

AMA/Specialty RVS Update Committee
Meeting Minutes
September 18 – 21, 2003

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Saturday, September 20, 2003 at 8:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)	M. Douglas Leahy, MD*
James Anthony, MD*	J. Leonard Lichtenfeld, MD
Dennis M. Beck, MD*	Charles D. Mabry, MD*
Michael D. Bishop, MD	John E. Mayer, MD
James Blankenship, MD	Bill Moran, Jr., MD
James P. Borgstede, MD	Bernard Pfeifer, MD
Neil H. Brooks, MD	Gregory Przybylski, MD
Norman A. Cohen, MD	Sandra B. Reed, MD*
Brett Coldiron, MD*	Daniel Mark Siegel, MD
James Denneny, MD*	J. Baldwin Smith, III, MD
John Derr, Jr., MD	Peter Smith, MD*
John O. Gage, MD	Nelda Spyres, LCSW*
William F. Gee, MD	Susan M. Strate, MD
Meghan Gerety, MD	Trexler Topping, MD
Robert S. Gerstle, MD*	Arthur Traugott, MD*
David F. Hitzeman, DO	James C. Waldorf, MD*
Peter Hollmann, MD	Maurits J. Wiersema, MD
Richard J. Haynes, MD*	Richard W. Whitten, MD
Charles F. Koopmann, Jr., MD	Robert M. Zwolak, MD
Gregory Kwasny, MD*	
George F. Kwass, MD*	

* Alternate

II. Chair's Report

Doctor Rich welcomed the RUC and made the following announcements:

- Those observing the meeting include:
 - American Speech-Language and Hearing Association:
Connie Barker, PhD, Becky Cornett, and Linda Wyatt
 - American Dental Association:
Frank Pokorny, Pam Proembski, Patricia Serpico, and Karin Wittich
 - American Academy of Dermatology: Alice Church, Bruce Dietchman, MD, and Vernell St. John
 - American Society of Neuroradiology: Robert Barr, MD
 - American College of Surgeons - Albert Bothe, MD

- American Academy of Ophthalmology - Andrew Calman, MD
- American Academy of Audiology - Jodi Chappell
- Society for Therapeutic Radiology and Oncology - Gregorio Hunt
- American Academy of Physical and Rehabilitative Medicine - Kim Kuman
- American Society of Gastrointestinal Endoscopy – Klaus Mergener
- American Society of Anesthesiologists - Brenda Lewis, MD
- Society of Nuclear Medicine - Denise Merlino
- American Optometric Association - Christopher Quinn, OD
- American Association of Clinical Endocrinology – W. Patrick Zeller, MD
- Medicare Carrier Medical Director for AZ and NV - William Mangold, Jr., MD
- New RUC members participating in this meeting include:
 - Peter Hollmann, MD, CPT Editorial Panel
 - Nelda Spyres, LCSW, substitute for Mary Foto, OTR
 - Dan Siegel, MD, American Academy of Dermatology
 - Maurtis Wiersema, MD, American Society for Gastrointestinal Endoscopy
 - Robert Zwolak, MD, American Association for Vascular Surgery
- CMS Staff attending the meeting include:
 - Edith Hambrick, MD, JD, CMS Medical Officer
 - Carolyn Mullen, MPA, Deputy Director of the Division of Practitioner Services
 - Ken Simon, MD, Medical Assistant to CMS Director Tom Scully- Congratulations to Doctor Ken Simon on his new responsibilities!
 - Pam West, PT, MPH, CMS Health Insurance Specialist
- David McCaffree, MD is retiring from the RUC. Doctor McCaffree's contributions as a founding member are greatly appreciated. The RUC extends a thank you to Doctor McCaffree for his efforts over the past 12 years.
- In June 2003, at the Annual Meeting of the AMA House of Delegates, Doctor Traugott presented Resolution 115. This resolution was very effective and was the subject of an article in the AMA Voice. For an update in the progress of this resolution, a large display has been created for viewing.

As the new Chair of the RUC, Doctor Rich shared administrative goals and procedures for RUC Meetings:

- Conflict of Interest Statements for RUC Members and Alternates must be signed and submitted to AMA Staff prior to participation in the RUC. In addition, all presenters must sign a Financial Disclosure Statement prior to their presentation to the RUC. Any presenter with a conflict of interest must verbally state his/her conflict of interest prior to their presentation. This policy will be strictly monitored and enforced
- Facilitation Committees –Chairs of facilitation committees should make certain that the committee’s decisions have solid written rationales and utilize RVUs from other CPT codes to further support the committee’s rationale.
- RUC Members and Alternates Reminder – Only the RUC representative or the RUC alternate should be seated at the table. If there are special circumstances requiring alternate substitutions, please provide written notification to the Chair and Sherry Smith so that the request may be considered prior to the meeting.
- Written Ballots – When a written ballot is used, and the member does not approve the specialty society recommended value, the member should mark “do not accept”, and note a relative value and rational that would be appropriate.

Other items of business:

- Proposed Rule Comment Letter – All RUC participants should have received and reviewed the RUC Comment Letter on the Proposed Rule. This will be discussed at the end of the meeting.
- Doctor Rich complimented the RUC staff on the New Staff and Advisor Orientation Program and the Mentor Program. He requested that the participants of this program provide feedback to staff.
- Doctor Rich noted that the Medicare Coverage Symposium, convened on September 18, 2003, was successful and well attended. He will send a thank you to Sean Tunis, MD, and Ron Davis, MD for their presentations to the RUC.
- Doctor Rich announced the members of the facilitation committees:

Facilitation Committee 1

(Pre-facilitation – Intrauterine Fetal Surgical Procedures Saturday, September 20, 7am)

Gregory Przybylski, MD, Chair

James Blankenship, MD

Neil Brooks, MD
John Gage, MD
Charles Koopmann, Jr., MD
Chester Schmidt, MD
Daniel Siegel, MD
J. Baldwin Smith, MD

Facilitation Committee 2

James Borgstede, MD, Chair
Michael Bishop, MD
John Derr, Jr., MD
Mary Foto, OT
Meghan Gerety, MD
John Mayer, Jr., MD
Trexler Topping, MD
Richard Tuck, MD
Richard Whitten, MD

Facilitation Committee 3

J. Leonard Lichtenfeld, MD, Chair
Norman Cohen, MD
William Gee, MD
David Hitzeman, DO
Bill Moran, MD
Bernard Pfeifer, MD
Susan M. Strate, MD
Maurtis Wiersema, MD
Robert Zwolak, MD

III. Director's Report

Sherry Smith made the following announcements:

- The next RUC meeting will be held January 29 – February 1, 2004 in Scottsdale, AZ at the Doubletree Paradise Valley. Please review the calendar of scheduled meeting dates
- RUC advisors and staff have the option to attend the RUC lunch, if they are willing to pay the cost of the lunch in advance. Those who have previously paid for the RUC lunch will find tickets behind their name badges. Upon entrance, these tickets must be presented to the servers.

