentation guidelines. Doctor Rudolf responded by stating that there is a program memorandum that has not been released to make these documentation guidelines easier to use. These regulations require that the teaching physicians for E/M services personally document the fact that he/she was present and participated in the care of the patient. CMS' goal is to minimize the requirements for repeating documentation already provided by the resident. [Staff Note: This program memorandum was released on November 22, 2002]
- Doctor Sawchuck asked for clarification regarding new regulations for E/M services provided by a mid-level practitioner and a physician. Specifically, he questioned the instance when a visit is split between a nurse practitioner and a physician in a hospital setting. Doctor Rudolf stated that this issue pertained to changes in the Medicare Carrier Manual. The issue has not been entirely resolved, however there is some agreement that if the physician does a substantive face-to-face encounter as part of that split service then the service can be billed under the physician's UPIN number even if its less than half of the work of the service.
- Doctor Przybylski questioned the increases in professional liability insurance for Neurosurgery, as well as other specialties, and questioned whether any action will be taken by CMS to adjust the PLI RVUs. Doctor Rudolf stated that this topic had been discussed at PPAC just prior to the RUC meeting. The malpractice RVUs will be updated with data received from Spring 2002. Any action will be based on the most current data received.
- Doctor Rich questioned whether CMS would comment on the AMA's recommendation to have drugs eliminated from the SGR. Doctor Rudolf stated that this topic would be addressed in the Final Rule.

#### **VII. Washington Update**

Sandy Marks, AMA Assistant Director of the Federal Affairs Office, reviewed several legislative and regulatory issues.

- **Medicare Payment Update:** Under current law and given current CMS assumptions about the Medicare Economic Index (MEI) and other factors affecting payment

updates, Medicare payments to physicians would be cut by 12 percent over the next 3 years, from 2003-2005, in other words 4.4 percent per year. This 4.4 percent cut for the next three years would be on top of the 5.4 percent cut in 2002.

- This 12 percent cut is an average cut to each physician who sees Medicare patients of \$17,000. In contrast, the Medicare bill passed by the House, HR 4954, would increase federal funding for Medicare physician services by \$21.3 billion over the next 5 years. The 10-year cost is closer to \$11 billion because the sharp cut would kick in beginning with the 2006 update. On a per physician basis, the House bill would increase federal Medicare funding by an average of \$28,000 per physician relative to current law for 2003-05. So, while your AMA would have preferred to see a long-term solution to the update problem enacted this year, \$28,000 per physician is a major commitment of federal dollars and it is a big step forward in addressing the immediate crisis.
- The House bill accomplishes the 3-year changes by temporarily changing the SGR formula. Instead of the 1996 SGR base year, the House bill changed the base year to 2002 to avoid the effects of the 1998 and 1999 projection errors.
- CMS also made an important administrative change affecting the payment update system in its 2003 Proposed Rule by adjusting the MEI for productivity to a multi-factor productivity adjustment from a labor productivity factor. This change increased the MEI for 2003 by 0.7 percent and it will lead to more realistic government estimates of medical practice cost inflation every year than the previous estimates. As a result, the MEI is offset to a smaller degree by productivity gains. Sandy expressed her gratitude to the several RUC members and advisors who provided very helpful information to our AMA on physician productivity, which was presented to CMS.
- Senators Baucus and Grassley, the Chairman and Ranking Member of the Senate Finance Committee, have now agreed on a package of provider payment provisions and released an outline. The outline indicates that they will be proposing something at least very similar to the House-passed provisions on the physician update. Also, the House package included the same regulatory relief language that it had passed last December but the Senate bill will include a somewhat different regulatory relief bill. We have been helped considerably by the emergence of data confirming that Medicare payment cuts do hurt patient access.
- The AMA has been continuing to push for additional administrative changes to bring down the cost of a long-term fix. These include removing Medicare-covered outpatient drugs from the SGR system, fixing the 1998 and 1999 projection errors, and accounting for new regulations, including national coverage decisions, in the SGR. On the drug issue, we did an in-depth analysis of exactly what was driving the growth in Medicare drug spending and prepared a letter explaining to CMS that this growth was clearly being driven by better treatment options and not by inappropriate utilization.
- Medical Liability Reform: the full House of Representatives passed the HEALTH Act, H.R. 4600, on Thursday afternoon at 3:27 p.m. by a vote of 217-203. Passage of the bill by the House followed favorable mark-ups by the House Judiciary and Energy and Commerce Committees within the last couple weeks. In addition, a major boost to the issue was giving by President Bush this summer, who highlighted the need for medical liability reform in several speeches and at his Economic Forum in Waco last month.

- Antitrust: On September 9, AMA President-elect Donald J. Palmisano, MD, and California Medical Association Vice President of Legal Affairs and General Counsel Catherine Hanson participated in a Federal Trade Commission Workshop on Health Care Competition Law and Policy. Their participation garnered significant favorable media attention on the issues impacting physicians in the current marketplace. Doctor Palmisano called on the FTC to redirect its healthcare efforts towards health insurers, in light of the levels of consolidation, followed by increased premiums, and increased health insurer profits. The press reports suggest that FTC got the message.
- Other issues the AMA has been addressing in Washington through either administrative or legislative action include 1.) EMTALA, 2.) Covering the uninsured, 3.) Limited English proficiency, 4.) Drug and vaccine shortages, including payment for vaccine administration consistent with what the RUC has recommended, 5.) Opposing consolidation of the CMDs and CACs, 6.) Medicaid and the Medicare coverage policy decision process, 7.) Patient safety, 8.) HIPAA, 9.) Disaster preparedness and 10.) A variety of public health issues including tobacco control, dietary supplements and antibiotic resistance.
- Doctor Rich commented on the Medicare Update issue. He noted that it is tragic that Medicine often does not speak with one voice on issues important to all practicing physicians as this has often caused medicine to be ineffective on the hill. He urged RUC Members and the leadership of specialty societies to understand what activities and policy positions their staff have been engaged in to form a united front on the Medicare Conversion Factor Update issue.
- Doctor Hoehn asked Ms. Marks to send all RUC participants a one-page summary report on the request for removing Medicare covered drugs from the SGR system. In addition, he requested the addition of all of the RUC participants' e-mail addresses to the AMA's grassroots global e-mail list so that they may be informed of the various issues the AMA is addressing.

#### VIII. Relative Value Recommendations – Requests from CMS:

##### **Excision of Benign Tumor of Mandible/Maxilla (Tab 4)**

**Presenter: Lanny Garver, DMD, American Association of Oral & Maxillofacial Surgeons/American Dental Association**

Two revised CPT codes (21030 and 21040) were re-reviewed by the RUC in September 2002. Previously, the RUC reviewed four new codes in this family and made recommendations to the Center's for Medicare and Medicaid Services in May 2002. The four new codes (21046, 21047, 21048 and 21049) were developed to reflect the increased intra-operative time, the extent of surgery and the increased intensity level required to perform these services as compared to the codes currently being used, which inadequately describe the intensity of the procedures being performed.

##### **Codes 21030 and 21040**

In April 2002, the RUC reviewed codes 21030 *Excision of benign tumor or cyst of facial bone other than mandible, maxilla or zygoma, by enucleation and curettage* and 21040 *Excision of benign cyst or tumor, tumor or cyst of mandible, by enucleation and curettage simple*. The RUC decided to table these codes pending review of the CPT panel to clarify some language issues and the possible re-surveying of these codes by the



specialty societies pending the CPT decision. The CPT Editorial Panel did review these codes in May 2002 and modified the codes to state “enucleation and/or curettage.”

At the September 2002 meeting, the RUC reviewed survey data obtained by the specialty society. The reference CPT code 21555, *Excision tumor, soft tissue of neck or thorax; subcutaneous*, was selected by the survey respondents as having similar total work (work RVU= 4.35), and is comparable to the survey median RUV for CPT code 21030 and the 25<sup>th</sup> percentile for CPT code 21040. In addition, IWPUT analysis demonstrated that the RVU for of 4.50 is reasonable for both codes. The survey time for codes 21030 and 21040, 30 minutes pre-service time, 33/37 minutes, respectively, intra-service time, and 15 minutes post-service time, is similar to the Harvard time for 21555 (27 minutes pre-service time, 41 minutes intra-service time, and 10- minutes post-service time). Further, the total RVU for these two codes is less than budget neutral, and therefore is appropriate. CPT code 21030 had previously been valued at 6.46 with 10,330 claims and 21040 had previously been valued at 2.11 with 2,342 claims. **The RUC recommends a work relative value of 4.50 for CPT codes 21030 and 21040.**

#### **Previously Approved RUC Recommendations**

##### **Code 21034**

The work RVU for code 21034, *Excision of malignant tumor of maxilla or zygoma*, was not revised by the RUC, as the RUC viewed the CPT changes to be editorial in nature.

##### **Codes 21046 and 21048**

The RUC examined codes 21046 *Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion* and 21048 *Excision of benign tumor or cyst of maxilla, requiring intra-oral osteotomy (eg locally aggressive or destructive lesion(s))*. The RUC agreed with the specialty societies’ recommendations that these codes were needed to describe the intensity level of the service being performed. The RUC also agreed that the recommended relative work value for 21046 and 21048, both the survey medians, were appropriate. Both of these services are comparable in work to CPT code 21206 *Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)* (work RVU = 14.10 with a pre-service time of 75 minutes, intra-service time of 108 minutes post-service time of 57 minutes, post-op hospital time of 41 minutes and post-op office visit time of 95 minutes. Code 21046 and 21048 both had survey time of 75 minutes for pre-service, 120 minutes of intra-service, 30 minutes of post-service 1 hospital visit, discharge day and 5 office visits. The survey respondents did indicate that 21048 was more intense than 21046, therefore an incremental increase is appropriate.