IV. Approval of the Minutes for the April 24 – 27, 2003 RUC Meeting

The minutes were reviewed by the RUC and were accepted.

V. CPT Update

Doctor Peter Hollmann briefed the RUC on the following issues:

- Actions of the May and August CPT Meetings – Refer to the CPT Editorial Panel Coding Changes for 2005 Summary for recent actions.
- Comment on Conscious Sedation – At the August CPT Editorial Panel Meeting, the Panel agreed with the RUC that a list should be developed for procedures where conscious sedation is inherent to the procedure.

The Editorial Panel discussed the notes/guidelines to be included within CPT regarding the conscious sedation list. During the discussion, a few Panel members expressed the following concern: Should a reduced services modifier be used when an anesthesiologist provides the conscious sedation, as in the case of a complex patient? In this case, the physician would not be managing the conscious sedation directly.

Doctor Hollmann informed the RUC that a CPT workgroup including members from the RUC and PEAC has been formed to review this issue and it will be discussed at a future CPT Editorial Panel meeting

- November Annual CPT Advisors Meeting – Several topics will be discussed including: online evaluation and management services, XML hierarchy, work impairment assessments, and molecular genetics. The CPT HCPAC will address the definition of qualified professionals for testing and therapeutic procedures.
- E&M Workgroup – The goal of this workgroup is to better describe the current practices and to develop less restrictive descriptors that do not rely strictly upon the history, physical examination and medical decision making hierarchy. The workgroup proposed to base these procedures on magnitude estimation and using clinical examples as an instructive tool. A preliminary submission of 30 clinical examples from 11 specialties is under review, specifically, to edit language that could imply levels of severity. This process will be expanded to include all specialties once the review process is standardized. Next steps include implementing an internet survey to test the validity of the responses and then sending the clinical examples to Carrier Medical Directors for review. Finally, there will be cross-specialty analysis to determine work comparability across the clinical examples.

Concerns and questions raised by the American Academy of Family Physicians, the American College of Emergency Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology include: 1.) Physicians are familiar with the current E&M

system, and it would be difficult to change their current processes 2.) There is no guarantee that CMS would accept these new codes, and 3.) It is unclear whether CMS would require new documentation guidelines, or would the 1995 or 1997 guidelines be implemented. Other concerns included that many physicians have purchased documentation guidelines software based on the current E&M coding system and if this new system were to be approved this software would be obsolete. These issues will be addressed by the taskforce and, potentially, the AMA House of Delegates.

A RUC member questioned whether creating specialty specific Evaluation and Management (E&M) codes is still an option for the E&M Taskforce. Doctor Hollmann and Doctor Simon responded by stating that this topic has been discussed and is perceived as an unviable option.

- Doctor Neil Brooks, RUC Observer for the August 2003 CPT Meeting, reported that he found his experience highly educational and recommends that other RUC members take advantage of this unique opportunity. RUC members have volunteered to be RUC observers at the following CPT Meetings:
 - November 5 – 9, 2003 Doctors Richard Whitten and William Rich
 - February 6 – 8, 2003 Doctor Barbara Levy
 - April 29 – May 2, 2004 Doctor Charles Koopmann
 - August 12 – 15, 2004 Doctor Daniel Siegel
 - November 4 – 7, 2004 Doctor J. Baldwin Smith

VI. CMS Update

- Doctor Ken Simon stated that during the summer, the Centers for Medicare and Medicaid Services have addressed many issues including Medicare Reform, a Medicare prescription drug program, and HIPAA. The HIPAA transaction and code set guidelines, which take effect October 16, 2003, will be supervised and enforced by CMS officials. Upon review of the electronic claims submitted to CMS last month, approximately 11 percent of these claims were HIPAA compliant. It is anticipated that an announcement will be made September 25th, regarding whether CMS' contingency plan for non-compliance will go into effect, if so, claims submission for CMS and other private insurers will be described.
- CMS recently published a Proposed Rule that addresses the average wholesale price of drugs that physicians, principally oncologists, purchase for providing care to their patients. CMS has also proposed mechanisms to increase the practice expense payment component for the cost of administering these drugs in the office setting. Doctor Simon continued by stating that currently there are four different proposals outlined in the Proposed Rule that address different ways of refining AWP. In addition,

he alerted the RUC that oncologists are only one specialty affected by the refinement of AWP. Other specialties affected by this refinement include infectious disease, rheumatology, urologists and end stage renal disease specialists. Both the Senate and the House have an interest in these topics and are formulating their own proposals, however, it is currently unclear as to which proposal will be approved. It is anticipated that a decision will be rendered within the next couple of months.

- Doctor Edith Hambrick briefed the RUC on the recommendations to CMS regarding emergency departments and clinics from a joint task-force of the American Hospital Association (AHA) and the American Health Information and Management Association (AHIMA). The recommendations can be viewed on these organizations websites. Essentially, three levels of codes are involved for the clinic services, three levels for the emergency department, and one level for critical care. This system is primarily intervention-based, with a small increase for certain types of procedures that the task-force felt were important to recognize in the facility setting. CMS welcomes comments on this model, which is located on the AHA website and referenced in the Hospital Outpatient Rule.
- Doctor Rich requested that all specialties that deliver services referenced within this proposal carefully review this recommendation and the Hospital Outpatient Rule.
- Ms Carolyn Mullen reviewed established deadlines for the various Proposed Rules, recently published:
 - October 6th, the comment period for the Hospital OPPS Rule ends
 - October 7th - the comment period for the Final Physician Payment Schedule Rule ends.
 - October 14th - the comment period for AWP Rule ends.

Staff should send drafts for early review to cmullen2@cms.hhs.gov. Please send comments on code level items, that are more technical than policy driven (i.e. re-pricing issues or a mistake in the CPEP data), prior to including these concerns in a final comment letter, as these issues take more time to research and perhaps require a change the CMS database.

VII. Washington Update

Due to Hurricane Isabel, the Washington Update was not delivered. However, Doctor Rich stated that any changes to the Medicare Conversion Factor will require Congress to pass a Medicare reform bill. He encouraged all RUC members to educate their congressional representatives on this issue and advocate against the proposed Medicare cuts. He also encouraged all RUC

participants to carefully read the Proposed Rule, the comment letter, and AMA/Specialty Society updates to stay informed on this issue.

VIII. Relative Value Recommendations for CPT 2002

Non-Biodegradable Drug Delivery Implant (Tab 4)

William G. Gee, MD, American Urological Association

Codes 11981, 11982, and 11983 first appeared in CPT 2002, and were developed to describe insertion, removal, and removal with reinsertion of a non-biodegradable drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel kept the descriptors generic. At the April 2001 RUC meeting, the RUC recommended cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules. In 2002 the RUC again reviewed the issue and agreed to the interim crosswalk, but requested the specialty to conduct surveys for these codes and present a recommendation to the RUC at a future meeting.

During the September, 2003 RUC meeting the specialty explained to the RUC that a valid RUC survey could not be completed since the descriptors are too generic and not specific to urology. The specialty explained that it will submit a code change proposal to CPT requesting the insertion of a specific drug name into the descriptors.

The RUC discussed the potential difficulties involved in adding specific drug names to the code descriptor since it is the policy of CPT not to include proprietary drug or device names. The specialty may be faced with developing descriptors more specific to urology, but without a specific drug name reference.

The RUC also discussed how the need to recognize specific practice expenses should influence coding. Several RUC members were concerned that if CPT codes were developed for specific drugs or specific devices there would be a substantial increase in the number of CPT codes. This could lead to a situation where instead of having a single code, there would be multiple codes that differed only according to the device or drug used. The RUC discussed that one possible solution would be to maintain generic CPT codes, but foster the creation of drug or device specific HCPCs codes if there is really a need to differentiate among medical devices or drugs due to cost differences. The RUC requested that the Research Subcommittee begin to study this issue.

IX. Relative Value Recommendations for CPT 2004

Percutaneous RF Ablation of Bone Tumor Lesion (Tab 5)

**Bibb Allen, Jr., MD, American College of Radiology (ACR), Zachary Rattner, MD, Society of Interventional Radiology (SIR)
Facilitation Committee #3**

Percutaneous radiofrequency ablation of bone tumors or tumor-like lesions was approved by the Editorial Panel for CPT 2004. This is a new technology that could be a more effective and a safe alternative to, and/or supplement for, surgical treatment of the benign, but frequently painful bone tumor, osteoid osteoma.

The RUC initially heard from the presenters who agreed that the recommended physician work value should be reduced, and still reflect the amount of time and intensity required to perform the procedure. The RUC discussed several codes over a variety of comparable specialties. Specifically, the RUC agreed with the specialty societies' surveyed physician time, and used a building block approach to compare the relative value units across specialties, and to establish the proper work value.

The RUC believed that the intra-service work intensity could be compared to code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (010 day global, Work RVU = 15.19). Therefore the RUC used this code to establish the following building block approach to develop the proper work RVU for 20982. With this building block, the CT scan physician work is included in the intra-service time period.

Calculation of IWP/UT for 20982 using the Intra-Service Work Intensity from 47382:

Pre-Service

23 minutes of evaluation time with an intensity of 0.0224 = 0.515
15 minutes of positioning time with an intensity of 0.0224 = 0.336
10 minutes of scrub, dress, and wait with intensity of 0.0080 = 0.080

Intra-Service time of 80 minutes with an intensity of 0.0710 = 5.68

Post Service time of 30 minutes with an intensity of 0.0224 = 0.672

Total Recommended Relative Work Value for code = **7.28**

The RUC believed that the recommended value of 7.28 was an accurate work recommendation in relation to code 62287, *Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)* (090 day global,

Work RVU = 8.08) after backing out the post-service discharge day management and office visit information. In addition, the specialty societies' survey results indicated that the responders would agree with the recommended value.

Furthermore, the RUC reviewed codes 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (000 day global, work RVU = 7.39), and 45383 *Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (000 day global, work RVU = 5.87). RUC members believed that the similarities in the global periods, physician work, and time placed this new code within its proper rank order among these codes. **Therefore, the RUC recommends a relative work value of 7.28 for code 20982.**

Practice Expense Recommendation

The RUC reviewed the recommended practice expense inputs and determined that several modifications should be made to align the recommendations with PEAC standards. The clinical labor time for preparing the patient, cleaning the room and equipment were reduced from the specialty's initial recommendation. Medical supplies were modified to reflect the evaluation and management visit typically billed with this procedure. In addition, the RUC agreed with the specialty that the procedure could be performed in the facility and in a physician's office. The RUC recommended practice expense inputs are attached.

Hyoid Myotomy and Suspension (Tab 6)

James Denneny, III, MD, American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)

In November 2002, the CPT Editorial Panel created one new CPT code 21685, *Hyoid myotomy and suspension*, to describe a surgical procedure designed to help correct sleep-disordered breathing (obstructive sleep apnea syndrome) by functionally enlarging the retrolingual hypopharyngeal airway. Currently, unlisted code 21299, *Unlisted craniofacial and maxillofacial procedure* is used to describe this procedure, however, with the increasing recognition of sleep disordered breathing and the recognition that many of these patients have retrolingual airway narrowing, hyoid myotomy with suspension has become a commonly used method for surgical management of the disorder. The specialty society originally presented the code at the February 2003 RUC meeting. The RUC requested that the specialty society revise the code's vignette and re-survey the code. Due to conflicts in scheduling, the specialty society determined that it should represent the codes

at the September 2003 RUC Meeting. In the interim, the RUC recommended that the code be carrier priced for 2004.