**The RUC recommends a work relative value of 13.00 for 21046 and 13.50 for 21048.**

##### **Code 21047**

The RUC considered the specialty societies’ recommendation for code 21047 *Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg locally aggressive or destructive lesion)*. The RUC compared the work of 21047 to 21046 and agreed that the additional 120 minutes of intra-service work justified the increment of 5.75 over the base code. **The RUC recommends a work relative value of 18.75 for 21047.**

**Code 21049**

The RUC assessed the specialty societies' recommendation for code 21049 *Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)*. Because of the aggressive nature of the ameloblastic fibro-odontoma, which requires radical excision to obliterate them and prevent re-occurrence, the RUC agreed with the intensity of this service. Additional justification for this recommendation included the increased intensity associated with the extra-oral approach and the higher surveyed intensity as compared to the reference code 21206 *Osteotomy, maxilla, segmental (eg Wassmund or Schuchard)* (RVU = 14.10). In addition, the total time for the surveyed code (543 minutes) far exceeded that of the reference code (348 minutes). **The RUC recommends a work relative value of 18.00 for 21049.**

**Practice Expense**

The RUC reviewed the practice expense inputs for 21046-49 and recommends that the standard 90-day global package would be applied to all of these codes. For CPT codes 21030 and 21040, the RUC eliminated the one half 99238 discharge visit, (6 minutes) for the clinical staff time, as this service is typically performed in an office setting. All other inputs were approved.

**Gastrointestinal Endoscopic Services (Tab 5)**

Gastrointestinal Endoscopy Services (43259, 43231, 43232, 43242, 45341, 45342, 43219, 43256, 43268, 43269, 44370, 44383, 44397, 45327, 45345, and 45387): the specialty has indicated that they will not seek the RUC's further review of this issue.

**Ambulatory Blood Pressure Monitoring (Tab 6)**

**Presenter: James Maloney, MD, FACC, American College of Cardiology, Doug Leahy, MD, FACP, American College of Physicians – American Society of Internal Medicine**

The RUC reviewed four new codes that were established to describe the use of an ambulatory blood pressure monitoring system.

**CPT codes 93784 and 93790**

Two codes 93784, *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* and 93790, *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report* describe the physician work component. The RUC agreed with the specialty society that 0.38 work RVU is roughly equivalent to the work involved in 93734, *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming*. The RUC did not agree that there would be pre- or post-physician times and, therefore, deleted these times. **The RUC recommends a work RVU of 0.38 for CPT codes 93784 and 93790.**

**CPT codes 93786 and 93788**

Both CPT Codes 93786 and CPT code 93788 describe technical components of the procedure and do not include values for physician work. The RUC questioned the need for four codes, two that describe similar work procedures with similar technical components. The presenters clarified that two different physician codes are necessary, as the procedures can either be conducted in the office where the device does not require a third party, or in the office where a third party is necessary to obtain the device and the readings. Therefore, the different types of technical procedures performed could not be separated from the two descriptions of physician work.

**Practice Expense**

The practice expense direct inputs for codes 93784, 93786, and 93788 were modified. For codes 93784 and 93786 the amount of time required clinical staff to fill out paper work prior to providing ABPM services was reduced from 7 to 4 minutes and the service period was reduced from 28 minutes to 18 minutes. The staff type for the procedures of all three codes were modified from RN/Tech to RN/LPN/MTA. The amount of time for education/instruction/counseling was reduced from 10 minutes to 5 minutes. The amount of time for applying the monitor, calibrating and obtaining blood pressure readings was reduced from 15 minutes to 10 minutes. The specialty society request that 93786 and 93788 remain in the zero-work pool. The specialty indicated that an appropriate crosswalk of practice expense values is to the holter monitor codes, 93225 and 93226 respectively.

**Central Nervous System Assessments/Tests (Tab 7)**

The specialties involved requested more time to evaluate the data collected. They will present data on these services at the February 2003 RUC Meeting.

**IX. Relative Value Recommendations for CPT 2003**

**Bone Marrow Procedures (Tab 8)**

**Presenter: James Gajewski, MD, American Society for Blood and Marrow Transplantation, and Sam Silver, MD, American Society for Hematology Bone Marrow Facilitation Committee**

Thirteen new CPT codes were added and two were deleted to provide greater granularity to accurately code the specific procedures performed for each patient receiving bone marrow or stem cell transplantation. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 38205-38215 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic carcinoma)* to allow for different work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a Bone Marrow Transplant. Present codes 38231 and 86915 were not designed for modern procedures in bone marrow transplant and have virtually no relevance to the present stem cell harvesting and

processing work and procedures. The RUC understands that these services are not commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore, the smaller number of survey respondents (21) was expected.

**38204 Management of recipient hematopoietic progenitor cell donor search and cell acquisition**

The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient ... a level 4 new patient office visit representing 45 minutes of physician time* (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25<sup>th</sup> percentile surveyed intra-service time. The RUC agreed that there is no pre- and post-service time. **The RUC recommends a relative work value of 2.00 for CPT code 38204.**

**38205 Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; allogeneic**

**38206 Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; autologous**

These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 38205 and 38206.**

**38210 & 38207 – 38215**

In April 2002, the RUC reviewed CPT code 38210 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 38205 through 38215. The RUC first recognized that the vignette did not reflect an accurate description of the service of 38210, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison to the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 38207-38215. The RUC emphasized that these interim values should not be viewed as a "ceiling" for the future review, but serve as the best alternative until

future review is completed. Considering the similarities in work of code 86077 and 38210, the RUC had recommended an interim value of 0.94 for code 38210.

The RUC compared similarities in work and intensity of codes 86077 and 38210, and then agreed with the rank order established by the specialty society for the family of codes 38207 through 38215. The RUC agreed with the specialty society's recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. The RUC had recommended the following interim work relative values for CPT codes 38207-38215:

CPT Code	April 2002 Interim RUC Recommendation
38207	0.47
38208	0.56
38209	0.24
38210	0.94
38211	0.71
38212	0.47
38213	0.24
38214	0.24
38215	0.55

In September 2002, the RUC formed a facilitation committee to extensively discuss each of the services described in new CPT codes 38207 – 38215 and establish work relative value recommendations. The committee affirmed the decision made in April 2002 that these services do require direct physician involvement on a per patient level and should have assigned physician work. The RUC, however, remains concerned that the survey instrument and the corresponding summary of recommendation forms were not properly constructed. In addition, the RUC was concerned that further clarification is necessary in the CPT nomenclature for a few of these codes. Therefore, the RUC recommends that after further CPT revision, the specialty society conduct a re-survey of these services. The RUC proceeded to develop revised relative value recommendations, but will consider these relative values interim until the specialty society has the opportunity to re-survey.

In April, as an attempt to assign interim values, the RUC cross-walked the work relative value for 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) to new CPT code 38210 *Specific cell depletion within harvest, T-cell depletion*. Work relative values were then extrapolated to the remaining codes in this family, utilizing the relativity established by the specialty society recommendations. In September, the specialty suggested, and the RUC agreed, that the 86077 should have been cross-walked to 38212 *Red blood cell removal*, rather than 38210. The RUC intra-service time for 86077 is 40 minutes, which is closer to the survey intra-time of 38212 (30 minutes) than is the survey intra-time of 38210 (60 minutes).

The RUC reviewed, in detail, the physician involvement and work in the service described in CPT code 38212. The physician work is as follows:

- Pre-work: Reviewing data available prior to the time cells arrive in lab. This includes the phenotyping on donor and recipient; antibody information; and donor and recipient body weight. The committee agreed that the survey pre-time of 5 minutes seemed reasonable.
- Intra-work: The intra-work begins when the cells arrive in the lab. The tech would get the Hct. The physician would then look at CD 34 (flow cytometry) on monitor. Based on the cell counts and Ab counts, the physician would decide which technique to use to deplete the red blood cells. The tech then does the process. After the bleed off of red blood cells, the physician judges where to divide the sample. A Hct and CD34 are repeated. The physician looks at the results and decides whether to recombine components and repeat the separation. The typical patient has this process one time through (without the recombining), about one-third require re-separation. The RUC agreed that 30 minutes of physician intra-service work was reasonable. This includes multiple flow cytometry readings, decision-making, and other interactions with the technician.
- Post-work: Report and documentation. The RUC agreed that the specialties indication that this takes the form of a handwritten note is reasonable, given the detailed, sensitive information. The survey post-time of 15 minutes may be slightly over-stated. The RUC agreed that 10 minutes of post-service time was reasonable for the written report.

The RUC noted several additional factors in walking through the physician involvement and work in providing this service:

- The procedure requires intermittent physician time, sometimes over several hours. During that time, the physician is interacting with the technicians intermittently to determine how best to process cells.
- The procedure does not involve face-to-face patient contact. It occurs in an isolated laboratory.
- Physician work related to this procedure includes quality assurance work to support quality assurance for the lab. Physicians have not historically been separately compensated for quality assurance in the lab. Therefore, it is legitimate to consider this work as part of the work of the procedure.
- The risks to the patient are real. Mistakes can cause patient death. This adds to the stress of the procedure and decision-making.