The RUC considered random survey responses from 51 physicians. Survey respondents indicated that the new procedure had 75 minutes of pre-service time, 75 minutes of intra-service time, and 157 minutes of post service time. The RUC questioned the differences in pre-service time when comparing the reference service code 21199, *Osteotomy, mandible, segmental; with genioglossus advancement* (pre-service time= 30 minutes), to new code 21685 (pre-service time 75 minutes). The specialty society commented that new CPT code 21685 requires more pre-service time than the reference service code because service is typically performed on a patient with several comorbidities including obesity, hypertension, coronary artery disease and gastric disorders. These patients require significant pre-service coordination with other physicians. In addition, the specialty society commented that differences in the survey pre-service time may be attributed to one or more of the following factors: more survey responses on the current survey (51 vs. 23); better understanding of the existing procedure and the peri-operative work; and/or a different survey instrument. Although both CPT code 21685 and CPT code 21199 are similar, reference code 21199 has a slightly higher intensity/complexity for most measures when compared to CPT code 21685. Intra-operative, 21199 takes longer to perform and is more complex than the new code 21685 due to the four separate ostomoses in the mandible, which require a precise connection to one another. The survey indicated that the median RVW for the services should be 13 RVUs for new CPT code 21685. This takes into account the differences in time and work placing new CPT code 21685 below CPT code 21199. This also places 21685 at about the same work RVU as 31588, *Laryngoplasty, not otherwise specified (e.g. for burns, reconstruction after partial laryngectomy)* (work RVU=13.11) another reference code frequently chosen by survey respondents. The RUC agreed that the length of stay number of visits were appropriate as the patient's airway could be compromised and this process requires monitoring. **The RUC recommends a work relative value for CPT code 21685 of 13.00.**

Practice Expense

The RUC accepted the practice expense inputs after revising the medical supplies. The RUC questioned whether both the staple removal and the suture removal kit were necessary, the specialty society said that either could be used; the suture removal kit is most typical. In addition, there was a question about whether all of the masks and the sterile gowns were necessary in the post-operative visits. The number of sterile drape-towels was reduced from 9 to 6 and the number of sterile gowns was reduced from 3 to 2.

Bone Marrow/Stem Cell Services (Tab 7)

During the September, 2003 RUC meeting, the RUC developed interim recommendations for a series of bone marrow procedure codes. (code 38207 – 38215) However, CMS did not publish RVUs for these procedures since CMS is unsure about the extent of physician work involved in the codes. The specialty society has been in contact with CMS and is working on arranging site visits for CMS officials to observe the procedures. Since the RUC interim recommendation is valid for one year, the specialty requested an extension of the RUC interim recommendation while it continues its discussions with CMS. The RUC approved the following motion:

The RUC agrees to continue the interim recommendations for the bone marrow procedures codes (code 38207 – 38215), for another year until September 2004.

Intrauterine Fetal Surgical Procedures (Tab 8)

**George A. Hill, MD, American College of Obstetricians and Gynecologists (ACOG)
Pre-Facilitation Committee #1**

The CPT Editorial Panel has created a new family of intrauterine fetal surgical procedures to reflect this new technology performed to correct fetal abnormalities. Obstetrics and Gynecology worked with specialists in maternal fetal medicine to conduct two surveys, one mailed and one web-based and to convene a consensus panel to develop appropriate work relative values and practice expense inputs for these codes.

The RUC reviewed the family of services and made the following general observations:

- These codes represent services seldom performed. These services are performed by a small segment of specialized physicians in maternal fetal medicine or pediatric surgery, largely in academic medical centers.
- Each of the services include ultrasound guidance, therefore, the ultrasound guidance codes may not be separately reported.
- It is unlikely that more than one of these services would be reported on the same date. If in the rare occurrence that multiple services, or codes from this family, are reported on the same date, the multiple procedure modifier -51 would apply.
- There is extensive pre-service time for each of these services as the consent issues are more time-consuming and intense. The physician

must discuss potential complications for both the mother and baby. The physician must plan and discuss contingencies with the mother if there is fetal distress as a result of the procedure.

- The positioning time occurs both in the pre-time and then again during the intra-service time. The physician must determine where the baby is located prior to initiation of the service and may need to reposition the baby. The physician must then review the positioning of the baby again when performing the service and potentially re-position the mother and/or baby.
- The RUC approved the consensus panel time for each of these four services. CPT code 59072 was adjusted to include only 40 minutes pre-service evaluation time, rather than the originally recommended 60 minutes. It was also understood that CPT codes 59076 and 59072 would include a $\frac{1}{2}$ discharge day within the 30 minutes post-service time.

59076 (DD1) Fetal shunt placement, including ultrasound guidance

CPT code 59076 describes a service where a very large (13 gauge) needle is advanced into the fetus that is floating in amniotic fluid. Because of the larger instrument, the risk of damage to maternal abdominal wall, uterine, or placental vascular structures is much greater. The shunt has to be placed beneath the umbilicus, between the umbilical arteries (in a mid-trimester fetus this is a triangle 3 cms. high and 1 cm. wide at its base). Since the fetus is floating in fluid, if the needle approach is not nearly perpendicular to the fetal puncture site, the needle will cause the fetus to rotate and the needle will move tangentially through the fetal abdominal or bladder wall potentially lacerating an umbilical artery or other fetal vascular structure. The specialty argued that the work related to 59076 is much more intense than CPT code 36460 *Transfusion, intrauterine, fetal* (work rvu = 6.59) as the pre-service time is greater for 59076. The intensity of 59076 is higher than 35460 which describe a service utilizing a small needle, which is advanced into the umbilical vein, usually at the insertion of the umbilical cord into the placenta (i.e., a fixed structure). **The RUC recommends a work relative value of 9.00 for CPT code 59076.**

59072 (DD2) Fetal umbilical cord occlusion, including ultrasound guidance

The specialty presented that the work related to CPT code 59072 is greater than CPT code 36460. As stated above, 36460 describes a service where a small (20-22 gauge) needle is advanced into the umbilical vein, usually at the insertion of the umbilical cord into the placenta (i.e., a fixed structure). In the case of 59072, a large (3-5 mm.) expandable cannula is introduced into the amniotic cavity. Because of the larger instrument, the risk of damage to maternal abdominal wall, uterine, or placental vascular structures is much greater. Bipolar coagulation forceps are then introduced into the amniotic

cavity to attempt to grasp a floating loop of umbilical cord. One needs to be certain that the cord is, in fact the cord belonging to the affected fetus. Once one is certain that the correct cord has been grasped, that cord has to be coagulated, released, re-grasped and re-coagulated until one visually confirms terminal bradycardia or asystole in the affected fetus. The RUC also understands that the pre-service time is greater for 59072 as the physician must plan for contingencies if the healthy twin suffers fetal distress during this service. The RUC agreed that the work of 59076 and 59072 is comparable.

The RUC recommends a work relative value of 9.00 for CPT code 59076.

59074 (DD3) Fetal fluid drainage, (eg vesicocentesis, thoracentesis, paracentesis), including ultrasound guidance

The specialty presented that CPT code 59074 describes a service which involves inserting a needle under ultrasound guidance into a fluid filled structure within the fetus. 59001 involves inserting a needle under ultrasound guidance into a **very large** over distended uterus and then draining (through a fairly large (18 gauge) needle 1-2 liters of amniotic fluid while visualizing the needle tip to avoid injuring the fetus. When performing 59074 one has to insert a needle through the maternal abdominal and uterine wall into a much smaller amniotic cavity. Once the needle is visualized within the amniotic cavity, the needle needs to be redirected into the fetal organ or space targeted for drainage. The operator must visualize and avoid major fetal vascular structures and guide the needle so as to enter both the fetus and fluid collection with the needle approximately perpendicular to the fetal body wall and fluid collection. Since

the fetus is mobile if the needle course is not nearly perpendicular to the fetal body wall the needle will cause rotation of the fetus and the needle will track subcutaneously lateral to the puncture site, risking fetal injury. If the needle approach to the fluid collection is not perpendicular, the needle will frequently track in the wall of the organ to be drained, precluding drainage. The needle is usually relatively small (20-22 gauge) therefore drainage is relatively slow. Draining a structure within the fetus requires more skill and incurs more risk than draining a large pocket of amniotic fluid.

The RUC compared this service to CPT codes 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* (work RVU = 2.00, pre-time = 40 minutes; intra-time = 45 minutes, and post time = 20 minutes) and 61107 *Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device* (work RVU = 5.00, intra-service time = 30 minutes). The RUC agreed that 59074 (pre-time = 65 minutes; intra-time = 30 minutes, and post-time = 30 minutes) requires greater pre-service time and is more intense intra-operatively than these reference services. **The RUC recommends a work relative value of 5.25 for CPT code 59074.**

59070 (DD4) Transabdominal amnioinfusion, including ultrasound guidance

The specialty presented that CPT code 59070 describes a service which involves inserting a small (usually 20-22 gauge) needle under ultrasound guidance into a potential space (the amniotic cavity devoid of amniotic fluid) and infusing fluid to distend the amniotic cavity. 59001 involves inserting a needle under ultrasound guidance into a **very large** over distended uterus and then draining through a fairly large (18 gauge) needle 1-2 liters of amniotic fluid while visualizing the needle tip to avoid injuring the fetus. When performing 59070 one inserts a needle through the maternal abdominal and uterine wall and frequently placenta into what appears to be the amniotic cavity. The operator attempts to puncture the amnion without injuring placental surface vessels, umbilical cord or the fetus. Small (1-5cc) aliquots of sterile fluid are infused under direct sonographic visualization and the needle is repositioned (often several times) until intra-amniotic placement is ensured. At that point, a volume of sterile fluid sufficient to adequately distend the amniotic cavity is infused through the relatively small caliber needle. The volume infused is usually smaller than the volume removed in 59001; however, because of the smaller needle caliber, the infusion time is frequently longer. More skill is required to insert a needle into a potential space and there is greater risk of fetal or maternal injury.

The specialty noted and the RUC understands that a detailed fetal anatomic ultrasound may be reported following this service on the same date as the ultrasound would not have been possible to perform when the amniotic cavity is devoid of amniotic fluid.

The RUC again compared this service to 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* (work RVU = 2.00, pre-time = 40 minutes; intra-time = 45 minutes, and post time = 20 minutes) and 25028 *Incision and drainage, forearm and/or wrist; deep abscess or hematoma* (work RVU = 5.25, pre-time = 43 minutes, intra-time = 35 minutes, and post-time = **62** minutes). The RUC agreed that 59070 (pre-time = 65 minutes; intra-time = 30 minutes, and post-time = 30 minutes) requires greater pre-service time and is more intense intra-operatively than these reference services. The RUC also agreed that CPT codes 59074 and 59070 describe comparable work. **The RUC recommends a work relative value of 5.25 for CPT code 59070.**

Practice Expense

The RUC reviewed the specialty's recommended direct practice expense inputs and made several modifications to clinical staff time. The RUC did agree that pre-service clinical staff time of 18 minutes for office and 30 minutes for facility is appropriate as the consent time and education time for the mother and other family members is significant. Minor modifications were made to the list of supplies, including the addition of indigo carmine to

CPT code 59070. The revised practice expense inputs are attached to the recommendation.

Computer-Aided Detection Diagnostic Mammography (Tab 9)

Bibb Allen, Jr., MD, American College of Radiology (ACR)

CPT deleted code 76085 *Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (List separately in addition to code for primary procedure)* (Work RVU = .06) and created two new codes to differentiate the use of computer analysis for lesion detection when it is used in screening mammography as opposed to diagnostic mammography. CPT initiated this coding change at the request of CMS. Since CMS reimburses for screening mammography based on the physician payment schedule and diagnostic mammography is reimbursed from the hospital outpatient prospective payment system, CMS needed to have codes that differentiate between the use of computer analysis for lesion detection for screening and diagnostic mammography. CPT agreed to delete the existing codes and have the new codes specifically state whether the codes should be used for screening or diagnostic mammography. The RUC reviewed the coding changes and agreed with the presenters that the two new codes were equivalent in work and practice expenses to the deleted code 76085. The RUC reviewed the recommendation it made in February 2002 for code 76085 and concluded that the new codes had equivalent physician work and practice expense. Therefore, the RUC recommends cross walking the physician work relative values and the practice expense inputs of 76085 to codes 76082 *Computer analysis for lesion detection and further physician review for interpretation, with or without digitization of film radiographic images; screening mammography* and code 76083 *Computer analysis for lesion detection and further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography*.

**The RUC recommends a work relative value of .06 for CPT code 76082.
The RUC recommends a work relative value of .06 for CPT code 76083.**

Practice Expense

The RUC recommends that the practice expense direct inputs assigned to code 76085 should be cross walked to 7608X1 and 7608X2.

X. Relative Value Recommendations for CPT 2005

Endoscopic Anti-reflux Procedure (STRETTA) for GERD (Tab 10)

**Joel Brill, MD, American Gastroenterological Association (AGA),
Michael Levy, MD, American Society for Gastrointestinal Endoscopy (ASGE), Michael Eye, MD, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)
Pre-Facilitation Committee #2**

A CPT code was created to reflect a new approach for treating Gastroesophageal Reflux Disease (GERD). This approach involves the delivery of endoscopically-guided, radiofrequency energy via electrodes to the distal portion of the lower esophageal sphincter and the gastric cardia.