Doctor Paul Rudolf, from the Centers for Medicare and Medicaid Services, informed the committee that deleted CPT code 86915 *Bone marrow or peripheral stem cell harvest modification or treatment to eliminate cell type(s) (e.g., T cells, metastatic carcinoma)*, where the services described in 38210-38213 were previously reported is paid on the clinical lab fee schedule. He noted that currently the payment for 86915 is based on reasonable cost. The specialty and RUC agreed that CMS would need to make a technical correction to the cost reporting instructions to eliminate the physician compensation from these specific labs if compensation for the physician's professional

service is included on the cost report. *Staff Note: Subsequent to the RUC meeting, the specialty determined that current program instructions provide for Code 86915 to be reimbursed on a reasonable charge basis when performed by independent laboratories and through the hospital outpatient prospective payment system when performed in outpatient departments. This information was shared with CMS.*

The RUC reviewed the proposed crosswalk of code 86077 *Blood bank physician services*, which has 40 minutes of intra-time and a work relative value of 0.94, to CPT code 38212. The RUC noted that since documentation is also required for 86077, the 40 minutes of intra-time might include some actual post-work. The RUC also agreed that the intensity of 38212 would be greater than 86077. After reviewing 38212 in detail, the RUC agreed that a comparison and crosswalk between 86077 and 38212 was reasonable.

The RUC also reviewed the appropriate work relative value for 38212 by using a building block method. CPT code 38212 includes two flow cytometry procedures. 88180 *Flow cytometry; each cell surface, cytoplasmic or nuclear marker* (work rvu = 0.36), includes a pre-service time of 5 minutes, intra-service time of 10 minutes, and post-service time of 10 minutes. The RUC agreed that a multiple of two 88180, with additional work for the interaction with the technician and the medical decision-making offered another validation of a work relative value of 0.94 for 38212. The RUC also recommends that a note be added to CPT to indicate that 88180 should not be reported in addition to this series of codes, as they include the work of flow cytometry.

**The RUC recommends a work relative value of 0.94 for CPT code 38212. The RUC recommends physician time of 5 minutes pre-time, 30 minutes intra-time, and 10 minutes post-time.**

The RUC then discussed the best way to extrapolate the appropriate value of 0.94 for 38212 to the rest of the family of codes. The RUC no longer agreed that the specialty society's recommended values were in the appropriate relativity, as these were derived from a very small consensus panel (two or three physicians). The survey medians appeared to correspond with the intra-service time for most services, so the committee agreed to use the survey medians for relativity. The RUC agreed that the intra-service survey time should be used, but felt that a standardized pre-service time of 5 minutes, and standardized post-service time of 10 minutes should be applied to all of the codes in this family. The RUC had significant concern, however, regarding the survey medians for three codes, 38208, 38209, and 38213. CPT code 38213 *Platelet depletion* was grossly overvalued by the survey respondents. CPT codes 38208 *thawing of previously frozen harvest* and 38209 *washing of harvest* should be referred back to CPT to create codes that describe thawing without washing and thawing with washing. The specialty had indicated a specimen must always be thawed before washing, so the current coding structure is not appropriate.

**The RUC, therefore, recommends the following for this family of services:**

- **CPT should add a note to this family of services to specify that CPT code 88180 *Flow cytometry* should not be reported in addition to these services as it is included in the valuation of these codes.**

- CPT should review the coding language for codes 38208 and 38209, as thawing of the harvest must always occur prior to washing of the harvest. The codes should be formatted as thawing without washing and thawing with washing.
- After these changes have been made by the CPT Editorial Panel, the specialty should re-survey the entire family of services with the following improvements to the survey instrument:
  1. a better reference service list, with other similar services included
  2. better education of survey respondents regarding the survey process
  3. better descriptions of the physician work involved
  4. assistance from the RUC facilitation committee prior to dissemination of the survey instrument
- The work relative values developed at the September RUC meeting are more valid than the values developed in April, however, the values for CPT codes 38207 – 38215 should remain interim until after these codes have been re-surveyed and re-presented to the RUC.
- A standardized pre-time of 5 minutes and post-time of 10 minutes should apply to each code. The survey median intra-service time should be recorded into the RUC database for all of the services.
- The work relative value for CPT code 38212 should be cross-walked from CPT code 86077 and the survey median relativity should be used to extrapolate work relative values to the rest of the services in the family, as follows:

**Commented [HLS1]:** Ultimately, 38213 should not have pre-service time ... does not involve donor data to review, only the recipient

CPT Code	September 2002 Interim RUC Recommendation
38207	0.89
38208	0.56
38209	0.24
38210	1.57
38211	1.42
38212	0.94
38213	0.24
38214	0.81
38215	0.94

**38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions**

The specialty presented a typical patient that is severely ill and in great risk. Approximately 25percent of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25<sup>th</sup> percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face)*



*patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 38242 was less intense than the reference code 38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic (work RVU = 2.24, Harvard total time 53). The RUC recommends a relative work value of 1.71 for code 38242, which has the approval of the specialty society.*

**Practice Expense:** The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

**Therapeutic Apheresis (Tab 9)**

**Presenter: Robert Weinstein, MD, and Sam Silver, American Society for Hematology**

**Therapeutic Apheresis Facilitation Committee**

New CPT codes 36511-36516 replace codes 36520 *Therapeutic apheresis; plasma and/or cell exchange* (Work RVU = 1.74) and code 35521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion* (Work RVU = 1.74) to allow reporting for the different types of therapeutic apheresis that are now performed. This also allows for better recording of the frequency of the different therapeutic apheresis procedures. Previously reported codes 36520 and 36521 were too vague to code for all the different apheresis procedures now in existence.

At the April 2002 RUC meeting, the RUC reviewed these new CPT codes and determined that the specialty should coordinate a survey process to collect data to present at the September 2002 meeting. The RUC recommended interim values of 1.74 for each of the therapeutic apheresis services, which is the value cross-walked from current codes 36521 and 36520.

In summer 2002, the specialty coordinated its survey efforts with subspecialty organizations and other specialties (eg, nephrology and rheumatology) and completed a survey of the work relative values for these services. The American Society of Hematology (ASH) also contacted the manufacturer associated with the supplies and equipment for this service to best determine the institutions that are currently performing this service. Data was accumulated and reviewed for presentation to the RUC in September.

The RUC reviewed the survey data and confirmed that the survey respondents understood that these six new CPT codes were assigned a global period of 000, and that all services typically provided to a patient on the day of the apheresis procedure are considered to be part of that procedure. It was understood that evaluation and management services typically provided to the patient on the day of the apheresis service would be included in the valuation of this service. Thus a separate visit code, such as an office or outpatient visit or subsequent hospital care, should generally not be reported by the physician on the day in which he/she reports an apheresis service. Separate reporting is permitted,

however, for a consultation, initial hospital care or discharge day management, when these separately identifiable services are performed.

The specialty indicated that most typically two physicians are involved in the treatment of these patients, one treating the disease and one providing the apheresis treatment. The typical patient receives numerous treatments. Therefore, the majority of the services are performed on a date when a consultation service would not be performed or reported.

The RUC reviewed and discussed whether it was appropriate for all six codes to be valued the same. The RUC had initially requested the survey following the April 2002 RUC meeting, as it appeared that there should be a differentiation in the work values between these codes. The specialty argued that the specialty is unable to identify any differentiation in work between these services, at this time. The specialty indicated that it was a priority to differentiate the coding to capture the facility expense related to these services. The RUC concluded that the work relative value should be consistent between the first five codes, 36511-36515 (U1-U5).

However, the RUC was not compelled that the work has changed for these services and recommends the existing relative value of 36520 (1.74), rather than the specialty recommendation of 2.10. The RUC also recommended that the new survey time be incorporated into the RUC database for these five services. The RUC also agreed that the physician time for codes 36511 – 36515 (U1-U5) should be consistent and recommends the survey time of 40 minutes pre-time, 20 minutes intra-time, and 15 minutes post-time.

The RUC, however, noted that the work relative value of 1.74 was too high for code 36516 (U6). The RUC recommends that CPT code 90935 *Hemodialysis procedure with single physician evaluation* (work RVU = 1.22), be used as a crosswalk. The intra-service time and the types of services are similar, and there is relative proportionality with the time difference between U6 and U1-U5. **The RUC recommends that the specialty request that CPT change the descriptor to specify “with physician evaluation.”**

**The RUC recommends the following work relative value units for these services:**

36511	U1	Therapeutic apheresis; for white blood cells	1.74
36512	U2	for red blood cells	1.74
36513	U3	for platelets	1.74
36514	U4	for plasma pheresis	1.74
36515	U5	with extracorporeal immunoadsorption and plasma reinfusion	1.74
36516	U6	with extracorpeal selective adsorption or selective filtration and plasma reinfusion	1.22

**Practice Expense Inputs:**

The specialty had determined these services are performed more than 95 percent in the facility setting and the RUC agreed that they should not be priced in the non-facility

setting at this time. Therefore, there are no direct practice expense input recommendations.

#### **Minimally Invasive Repair of Pectus Excavatum (Tab 10)**

These codes were developed to describe a new minimally invasive technique in reconstructive repair of the pectus excavatum or carinatum.

The specialty society and the RUC request that the minimally invasive approach for reconstructive repair of pectus excavatum or carinatum (CPT codes 21742 and 21743) remain carrier price until the specialty is able to acquire data for these services.

#### **Refilling of Implantable Infusion Pumps (Tab 11)**

**Presenter: Samuel Hassenbusch, MD, PhD, American Academy of Pain Medicine, Scott Fishman, MD, American Society of Anesthesiologists, Karl Becker, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons Facilitation Committee: Doctors Melvin Britton, Neil Brooks, John Derr, David McCaffree, Bernard Pfeifer, Gregory Przybylski, and Ken Simon, CMS observer**

CPT created a new code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)*. Although some providers were reporting this service with CPT code 96530, *Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* the specialty indicated that this code was inappropriately utilized. The physician services that are described by CPT code 95990 should have been previously reported using code 64999, *Unlisted procedure, nervous system*. Code 95990 describes a service requiring direct physician involvement and therefore, the service should have an assigned work value. The RUC clarified with the presenters that the physician and a registered nurse typically provide the service together. With this in mind, the RUC recommends that code 95990 include an editorial note to indicate that the physician is always present during the performance of this service.

A coalition of several specialties, including pain medicine, anesthesiology, neurosurgery, and spine surgery reviewed and surveyed the new CPT code 95990. A survey median of 1.82 was collected from 67 physicians, who indicated a pre-service time of 10 minutes, an intra-service time of 20 minutes, and a post-service time of 10 minutes. After the review of survey responses, the societies felt that the median survey value (1.82) was too high, therefore, the specialty society recommended 1.38, which is between the 25<sup>th</sup> percentile (1.11) and the median. The RUC did not agree that a work RVU of 1.38 was appropriate.

Although this code is billed often with an E/M code, the RUC understands that the survey respondents were surveyed for the specific work of the service only. The group identified relatively similar services for which they could compare work, time, and intensity. The RUC focused its comparison on two codes, 67500 *Retrolubar injection; medication (separate procedure, does not include supply of medication)* (Work RVU = 0.79) and 62252 *Reprogramming of programmable cerebrospinal shunt* (Work RVU = 0.74). The RUC surveyed the physician time for the 62252 is 15 minutes pre-service

time, 20 minutes intra-service time, and 10 minutes post-service time. This was comparable to the time for 95990 and the RUC agreed that 62252 serves as a good cross comparison to this new code. **The RUC recommends the work RVU of 0.77 for CPT code 95990.**

#### **Physician Time**

For code 95990, the RUC agreed that the 15 minutes pre-service time and the 20 minutes post-service time were reasonable. However, as the RN was also involved in the provision of the service, the RUC was concerned that the physician time in the post-operative period was too high, and the presenters agreed. The RUC recommends that the post-operative physician time should be reduced from 10 minutes to 7 minutes to eliminate this duplication of work.

#### **Practice Expense**

The RUC reviewed in detail the practice expense inputs for code 95990, and understood that with the types of drugs being administered, a RN staff type was appropriate for all the clinical staff activities except for time for cleaning the room. The RUC members agreed with the time distributions among the various clinical activities, as well as the medical supplies and equipment typically used for the service. The practice expense recommendations presented by the specialty society were accepted by the RUC.

### **X. Relative Value Recommendations for CPT 2004**

#### **Urethrolysis (Tab 12)**

**Presenter: James B. Regan, MD, American Urological Association**

CPT created one new code 5352X, *Urethrolysis, transvaginal, secondary, open (e.g. postsurgical obstruction scarring)*, to describe urethrolysis. Urethrolysis is a distinct operative procedure reserved for women who have undergone a prior urethral suspension procedure and have subsequently developed excessive periurethral scarring and obstructive voiding symptoms. Current codes do not capture the operative technique and work involved in dissecting and mobilizing the urethra away from the dense surrounding fibrous tissue.

The specialty society surveyed 79 physicians who perform the procedure and a majority of the respondents indicated that the key reference service code should be CPT code 57287, *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* (RVU=10.71). The survey median for urethrolysis was 14.06, substantially higher than the RVU for the reference service code. However, physician work for the new code was consistently identified as being more intense and more complex than that of sling removal or revision, also reflected by the longer intra-service time for urethrolysis (90 minutes) when compared to the reference service code intra-service time (70 minutes). After review of the data, the RUC and the specialty society determined that the 25<sup>th</sup> percentile RVW (12.21) accurately reflected the actual work performed in comparison to the key reference service. **The RUC recommends a work relative work value of 12.21 for CPT code 5352X.**

CMS recommended that the specialty society provide a letter to Administar regarding the use of cystourethroscopy. The Correct Coding Initiative may require that an edit to appropriately indicate that cystourethroscopy should not be reported in addition to Code 5352X. The RUC requests that specialty society work with CPT to editorially revise the description of the code to include that the procedure cystourethroscopy is included in this services and should not be reported separately.

#### **Practice Expense**

The RUC accepted the practice expense inputs as submitted, which are based on the standard 090 practice expense inputs.

### **XI. Practice Expense Advisory Committee (PEAC) Update**

Doctor Moran informed the RUC that the PEAC met earlier in September and reviewed over 400 codes. The PEAC recommendations for those codes will be forwarded to the RUC at the January 2003 meeting. The PEAC agreed to standard pre-service times for 000 and 010 day global codes. Specialties have already identified approximately 500 codes that might contain pre-service time and the PEAC will review these codes at its January 2003 meeting. The PEAC also agreed to review the codes in the zero-work pool, the CMS crosswalked codes, as that the remaining 090-day global period codes that have not been fully refined. Based on the remaining work, the PEAC anticipates that it will complete its work by March 2004.

### **XII. Research Subcommittee Report (Tab 14)**

Doctor Hayes presented the report of the Research Subcommittee. The RUC first discussed the recommendations pertaining to the use of IWPUT in the RUC process. The research subcommittee presented four recommendations on IWPUT. Doctor Lichtenfeld proposed amendments that would 1) clarify the role of IWPUT in the RUC process and 2) codify the currently accepted principle that the primary source of information for evaluating physician work is the RUC survey.

Doctor Lichtenfeld stated that his amendments are intended to clarify the survey instructions by adding language stating that the RUC has the option to allow the use of building block/IWPUT analysis to determine physician work, provided there is acceptable evidence explaining why survey data should not be used. The RUC discussed the role of IWPUT and agreed that the option of accepting building block/ IWPUT analysis for a particular code as the primary source of determining physician work is sufficiently justified. It was pointed out that the RUC has always used the RUC survey as the primary source, however, the RUC has allowed specialties to vary from using RUC survey data as long as there was acceptable evidence indicating why survey data should not be used. This use of IWPUT is therefore at the RUC's discretion. The RUC accepted these amendments as part of the Research Subcommittee recommendations.

The second issue addressed by Doctor Lichtenfeld's proposals intends to codify the currently accepted principle that the RUC survey is the primary source for evaluating physician work. Although the existing RUC documents can be interpreted as requiring RUC surveys, several RUC members felt that the current survey instructions did not

explicitly state that the RUC survey data is the primary source of information. The RUC members agreed that the instructions should be revised to clearly state that the survey is the primary source of data.

In reviewing these recommendations by the Research Subcommittee, the RUC refined motion 3 so that it is clear that specialties have the option to use IWPUT, and it is not a requirement. If a specialty chooses to use IWPUT to support their recommended RVU, they should add a Building block/IWPUT analysis table for both the survey code and the reference code.

Doctor Hoehn stated that once staff make the changes to the survey instructions, the RUC will have an opportunity to review the wording changes based on the following four recommendations. [Staff Note: The revised documents were e-mailed to the RUC for review on October 31, 2002].

**Motion 4**

**Modify the “AMA/Specialty Society RVS Update Process: Instructions for Specialty Societies Developing Work Value Recommendations,” to add the following:**

**Building Block/IWPUT analysis may be used to validate survey data.**

**Note: Provided acceptable evidence, the RUC has the option for accepting Building Block/ IWPUT analysis for a particular code as a source to determine physician work.**

**Revise “Instructions for specialty societies developing work value recommendation” to include the principle that survey data remains the primary source of information to value physician work for codes presented to the RUC. (The RUC instructions will be consistent with the standard RUC methodology document, which specifies that a survey with 30 respondents is required for each service)**

**Motion 3:**

**Modify the Summary of Recommendation Form, as follows:**

- **Redesign the “data summary” section as a table that includes all of the time and visit elements asked for on the RUC survey (see Attachment B);**
- **Add a “total time” row to the table that compares time components of the survey code and the reference code(s) (see Attachment C); and**
- **If the specialty society elects to use an IWPUT analysis to develop the work relative value units, add a Building Block/ IWPUT analysis table for both the survey code and the reference code (see Attachment D).**

**Motion 2**

**Modify Question 2 of the 000, 010, and 090 AMA/RUC physician work surveys to separately ask for**

- **Pre-service “evaluation and positioning time” and, “scrub, dress, and wait time” (See Attachment A).**

**Motion 1**

**Accept the following standard IWPUT formula for codes that have a global period, when total work RVW, intra time, and pre/post time and visits are available (note: RVW stands for work RVU):**

**Pre-service RVW** = [0.0224 x (day prior evaluation time + same day evaluation time + positioning time)] + [0.0081 x pre-service scrub, dress, wait time]

**Post-service RVW** = (0.0224 x immediate post-service time) + (hospital/office visit E/M RVWs)

**Intra-service RVW** = (IWPUT) X (Intra-service time), **or**

**Intra-service RVW** = (Total RVW) – (Pre-service RVW + Post-service RVW)

**IWPUT** = (Intra-service RVW) / (Intra-service time)

(This formula will also be included in the RUC’s instructions)

**Critical Care in the Global Period**

The Research Subcommittee proposed acceptance of a RUC statement of critical care that will be shared with CMS to prevent a reduction in payment for surgical codes as well as to prevent denial of payments to critical care physicians. The statement was based on the draft RUC statement that was reviewed at the last RUC meeting and was revised by the Society of Critical Care Medicine. Doctor Mayer proposed several additions to the statement to recognize that critical care services related to the surgery that are provided by the surgeon have always been bundled in the surgical global payment. Doctor Mayer stated that such a change will help to prevent a reduction in surgical payments for those global surgical services that explicitly include critical care services as part of the global package, as well as to prevent a denial of payment to critical care physicians.