Code 432XX

The RUC reviewed the survey results provided by the specialty societies and observed that the societies' reference code, CPT code 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterectomy/papillotomy* (work RVU=7.39) had significantly more pre-service time (50 Minutes) in comparison to the pre-service of the surveyed code (35 Minutes). In addition, in comparing 432XX with the reference code 43262, the RUC noted that although the intensity/complexity measures for intra-service times are comparable, the intensity/complexity measures for psychological stress were significantly less. Therefore, the RUC agrees with the specialty societies' recommendation of 5.50 work RVUs, the 25th percentile of the survey data. **The RUC recommends a work RVU of 5.50 for CPT code 432XX.**

Practice Expense

This service is performed in the facility setting only. The specialty society's practice expense inputs for the facility setting were accepted. These practice expense inputs are consistent with other GI Endoscopy services (e.g. CPT code 43262) approved by the PEAC and the RUC.

ECG Vest (Tab 11)

James Blankenship, MD, American College of Cardiology (ACC)

In May, 2003 CPT approved a new code 937XX to describe the set up and programming if a wearable ECG vest. Two other codes 93741 and 93742 were revised to include the wearable cardioverter-defibrillator vest. The specialty requested that the RUC recommend carrier pricing for code 937XX because the ACC has been unable to find a sufficient number of physicians that perform the procedure. Specifically, the manufacturer of the device provided the specialty with the names of only 17 physicians that perform the procedure. The RUC questioned the creation of the code if the procedure is not widely used and some suggested that a category III code might be more

appropriate if the technology is not in widespread use. The specialty concluded that it would contact the manufacturer again and identify a larger group of physicians that would participate in the survey and present a recommendation to the RUC at either the February or April 2004 meetings.

The RUC approved a motion to table the issue.

XI. Five-Year Review Workgroup Report

Doctor Meghan Gerety presented the Five-Year Review Workgroup report regarding the timeline, processes, and methodology for the next Five-Year Review. The Workgroup will convene conference calls and meet again in January 2004 to finalize a proposal to submit to CMS.

The RUC extensively discussed the need to have all of the Rules and Procedures in place earlier in the initial process, so that specialties may begin to plan their review:

The RUC reviewed the timetable and recommends that all approved methodologies in effect at the February 3-6, 2005 RUC meeting, including the RUC survey instrument, will be acceptable methodologies in the Five-Year Review. The RUC also understands that specialties must present any alternative methodologies by the April 28-May 1, 2005 meeting, but emphasized that it is in a specialty society's best interest to present this information as soon as possible.

The RUC reviewed the methodological and procedural issues that were identified by the workgroup to be discussed further and resolved prior to finalizing the process for the next Five-Year Review. The RUC agreed with the workgroup that a RUC action regarding the role of practice expense refinement is necessary to resolve at this meeting. As the PEAC is continuing to meet until March 2004, it is unlikely that specialty societies would identify any practice expense input issues, independent of work value issues, in late 2004. A RUC member asked the RUC to clarify its statement to indicate that the RUC will "propose" to exclude practice expense refinement to CMS, as CMS will ultimately determine the process. The RUC recommended the following:

In developing the RUC proposal to CMS on the Five-Year Review, the RUC will propose that CPT codes identified for the third Five-Year Review should be based on potential mis-valuation of physician work. Refinements to direct practice expense inputs will occur as a result of changes in physician time, visit data, etc. The RUC will recommend to CMS that CPT codes should not be identified for this particular Five-Year Review based solely on concerns regarding the direct practice expense inputs only.

The RUC was in agreement with the Workgroup recommendation that **the RUC begin discussions with CMS regarding identification of mis-valued codes**. The RUC understands that the next Five-Year Review may include some mechanism to identify potentially mis-valued codes, along with the usual comment process. The Workgroup will continue to discuss this issue and agreed that the RUC begin discussing this issue with CMS.

The Five-Year Review Workgroup Report was accepted as modified and is attached to these minutes.

XII. Professional Liability Insurance Workgroup Report

Doctor Gregory Przybylski presented the Professional Liability Insurance Workgroup Report. The RUC supported the PLI workgroup's position that the RUC should take a more proactive role in PLI RVU issues and accepted the following RUC recommendation:

The RUC engage in the establishment of PLI relative values. The Research Subcommittee should add question(s) to the survey instrument and/or *Summary of Recommendation* form to enable the RUC to provide recommendations on an appropriate temporary crosswalk for the PLI relative value and the assignment of a surgical or non-surgical risk factor.

The RUC recommended that the following regarding the PLI component of the Physician Fee Schedule is included in the RUC comment letter on the August 2003 Proposed RUC:

1. **CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years.**
2. **CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.**
3. **In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to Assistant at Surgery should be removed from this analysis.**
4. **The RUC will reiterate its request for the PLI data discussed with Mr. Scully at the April 2003 RUC meeting. Page 3 and 4 of the current**

draft of the comment letter currently includes a paragraph related to this request.

- 5. The RUC will request a list of all CPT codes with their assigned category of risk (i.e., surgical or non-surgical).**
- 6. The RUC will comment that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable. That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not rescaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.**
- 7. The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume.**

RUC members also requested that AMA staff provide the RUC with information on the status of data collection by the AMA at an upcoming meeting. Doctor Mayer suggested that CMS needs to “think out side the box” regarding sharing the costs of PLI premiums, and made a motion to add the following recommendation to the RUC Comment Letter:

- 8. The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.**

The RUC approved the revised PLI Workgroup Report. A copy of the PLI Workgroup Report is attached to these minutes.

XIII. PEAC Transition Workgroup Report

Doctor Bill Moran informed the RUC that the PEAC Transition Workgroup had met and would resume discussions in January. The workgroup will focus on ideas to maintain the experience of the PEAC process going forward. There was no discussion regarding Doctor Moran’s comments.

The PEAC Transition Workgroup Report was filed.

PEAC Update

Doctor Moran also discussed the August 2003 PEAC meeting and stated that these recommendations would be presented to the RUC at the January 2004 RUC meeting. Doctor Moran did ask the RUC to approve two issues from the

August 2003 meeting so that they may be included in the RUC comment letter.