**The RUC accepted the statement with the following changes:**

Critical care services related to the surgery, when performed by the operating surgeon, have always been bundled into surgical global payment. In addition, CMS has had a long-standing policy that Medicare would pay for critical care services provided by the operating surgeons or other practitioners, when these services were unrelated to the primary surgical procedure or were provided to burn or trauma patients.

In order to better capture time and surrogate work value, the RUC in 1998 refined its survey instrument by listing the critical care codes as possible surrogates for the value of post-operative critical care work in the ICU that the operating surgeon provides to patients following certain procedures.

The RUC, therefore, requests that CMS instruct carriers that the post operative critical care services provided by the ~~non-operating~~ another physician to patients are not duplicative of the post operative services that may be provided by the operating surgeon.

#### **ZZZ Codes**

Given the expected change in definition for ZZZ codes may be published by CMS on November 1, 2002, the RUC will need to begin examining the implications of the definition change. As a first step the RUC passed the following motion:

**After the ZZZ code definition change is published by CMS in the Final Rule, the RUC will ask specialties to identify any ZZZ codes whose physician work may be affected by the definition change.**

**The Research Subcommittee report was approved and is attached to these minutes.**

### **XIII. Administrative Subcommittee (Tab 15)**

Doctor William Gee presented the Administrative Subcommittee Report. The Administrative Subcommittee met Friday, September 27, 2002, to discuss five issues. Regarding the inclusion for permanent membership, there was extensive discussion. The RUC agreed that their previous April 2002 action should specifically list the criteria for membership on the RUC should be revised to address the following issues:

- **The inclusion of the criteria for permanent membership (eg, ABMS specialty) into the RUC's Structure and Functions should include specific language that clearly states that these are the criteria to be considered when a new application for a seat on the RUC is received. The current permanent members are not subject to removal from the RUC if they do not meet each specific criterion.**
- **The process for soliciting a permanent seat on the RUC should also be outlined in the RUC's Structure and Function document. The process will include a written request and will provide for the specialty to make a formal presentation to the full RUC. Data will be prepared by AMA staff to indicate whether the specialty meets each of the eligibility criteria.**

The Administrative Subcommittee also clarified that the RUC had indicated in its review of this issue at the April 2002 meeting that the Subcommittee had the discretion to review any issues related to the RUC's Structure and Functions and Rules and Procedures documents. The RUC will review any proposal submitted by the Administrative Subcommittee during the normal course of the RUC meetings.

**In addition, the RUC approved the following:**

**The RUC CD-ROM should not be distributed outside the RUC process until refinement of the physician time data and the direct practice expense inputs have been completed.**



**Regarding observers at the RUC Meetings, the RUC recommended that general counsel review the guidelines related to observers at the RUC.**

**The Administrative Subcommittee report was approved and is attached to these minutes.**

#### **XIV. Practice Expense Subcommittee Report (Tab 16)**

Doctor Barbara Levy presented the Practice Expense Subcommittee recommendations to the RUC.

##### **Physician Time Allocations**

The Subcommittee first reviewed and recommended physician time allocations, for practice expense purposes, for 14 codes presented by The American College of Surgeons and the American Academy of Ophthalmology. These time allocations are listed in the final subcommittee report attached to these minutes.

The Subcommittee also recommended a deadline of March 17, 2003 for the remaining 206 non-RUC surveyed codes for which the PEAC has requested time allocations. The Subcommittee recommended that AMA staff distribute the remaining list of codes to specialties so that specialties could look at all of the codes and determine whether any would apply to their specific specialty. [Staff Note: The list of codes was distributed to the RUC via e-mail on November 1, 2002.]

##### **Discharge Day Management and Surgical Procedures**

In February 2002 the practice expense subcommittee and the RUC agreed that there can be one or one-half of a discharge day management code for any surgical procedure code with global periods of 010 and 090 days when performed in the facility setting. At this subcommittee meeting, the subcommittee clarified its recommendation to:

**Administratively, for practice expense purposes, the RUC should allocate a full discharge day management code to those inpatient services and a half discharge day management time to outpatient or ASC codes, as determined by Medicare utilization data, with the caveat that specialty societies may look at their codes to determine place of service and tell the RUC, particularly those for which Medicare volume is lacking, where they fit. This does not change total physician time in the database, as this is an administrative change that will be noted in the database.**

##### Zero Work Pool Workgroup

The RUC accepted the following recommendations from the Practice Expense Subcommittee:

**The RUC will create a Zero Work Pool Workgroup that will focus on the following three items:**

- **Research the zero work pool issue**
- **Educate the RUC and specialty societies about the zero work pool as to what the implications are to be either in or out of the zero work pool**
- **To answer specific questions that CMS has raised in the Federal Register about the appropriateness of using their methodology**

**The full report of the Practice Expense Subcommittee is attached to the minutes.**

**XV. RUC HCPAC Review Board Report (Tab 17)**

Don Williamson, OD presented the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report. Doctor Williamson informed the RUC that Eileen Sullivan-Marx, PhD, RN, alternate Co-Chair and founding member of the HCPAC Review Board has retired and announced David Keepnews, PhD, JD, RN, FAAN as the American Nurses Association's new representative to the HPAC Review Board. Additionally, Doctor Williamson announced the October meeting of the Alternative Therapy Workgroup, an AMA sponsored group designed to work with alternative therapy providers to update their CPT code sets. Also, Doctor Williamson announced that the Structure and Functions of the RUC HCPAC as well as other related document are in the process of revision and a final draft recommendation will be presented to the Administrative Subcommittee at the February RUC Meeting.

The full report of the RUC HCPAC Board is attached to the minutes.

**XVI. Conscious Sedation Workgroup Report (Tab 18)**

Doctor Gee presented the report of the Conscious Sedation Workgroup. Doctor Gee indicated that the Workgroup is continuing to develop a list of codes where conscious sedation is an inherent component of the procedure. The Workgroup will review a revised version of this list at the February 2003 RUC meeting after another specialty society review is conducted. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

**The full report of the Conscious Sedation Workgroup is attached to the minutes.**

**XVII. Other Issues**

No other issues were discussed

**The meeting concluded at 4:50 p.m. on Saturday, September 28, 2002.**

**AMA/Specialty Society RVS Update Committee  
Research Subcommittee Report  
September 27, 2002**

On September 27, 2002 the Research Subcommittee met to discuss a variety of issues including the use of IWPUT in the RUC process, the RUC statement on critical care as well as other issues. The following subcommittee members were in attendance: Doctors James Hayes (chair), James Blankenship, Neil Brooks, James Borgstede, Melvin Britton, John Derr, John Mayer, Bernard Pfeifer, Don Williamson, OD, and Robert Zwolak.

**IWPUT**

The American College of Surgeons (ACS) and the American Association of Neurological Surgeons (AANS) made a presentation on the use of IWPUT in the development of physician work RVUs. Doctor Mabry outlined the history of the Harvard study and the development of intensity measures as part of the Harvard project. Doctor Mabry discussed in detail how CMS as well as the RUC have used IWPUT. The CMS contracted study by Health Economics Research was also discussed regarding its review of IWPUT. Doctor Mabry pointed out that CMS has used IWPUT, an integral part of ongoing refinement since the inception of the Medicare Payment Schedule, and also that the refinement of existing work RVUs can be accomplished without the need for surveys. The presentation concluded with the introduction of four recommendations on the use of IWPUT by the RUC. These include a standard IWPUT formula, a modification to the RUC survey, modification to the summary of recommendation form, and a modification to the RUC instructions to explicitly allow the use of IWPUT analysis.

The Subcommittee discussed in detail the ACS and AANS proposed recommendations. There were several questions regarding the development of the Harvard intensity measures and the “Stone Formula” and associated intensity measures. Several members were concerned that these values may need to be possibly reexamined in the future due to concern over the same sample sizes used to create the original intensity values. The Subcommittee also discussed the limitations of IWPUT calculations for either very short times or very large times. For example, it was pointed out that during long intra-service periods there are varying levels of intensity and using a single intensity may not be the most accurate measure. Also, it was discussed the IWPUT calculations for procedures with short times such as imaging codes may not result in accurate intensity values.

The committee also discussed the implications of using of IWPUT for groups of codes such as using a mini-survey or surveying an anchor code and using IWPUT and extrapolation to correct work values. Doctor Mabry stressed that any additional uses of IWPUT would need to be reviewed and ultimately brought to the RUC for discussion and approval.

Doctor Lichtenfeld discussed a number of concerns with the proposed recommendations. In particular he did not believe that IWPUT was used during the Harvard refinement process based on his participation in the process. Also, the RUC’s use of IWPUT can be characterized as a methodology that has been used primarily when the RUC determined that survey results were not valid. Since the RUC largely uses IWPUT as an exception, it should not be used as a standard for determining work RVUs. In addition, Doctor Lichtenfeld recommended that before widespread use of IWPUT calculations, better measurements of intra-service time such as operative logs would be needed.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

The committee began by discussing the fourth recommendation, which recommends allowing the use of IWPUT. A number of committee members were concerned that this recommendation would change the current RUC process and allow specialty societies to use IWPUT as the primary means of developing a physician work RVU. Several committee members felt that the current RUC survey instructions were ambiguous regarding an explicit requirement for using a survey before alternative methodologies could be employed. Other members felt that the recommendation would not change the RUC process since a RUC survey would still be needed to collect time data for calculating an IWPUT.

The Subcommittee also agreed to revise the ACS/AANS proposed changes in the summary of recommendation form to better account for pre-service evaluation. See attached revisions.

The RUC passed the motions in reverse order as follows:

**Motion 4**

**Modify the “AMA/Specialty Society RVS Update Process: Instructions for Specialty Societies Developing Work Value Recommendations,” to add the following:**

**Building Block/IWPUT analysis may be used to validate survey data.**

**Note: Provided acceptable evidence, the RUC has the option for accepting Building Block/IWPUT analysis for a particular code as a source to determine physician work.**

**Revise “Instructions for specialty societies developing work value recommendation” to include the principle that survey data remains the primary source of information to value physician work for codes presented to the RUC.** (The RUC instructions will be consistent with the standard RUC methodology document, which specifies that a survey with 30 respondents is required for each service)

**Motion 3:**

**Modify the Summary of Recommendation Form, as follows:**

- **Redesign the “data summary” section as a table that includes all of the time and visit elements asked for on the RUC survey (see Attachment B);**
- **Add a “total time” row to the table that compares time components of the survey code and the reference code(s) (see Attachment C); and**
- **If the specialty society elects to use an IWPUT analysis to develop the work relative value units, add a Building Block/ IWPUT analysis table for both the survey code and the reference code (see Attachment D).**

**Motion 2**

**Modify Question 2 of the 000, 010, and 090 AMA/RUC physician work surveys to separately ask for pre-service “evaluation and positioning time” and, “scrub, dress, and wait time” (See Attachment A).**

*Approved at the September 27 – 29, 2002 RUC Meeting.*

**Motion 1**

**Accept the following standard IWPUT formula for codes that have a global period, when total work RVW, intra time, and pre/post time and visits are available (note: RVW stands for work RVU):**

**Pre-service RVW** = [0.0224 x (day prior evaluation time + same day evaluation time + positioning time)] + [0.0081 x pre-service scrub, dress, wait time]

**Post-service RVW** = (0.0224 x immediate post-service time) + (hospital/office visit E/M RVWs)

**Intra-service RVW** = (IWPUT) X (Intra-service time), **or**

**Intra-service RVW** = (Total RVW) – (Pre-service RVW + Post-service RVW)

**IWPUT** = (Intra-service RVW) / (Intra-service time)

(This formula will also be included in the RUC's instructions)

**Critical Care in the Global Period**

The workgroup discussed the issue outlined in the June, 2001 proposed rule concerning the inclusion of critical care in the global surgical package. In that Rule, CMS questioned the appropriateness of including work relative value units related to critical care services in the post-service period of surgical codes with a 90 day global period. At the February and April 2002 RUC meetings, the RUC discussed the Research Subcommittee recommendation regarding the inclusion of critical care in the global period. The RUC requested the subcommittee to develop a statement explaining the RUC's position on inclusion of critical care in the global period so that it would be forwarded to CMS so that CMS could send the statement to its carrier medical directors.

The draft statement was sent to all RUC participants for review and comment. The American Academy of Pediatrics suggested adding a paragraph that requests a change in CMS policy to allow surgeons to bill separately for critical care services if the value of these services were not included in the global package. The Subcommittee members were concerned that the AAP proposal was contrary to existing CMS policy and since there was not an AAP representative to clarify the recommendation, the Subcommittee did not approve the suggested change.

The Subcommittee focused its discussion on the draft RUC statement and an alternative statement prepared by The Society of Critical Care Medicine (SCCM). A representative from SCCM addressed the Subcommittee and stated that the intent of the SCCM proposed statement was to use the draft RUC statement so that it emphasizes that when critical care services are included in the global package, the RUC is using surrogate work values. In addition, since surgeons can bill critical care separately if it is unrelated to the surgery, the SCCMS statement also states this policy. A number of the Subcommittee members felt that the SCCM statement more succinctly described the RUC position on critical care services in the global period and recommended adoption of the statement. Other Subcommittee members felt that the SCCM document failed to specifically state that when critical care is included in the global package, the

*Approved at the September 27 – 29, 2002 RUC Meeting.*

surgeon is providing services that are equivalent to critical care services, and the full work value for critical care services may not have been reflected in the final work RVU.

**The RUC recommends acceptance of the SCCM prepared statement with the following changes:**

Critical care services related to the surgery, when performed by the operating surgeon, have always been bundled into surgical global payment. In addition, CMS has had a long-standing policy that Medicare would pay for critical care services provided by the operating surgeons or other practitioners, when these services were unrelated to the primary surgical procedure or were provided to burn or trauma patients.

In order to better capture time and surrogate work value, the RUC in 1998 refined its survey instrument by listing the critical care codes as possible surrogates for the value of post-operative critical care work in the ICU that the operating surgeon provides to patients following certain procedures.

The RUC, therefore, requests that CMS instruct carriers that the post operative critical care services provided by another physician to patients are not duplicative of the post operative services that may be provided by the operating surgeon.

**Preliminary Uncompensated Care Survey Results**

Sara Thran discussed the Patient Care Physician Survey (PCPS), the new physician survey that replaced the SMS. New questions were added on charity care, EMTALA care and on-call hours. The Subcommittee discussed the preliminary results and was interested in reviewing the final results when they become available. It was suggested that there would be local variation in the provision of charity and EMTALA care. A representative from the ACEP asked the Research Subcommittee to clarify what more it plans to do on the issues of uncompensated care, which is one of the practice expense related issues assigned to the Subcommittee by the RUC. It was clarified that in addition to adding the EMTALA questions to the PCPS, the Research Subcommittee was willing to reviewing any proposals from specialty societies regarding changes in the way CMS uses uncompensated care in its current practice expense methodology.

**Multiple Code Survey Template**

During the past several years, specialty societies have used a variety of reformatted RUC surveys when surveying a family of codes. This is done to reduce the amount of paper sent to survey respondents in an effort to obtain a higher response rate. Sandra Reed, MD explained the difficulty in surveying a family of six laparoscopy codes and proposed a template that other specialties could also use in surveying families of codes. This would help to ensure that specialty societies use a standard format when surveying multiple codes. The Subcommittee was interested in whether or not such a format would affect the responses and suggested further research as this methodology continues to be utilized. In addition, the subcommittee felt that this survey format should only be used for closely related codes in the same family. Some Subcommittee members felt that the proposed template would result in higher response rates and better survey results. ACOG agreed to meet with the subcommittee during the next RUC meeting to discuss lessons learned from this survey process.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

### **Reference Service Time**

The subcommittee discussed the pros and cons of changing the RUC survey to ask survey respondents to provide time estimates for the reference service as opposed to the current practice of including either RUC or Harvard times on the summary of recommendation form.

Several Subcommittee members were concerned that if times of reference codes were collected, the data might be used for purposes beyond simply comparing the new/revised code to the reference code. Subcommittee members felt that since there are established RUC times and Harvard times (in the case that RUC times are unavailable), then it is unnecessary to ask survey respondents to provide time estimates. Some of the drawbacks of collecting time data for reference codes were mentioned such as it may be difficult for the respondents to estimate time without a vignette and also specialties have found different times for the same reference code due to different groups of survey respondents. For these reasons, a number of Subcommittee members felt that it would not be beneficial to change the current survey instrument. Therefore, the Subcommittee agreed to not change the survey instrument for purposes of collecting reference service time.

### **Change in the Definition of the ZZZ Global Period**

The Subcommittee discussed the implications for the RUC due to the most recent CMS Proposed Rule for the 2003 Medicare Payment Schedule. In the Proposed Rule, CMS proposes changing the definition of ZZZ codes in accordance with a request from the RUC. During the PEAC refinement of practice expense data, several specialties proposed that a number of add on codes have separately identifiable practice expenses beyond the intra-service time period. Specifically, the specialties stated that certain codes have a separately identifiable office visit in the post-service time period. The RUC agreed, and requested CMS to change the definition for ZZZ codes to delete the word “intra-service.” from the definition of ZZZ codes.