In 1997, CPT created new codes to differentiate between open and percutaneous abscess drainage. Unlike their open procedure counterparts, all of the percutaneous codes were assigned a global period of 000 days. The work relative value for each of these codes is based on a 000 day global and does not incorporate any follow-up visits as it was determined that these visits are most typically performed by other physicians. As the codes were added to CPT after the CPEP process and prior to the PEAC/RUC process, CMS used a crosswalk to determine the practice expense inputs. It appears that CMS crosswalked the direct inputs from the open codes to the percutaneous codes. This crosswalk is inappropriate as the codes have different global periods.

Each of the following codes is currently priced in the facility setting only and is predominately performed in the inpatient setting. The RUC and PEAC agree that there should be **zero direct practice expense inputs and approved the following services** in the facility setting:

Current Staff Time in CPEP File:

<u>Code</u>	<u>Short Descriptor</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>% I/P</u>
32201	Drain, percutaneous, lung lesion	110	0	170	85%
44901	Drain app abscess, percutaneous	15	0	244	87%
47011	Percutaneous drain, liver lesion	15	0	207	78%
48511	Drain pancreatic pseudocyst	15	0	154	79%
49021	Drain peritoneal abscess	15	0	292	84%
49041	Drain, precut, abdominal abscess	15	0	292	85%
49061	Drain, precut, retroperitoneal abscess	15	0	292	81%
50021	Renal abscess, precut drain	74	60	377	69%
58823	Drain pelvic abscess, percutaneous	33	0	67	79%

In addition, CPT code 67875 was refined by the PEAC in March 2003 and approved by the RUC in May 2003. This code has an assigned global period of 000 and includes no post-op visits in the work relative value. However, the CPEP process appears to have assigned the code clinical staff time, supplies, and equipment related to a follow up visit:

67875 Closure of eyelid by suture 31 minutes post-time for both non-facility and facility. Also includes many supplies and equipment related to post-op visit.

The attached RUC recommendation submitted to CMS in May, reflects a 000 day global and no longer includes inappropriate post-time.

Doctor Moran also presented a letter from SIR requesting that CPT code 37203, *Transcather retrieval, percutaneous of intravascular foreign body (eg, fractured venous or arterial catheter) (For radiological supervision and interpretation, use 75961)*, be added to the conscious sedation list. The RUC approved these requests.

XIV. Multi-Specialty Points of Comparison Workgroup Report

Doctor James Blankenship presented the Multi-Specialty Points of Comparison Workgroup Report. In February 2002, the RUC recommended that the MPC include the codes that meet all of the absolute criteria (designated with the key "A"), as well as additional codes recommended by specialties. Codes with the key B are codes that do not have RUC time data available; however, the code is performed by several specialties and is well understood by many physicians. Codes categorized as "C" are codes that do not have RUC time available, but the specialty would like the code included as a reference point. The RUC agreed with the Workgroup's conclusion that going forward codes will not be added to the MPC that have not been surveyed by the RUC and do not have RUC physician time available.

From this point forward, only "A" category codes shall be added to the MPC lists.

Doctor Blankenship stated that while the Workgroup did not feel comfortable suggesting a change in policy to now exclude all "B" and "C" codes from the MPC, the Workgroup expressed concern that specialties have the opportunity to replace these codes with "A" codes in the future. In particular, the Workgroup was concerned that specialties not be mandated to survey "B" or "C" codes on the MPC, if the RUC receives a request to review these codes in the future. The RUC agreed with the Workgroup and recommends the following:

If external requests are imposed regarding the MPC list (ie, that all of the codes be considered validated by the RUC), specialty societies should be allowed to review codes on the list for addition and/or removal.

Doctor Blankenship reviewed each request from specialty societies to add or remove codes from the MPC list. The RUC agreed with the Workgroup and recommends the following:

The RUC recommends the deletion and addition of CPT codes as requested by specialty societies at this meeting. The only exception is in regard to CPT codes 28485 and 28525, which have not been reviewed by the RUC, and therefore, should not be added to the MPC. The following CPT codes were added to the list:

36556	<i>Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older</i>
44202	<i>Laparoscopy, surgical; enerectomy, resection of small intestine, single resection and anastomosis</i>
45110	<i>Proctectomy; complete, combined abdominoperineal with colostomy</i>
46221	<i>Hemorrhoidectomy, by simple ligature (e.g., rubber band)</i>
99294	<i>Subsequent pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child</i>
99296	<i>Subsequent neonatal critical care, per day for the evaluation and management of a critically ill neonate, 30 days of age or less</i>

The following CPT codes were deleted from the list:

31590	<i>Laryngeal reinnervation by neuromuscular pedicle</i>
36489	<i>Placement of a central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2</i>
45113	<i>Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy</i>
46060	<i>Incision and drainage of ischiorectal or intramural abscess, with fistulectomy of fistulotomy, submuscular, with or without placement of seton (Do not report 46060 in addition to 46020) (See also 45020)</i>
62311	<i>Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)</i>
75553	<i>Cardiac magnetic resonance imaging for morphology; with contrast material</i>

The RUC agreed that the MPC workgroup address how the MPC should be used in the next Five-Year Review and accepted the following motion:

For the purpose of refining and validating the MPC list prior to the upcoming 5-year review, the MPC workgroup will continue to meet over the next few months via conference call.

The Multi-Specialty Points of Comparison Workgroup Report was approved and is attached to these minutes.

XV. Research Subcommittee Meeting Report

The Research Subcommittee met to discuss a variety of issues concerning the inclusion of IWPUT on the MPC list, the rebasing of the MEI and its effect on RVUs, and the definition of the pre-service time period for 000 and 010 day global periods. Doctor James Borgstede presented the Research Subcommittee Meeting Report. The following recommendations were presented regarding the inclusion of IWPUT on the MPC list:

IWPUT be included on the MPC for category “A” codes with global periods of 90 days.

The version of the MPC list with the IWPUT included only be used internally by the RUC.

The MPC Workgroup review the use of the MPC and assign uses for the list; and

The MPC workgroup explore including other data elements for the inclusion on the MPC list.

The RUC discussed the Research Subcommittee’s recommendation to include IWPUT on the MPC list. It was noted that the decision to include IWPUT was not unanimous and that there were concerns about using IWPUT, even for 090 day global period codes. A RUC member reiterated concerns discussed by the committee including: 1) the vote by specialty societies was not unanimous regarding the use of IWPUT, 2) the list incorporates negative IWPUTs and has inconsistent CMS times, and 3) the inclusion of IWPUT would serve a formal endorsement of the use of IWPUT, which goes beyond previous RUC recommendations. While the RUC agreed with the Research Subcommittee’s recommendation to include IWPUT on the MPC list for category “A” codes, it stressed that additional review of codes should first take place by the MPC Subcommittee, as IWPUT is only one point of comparison.