Once CMS finalizes its decision regarding ZZZ codes in November, the RUC will need to determine how the definition change may affect the practice expenses and the physician work associated with these codes. Several Subcommittee members felt that a change in the ZZZ definition may have implications for physician work, but that it should be discussed as part of the five-year review when the ZZZ code and the base code can be examined together. The base code would need to be examined to determine if the additional work was initially captured in the base code. Others felt that specialties should not be forced to wait until a five-year review to present codes that may be affected by the definition change. The Subcommittee did not resolve the issues of how or when to review the codes affected by the definition change. It was suggested that the subcommittee discuss the issue again at the next meeting and made the following recommendation:

**After the ZZZ code definition change is published by CMS in the Final Rule, The RUC will ask specialties to identify any ZZZ codes whose physician work may be affected by the definition change.**

*Approved at the September 27 – 29, 2002 RUC Meeting.*

**AMA/Specialty Society RVS Update Committee  
Administrative Subcommittee Minutes**

The Administrative Subcommittee met 11 am, Friday, September 27, 2002, to discuss five issues. The following subcommittee members were present: Doctors William Gee (Chair), Alexander Hannenberg, Charles Koopman, Gregory Przybylski, Sheldon Taubman, Richard Whitten, and Nelda Spyres, LCSW.

1.) Request to review the process related to Gastroenterology's request for a permanent seat on the AMA/ Specialty Society RVS Update Committee

Doctor Lichtenfeld presented a letter requesting a review of the process used to consider the gastroenterology request for a permanent seat on the RUC. Doctor Lichtenfeld explained that he was concerned that the gastroenterology representatives did not have an opportunity to present their arguments to the full RUC committee. The Administrative Subcommittee explored this issue and agreed that the RUC did not have a formal process outlined regarding the process for such an application. The Subcommittee understands that while gastroenterology did make a presentation to the administrative subcommittee and would have been afforded the opportunity to make a verbal presentation to the full RUC, gastroenterology did not attempt to do so at the April 2002 RUC meeting. The gastroenterologists indicated that they did not feel their comments would be persuasive as the tone of the discussions at the full RUC indicated that the committee would not be receptive to changing the committee composition.

After extensive discussion of this issue, the RUC agreed that their previous April 2002 action should specifically list the criteria for membership on the RUC should be clarified to address the following issues:

- **The inclusion of the criteria for permanent membership (eg, ABMS specialty) into the RUC's Structure and Functions should include specific language that clearly states that these are the criteria to be considered when a new application for a seat on the RUC is received. The current permanent members are not subject to removal from the RUC if they do not meet each specific criteria.**
- **The process for soliciting a permanent seat on the RUC should also be outlined in the RUC's Structure and Function document. The process will include a written request and will provide for the specialty to make a formal presentation to the full RUC. Data will be prepared by AMA staff to indicate whether the specialty meets each of the eligibility criteria.**

The Administrative Subcommittee also clarified that the RUC had indicated in its review of this issue at the April 2002 meeting that the Subcommittee had the discretion to review any issues related to the RUC's Structure and Functions and Rules and Procedures documents. The RUC will review any proposal submitted by the Administrative Subcommittee during the normal course of the RUC meetings.

2.) Distribution of CD-ROM to Medical Directors

A request had been made to provide the RUC Database CD-ROM to the Medicare Carrier Medical Directors. The Administrative Subcommittee determined that while the database may be helpful to both payors and practicing physicians, it is not yet ready for dissemination. The Subcommittee recommends that the refinement of the physician time data and the direct practice expense inputs be completed prior to any distribution of the RUC CD-ROM.

*Approved at the September 27 – 29, 2002 RUC Meeting.*



**The RUC approved the following:**

**The RUC CD-ROM should not be distributed outside the RUC process until refinement of the physician time data and the direct practice expense inputs have been completed.**

3.) Template for RUC Review Process

At the April 2002 RUC meeting, Doctor Levy discussed the development of a template to aid the review of survey materials by RUC members. The RUC agreed that this template may be useful and suggested that the AMA staff circulate the document to RUC members prior to each RUC meeting.

4.) Creation of a mission statement

During the meeting, Dr. Chris Nunnick, a RUC observer, proposed the development of a formal mission statement for the RUC. The Administrative Subcommittee discussed the current wording of the "Purpose of the RUC" in the Structure and Function document and determined that at this time, the current wording sufficiently reflects "Purpose" of the RUC.

5.) Observers at the RUC

Doctor Hoehn requested that the Subcommittee review the discretion of the Chair to allow, or not allow, certain individuals to attend the RUC meetings. The Subcommittee reviewed the existing Structure and Functions document regarding Observers at the RUC meeting and agreed that no formal changes in this process were required. The Subcommittee, however, recommends that the names of individuals granted observation status at each RUC meeting, by the RUC Chair, be published in the agenda materials. This would allow members to review the names and provide any objections or comments prior to the meeting. The RUC recommended that general counsel review the guidelines related to observers at the RUC.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

## **AMA/Specialty Society RVS Update Committee Practice Expense Subcommittee Report**

The Practice Expense Subcommittee met during the September 2002 RUC meeting to continue its discussion of reallocating total physician time components, and on the creation of a zero work pool workgroup. The following subcommittee members participated: Doctors Levy (Chair), Brill, Brown, Gage, Gerety, McCaffree, Moran, Rich, and Schmidt.

### Reallocation of Physician Time Components

The during the April 2002, the RUC acted on two issues involving the reallocation of physician time, brought forth initially from the Practice Expense Advisory Committee (PEAC) in order to facilitate their practice expense refinement process. The first issue involved inconsistencies in the number and level of E/M services in the global period for 227 non-RUC surveyed 010 and 090 day global CPT codes. The second issue involved inconsistencies in the assignment of discharge day management services in the global surgical package. At the April 2002 RUC meeting, the subcommittee and the RUC resolved a small portion of its work on these two issues and were again presented with additional specialty society recommendations.

### Harvard Total Physician Time Allocation Codes

The Practice Expense Subcommittee first reviewed 14 specialty society recommendations relating to 227 non-RUC surveyed 010 and 090 day global CPT codes having only a Harvard total physician time component, and are missing post-operative hospital and/or office visits. The PEAC and the RUC use the number and level of post operative office visit data elements in refining and establishing practice expense input data associated with 10 and 90 day global period codes. Therefore the Practice Expense Subcommittee has the task of reviewing specific physician time component allocations from specialty societies for these codes.

The American College of Surgeons (ACS) submitted one code and the American Academy of Ophthalmology (AAO) submitted 13 codes as physician time allocations.

Subcommittee members initially had some concerns that a few of the codes, according to the Medicare utilization data, were inpatient codes yet the specialty society hadn't allocated any time for the hospital. The subcommittee however, agreed that the specialty society's recommendation reflected current medical practice regardless of the Medicare data, and that the specialty has the most expertise in the standard of care for these codes. **The subcommittee reviewed each time allocation in detail and recommends the following physician time allocations to the RUC:**

*Approved at the September 27 – 29, 2002 RUC Meeting.*

Code	Specialty	Glob	Pre Time	Intra Time	Immed. Post	99231	99232	99233	99238	99212	99213	99214	Total Time	Hrwd Time
19020	ACS	090	48	48	14	19				45			174	174
21256	AAO	090	75	191	20		30			30	46	38	430	430
21280	AAO	090	60	74	15					15	46	38	248	248
21282	AAO	090	60	55	15					15	23	38	206	206
21390	AAO	090	60	147	20		30			15	23	38	333	333
40818	AAO	090	30	61	20					15			126	126
65860	AAO	090	45	44	15					15			119	119
66700	AAO	090	45	47	15					15	23		145	145
66710	AAO	090	45	41	15					15	23		139	139
66740	AAO	090	45	41	15					15	23		139	139
67414	AAO	090	45	94	30					15	23	38	245	245
67445	AAO	090	45	142	30					30	23	38	308	308
67570	AAO	090	45	124	30					30	23	38	290	290
68761	AAO	010	5	17						15			37	37

In addition the Subcommittee discussed a deadline for the remaining 206 non-RUC surveyed codes for which the PEAC has requested time allocations. Subcommittee members expressed their concern over the specialty society designation identified through Medicare utilization data, is incorrect. The Subcommittee recommended that AMA staff distribute the remaining list of codes to specialties so that specialties could look at all of the codes and determine whether any would apply to their specific specialty. Specialties would assign themselves to the codes, and present recommendations to AMA staff by March 17, 2003 for April 2003 RUC meeting. The Subcommittee believed these recommendations could be presented to the Subcommittee prior to this time but no later. Codes not reviewed at the April 2003 RUC meeting would remain as is in the database, and would have to be dealt with at the PEAC.

#### **Data Difficulties with Post-Operative Discharge Day Management Physician Time, for Surgical Procedures**

In February 2002 the practice expense subcommittee and the RUC agreed that there can be one or one-half of a discharge day management code for any surgical procedure code when performed in the facility setting; in addition the RUC should:

- A. Reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the RUC physician time database.
- B. Reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the RUC physician time database.

In order to reallocate the existing post service time for RUC surveyed inpatient and outpatient codes, AMA staff used Medicare utilization data to categorize RUC surveyed codes into 3 categories; inpatient hospital, outpatient hospital/ASC, or office based. When AMA staff attempted to carry out the above RUC action they found 3 data issues which prevented them from carrying out the RUC action, and needed specialty society input. The AMA staff identified the following data issues and requested specialty society review and feedback.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

**Issue 1.**

19 inpatient and 7 outpatient classified codes did not have enough post-operative physician time available to reallocate. Specialty societies have the option to re-survey or advise the practice expense subcommittee on the appropriate physician time allocation.

**Issue 2.**

80 outpatient surgical and 6 office based classified codes currently have a full discharge day management code and hospital visits, but Medicare utilization data indicate that these services are not typically performed in an inpatient hospital setting. These codes should be reviewed by the specialty societies for possible errors or new developments in physician time. The specialties have been asked to prepare an explanation for the discharge management and hospital physician time elements for this subcommittee meeting.

**Issue 3.**

112 inpatient and 29 outpatient codes were classified by site of service based on Medicare frequency less than 30. Due to the low frequency associated with these codes the subcommittee requested specialty societies review these codes and provide input as to the appropriate site of service. Specialties were to indicate the site of service where these services are typically provided.

The Subcommittee first reviewed specialty society recommendations for the data issue 1, where the codes did not have enough post-operative physician time available to reallocate. The specialty society recommendations took time from either the pre-service, intra-service, and post-service time components to complete the 36 minutes necessary for a full discharge day management code, 99238. Subcommittee members had several concerns about reallocating time into the discharge day management time component in this manner. Subcommittee members expressed concerns that for some vaginal delivery and abortion code specialty recommendations, there shouldn't be post operative time because one physician may do the delivery, but another would be involved in the post operative and discharge management care. In addition, Subcommittee members expressed their concern that codes reviewed by the RUC prior to 1998 would be disadvantaged by the physician time reallocation, as the RUC survey requested different information at that time. It was explained that prior to 1998, post-operative care was expressed in time and not necessarily the number and level of post-operative care visits. For example, when a code reviewed by the RUC prior to 1998 was surveyed, discharge day management time was viewed to be between zero and 30 minutes. RUC recommendations prior to 1998 presented discharge day management as being something less than 31 minutes, whereas today RUC discharge day management recommendations are presented with a 99238 which is then assigned 36 minutes of physician time. With this in mind, the subcommittee believed that reallocating physician time for PEAC purposes should be done administratively, and not by changing any RUC approved physician time components. The Subcommittee therefore recommends the following to the RUC:

Administratively, for practice expense purposes, the RUC should allocate a full discharge day management code to those inpatient services and a half discharge day management time to outpatient or ASC codes, as determined by Medicare utilization data, with the caveat that specialty societies may look at their codes to determine place of service and tell the RUC, particularly those for which Medicare volume is lacking, where they fit. This does not change total physician time in the database, as this is an administrative change that will be noted in the database.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

**With this in mind, the Subcommittee revisited its first recommendation of Harvard total physician time allocation, and removed time from the discharge day management time component from the 14 code recommendation and put the time back in its proper time slot. Specialty society time allocation recommendations accepted at the April 2002 meeting may be revisited by specialty societies and resubmitted to the Subcommittee. With these actions the Subcommittee concluded its work on the data difficulties of allocating physician time to the discharge day management time component.**

Zero Work Pool Workgroup

In the June, 2001 proposed rule, CMS discussed several options for the zero work pool, that were developed by the CMS contractor, The Lewin Group. CMS concluded that the alternatives to the physician work pool presented by Lewin were not feasible. To date, CMS has not developed an alternative approach. As a result, the PE RVUs for codes in the zero work pool are partially based on the 1998 PE RVUs, and changes in technology are not reflected in the relative values. Additionally new codes that are placed in the pool have their PE RVUs determined by crosswalks to existing codes. Currently there are 866 codes in the zero physician work pool.

The Practice Expense Subcommittee discussed the creation of a workgroup to enlighten, educate, and make recommendations concerning the zero work pool. Specifically the Subcommittee would like CMS to make a presentation to the new workgroup on the history, application, and future options for the zero work pool. The Subcommittee made the following recommendation:

**The Practice Expense Subcommittee recommends that the RUC create a Zero Work Pool Workgroup that will focus on the following three items:**

- **Research the zero work pool issue**
- **Educate the RUC and specialty societies about the zero work pool as to what the implications are to be either in or out of the zero work pool**
- **To answer specific questions that CMS has raised in the Federal Register about the appropriateness of using their methodology**

## **RUC HCPAC Review Board Report**

**Swissotel**

**Chicago, Illinois**

**September 27, 2002**

On September 27, 2002, the RUC HCPAC Review Board met to review issues related to updating the Structure and Functions of the RUC HCPAC Review Board. The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair

Don E. Williamson, OD, Co-Chair

Robert Fifer, PhD

Mary Foto, OTR

James Georgoulakis, PhD

James E. Hayes, MD

Marc D. Lenet, DPM

Samuel M. Brown, PT

Arthur Traugott, MD

Emily Hill, PA-C

Joe Johnson, DC

Karen Smith, MS, RD, FADA

Nelda Spryes, LCSW

David Keepnews, PhD, JD, RN, FAAN

### **I. Call to Order**

Doctor Williamson called the meeting to order at 12:15 p.m. and made the following announcements:

- Eileen Sullivan-Marx, PhD, RN, alternate Co-Chair and a founding member of the HCPAC Review Board, has retired due to additional responsibilities. A new Alternate Co-Chair will be elected at the April HCPAC meeting during the usual election time frame. If the Co-Chair will not be able to attend the February HCPAC meeting, Doctor Williamson will select someone to be an alternate co-chair for this meeting.
- Introduction of David Keepnews, PhD, JD, RN, FAAN will be the American Nurses Association's new representative to the HCPAC Review Board.

### **II. Alternative Therapy Workgroup**

Desiree Rozell of CPT Staff briefed the HCPAC Review Board on the formation of the Alternative Therapy Workgroup. This workgroup was founded in response to the National Committee on Vital Health Statistics recommendation that the AMA, through the CPT Editorial Panel, work with alternative therapy providers to update their CPT code sets. To achieve this task, the chair of the CPT Editorial Panel has formed an Alternative Therapy Workgroup consisting of national organizations representing providers of alternative therapy, non-physician health care professionals from the HCPAC, members of the CPT Editorial Panel and members of the payer community. This workgroup will be meeting in Chicago on October 3, 2002.

### **III. Discussion of Draft Revisions to the HCPAC Structure and Functions**

Requests have been made to update the Structure and Functions of the RUC HCPAC. Staff has initiated this review by creating a discussion-only document. This document and related documents were discussed and final draft recommendations will be presented to the Administrative Subcommittee at the February RUC meeting.

### **IV. Adjournment**

Doctor Williamson adjourned the meeting at 1:05 p.m.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

**AMA/Specialty Society RVS Update Committee  
Conscious Sedation Workgroup  
September 27, 2002**

The Conscious Sedation Workgroup met on Friday, September 27 to discuss several issues related to the provision of conscious sedation. The following members were in attendance: Doctors William Gee (Chair), James Blankenship, Steve Krug, Neil Brooks, John Derr, Lanny Garvar, Alexander Hannenberg, Charles Mick, Alan Plummer, J. Baldwin Smith, and Maurits Wiersema..

**Review of List of CPT Codes Where Conscious Sedation is Inherent**

At the April 2002 RUC Meeting, the RUC agreed to ask specialty societies to review their services and indicate which CPT codes, in today's practice, inherently include conscious sedation. Twenty-eight medical specialty societies and HCPAC organizations responded to this request. AMA staff compiled the list of more than 250 CPT codes identified by the specialties.

The Workgroup reviewed the list of codes and identified several issues for further review:

- Some specialties did not respond to this request and others may not have identified a complete list of codes that inherently include conscious sedation in today's practice. The Workgroup identified several CPT codes (eg, 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*) in which conscious sedation is discussed in the information in the RUC database (pre, intra, or post-service work descriptions). AMA staff will conduct a comprehensive review of the database to identify all of these services. The Workgroup agreed that the RUC should write a letter to each specialty requesting another review of the issue and identifying specific examples.
- The list of 250+ codes should be re-circulated to all of the specialty societies with additional definition and explanation. For example, the Workgroup agreed that the codes should be included whether IV or oral conscious sedation is inherently provided. In addition, it should be clarified that only services where the sedation services are administered by or under the supervision of the operator (physician performing the procedures) should be included. If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code should not be included in the specialty's list.

The Workgroup will review a revised version of this list at the February RUC meeting, after another specialty society review is conducted. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

*Approved at the September 27 – 29, 2002 RUC Meeting.*

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### **PEAC Update**

The PEAC has established a workgroup to review and establish standardized direct practice expense inputs for conscious sedation. It is anticipated that this review will be completed at the March PEAC meeting. The RUC will consider these recommendations at the April 2002 RUC meeting.

### **Review of CPT Codes 99141/99142**

The Workgroup agreed that any review of the work relative values of the stand-alone codes for conscious sedation (99141 and 99142) would be premature at this time. The Workgroup will review this issue after the list of codes is complete. The Workgroup also discussed the possibility that the nomenclature and notes relating to the stand-alone conscious sedation codes may need to be further addressed as this project progresses. In addition, Workgroup members questioned whether the CPT Editorial Panel may wish to re-examine the issue of creating new pediatric specific CPT codes to eliminate the broader need for the conscious sedation codes.

### **Gastroenterology Request for Increase in Conscious Sedation Work**

No further information was presented by gastroenterology at this meeting regarding their request to increase each gastrointestinal endoscopy service to capture the perceived increase in physician work for conscious sedation. The Conscious Sedation workgroup discussed the gastroenterology original request again, but was unable to conclude that an increase was warranted at this time. The Workgroup may review this issue in the future if compelling data and arguments are provided by the specialty(ies) affected by any change in the work of the provision of conscious sedation.

*Approved at the September 27 – 29, 2002 RUC Meeting.*