The RUC also discussed the Research Subcommittee’s recommendation that the MPC list be used for internal purposes only. Previously the RUC had determined that the use of the list should remain internal. Current concerns by RUC members included that the data included on the list is either incomplete or inaccurate, and therefore is not yet a final product for use. Doctor Borgstede clarified that it was the intent of the Research Subcommittee to recommend that the MPC committee review the information contained on the list in the context of its current uses and determine how the information should be used.

On the issue of the CMS proposal to revise the MEI and reduce the physician work and practice expense RVUs to maintain budget neutrality due to the increase in the PLI RVUs, RUC members stressed the importance of maintaining working RVUs and not adjusting them for CMS budget neutrality purposes. Based on the PLI Workgroup Report, the sentiment of the RUC is that the workgroup's recommendation should reflect the recommendations made by the PLI workgroup. The following recommendation was approved:

The RUC recommends support for the PLI workgroup recommendation of not changing the physician work or practice expense RVUs to maintain budget neutrality. In addition, CMS should not decrease the conversion factor as a result of the increase in PLI RVU; however, if CMS insists on maintaining budget neutrality, this should occur through the conversion factor.

The RUC reviewed the Workgroup recommendations regarding the pre-service time period definition of physician work for codes with 000 and 010 day global periods. Doctor Borgstede explained that this is a complicated issue that needs further study by a workgroup devoted to resolving this issue. RUC Members discussed the need to look at the impact of the differences between RUC and CMS definitions of physician work and determine whether E/M codes can be billed separately because changes in the definition should not prevent separate billing. Based on the need to review the definitions more thoroughly the following recommendation was approved by the RUC:

The RUC form a workgroup to review the issue of the RUC pre-service definition of 000 and 10 day global period.

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

XVI. Practice Expense Subcommittee Meeting Report

The Practice Expense Subcommittee met during the September 2003 RUC meeting to continue its work on the allocation of physician time components, discuss the practice expense implications of shifts in site of service, and discuss components of the AWP proposed rule. Doctor Robert Zwolak presented the PE Subcommittee Report.

For the allocation of physician time components, the following recommendation was accepted based on review of the submission from specialty societies:

The RUC recommends the following 15 physician time components be used for practice expense purposes; these components are available in the PE Subcommittee full report attached.

On the issue of the shift in practice expense from the facility to the non-facility for percutaneous endovascular codes and other services, the Practice Expense Subcommittee and the RUC agreed that the RUC should work to resolve this issue and recommends the following approach:

- **The RUC should form a workgroup to address this issue, with involvement of PEAC members.**
- **The RUC will request that CMS to conduct an impact analysis on pricing these percutaneous endovascular codes and other services newly priced in the office, that have been proposed to shift major resources from facility to the non-facility setting.**

It was pointed out by CMS representatives and the RUC, that the main shift in services would occur from the hospital outpatient to the office setting. In addition, since both sites of service are paid with Part B funds, a regulatory change rather than a legislative change may be made, and reflected in the “law and regulation” factor in the sustainable growth rate (SGR) allowed spending formula. The RUC made the following additional recommendations concerning services shifting sites of service:

- **For services transitioning from the facility to the non-facility settings, the RUC will advocate that CMS consider a regulatory change in the SGR update formula to increase allowed expenditures.**
- **The RUC agreed that the issue of shifting services from the I/P setting to the O/P setting (i.e., hospital visits to office visits) is an issue that needs focus and encourages CMS to continue to consider this issue.**

The August 20, 2003 Proposed Rule of Payment Reform for Part B Drugs and Increased Payments Related to the Costs of Furnishing or Administering Drugs was discussed by the Subcommittee and the RUC. RUC members expressed their concern over a provision contained in the Proposed Rule that would adopt supplemental practice expense survey data from the American Society of Clinical Oncology (ASCO). Some RUC members believed the supplemental data reflected unrealistically high practice expense values on the fee schedule. Other RUC members believed that ASCO had fulfilled the supplemental data requirements, but should have an opportunity to explain the data to the RUC. As the changes are not budget neutral, CMS clarified that additional money would be added to total practice expense pool of dollars for oncology services. These funds would be derived from the potential savings from the drugs, and any impact on other services will not be known until these savings are identified. CMS stated however, that the rule would not have a

significant negative impact on specialties. While the decision was not unanimous, the RUC determined that:

The RUC should submit a comment on the AWP rule stating that the RUC can not support adoption of the ASCO practice expense supplemental survey at this time, but welcomes the opportunity for further review of this data should the society choose to do so.

CMS reminded the RUC that this separate comment letter should be submitted by October 15, 2003.

In addition, RUC members expressed their concern that CMS does not require greater documentation directly from industry in regards to the pricing of medical supplies and equipment. Most members agreed that some authority should be given to CMS to solicit manufacturers for these prices. The RUC then made the following recommendation:

- The RUC should encourage CMS to use all available avenues to gain accurate equipment and supply prices.**

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

XVII. Administrative Subcommittee Meeting Report

Doctor John Derr presented the Administrative Subcommittee Report to the RUC. Regarding RUC Alternates, the RUC approved the following recommendation:

In the instance that neither the RUC Member nor the RUC Alternate are able to attend the RUC meeting, the specialty society shall notify the Chair of substitutions for representation in the form of a letter, in advance of the RUC Meeting. Approval of this substitute representative shall be at the discretion of the RUC Chair. In addition, the substitute representative shall be required to return a signed copy of the Conflict of Interest Statement to AMA Staff prior to the start of the RUC meeting.

The RUC reviewed the recommendation to approve the Criteria for Membership/Election Rules document determined that this issue should be extracted for discussion. RUC members suggested that the document be reviewed by legal counsel to determine whether the rules are aligned with Sturgis parliamentary procedure prior to its approval, therefore, the approval of the document was tabled until the ballot issue is reviewed by the AMA legal department. This issue will be discussed at the next Administrative Subcommittee Meeting.

The third issue discussed by the RUC was the Administrative Subcommittee's recommendation to provide the RUC database to Medicare Carrier Medical Directors. This item was extracted for discussion. The RUC had several questions regarding the report including:

- How will the AMA benefit from the release of the information?
- Is the database complete and accurate?
- Do CMD's or other members of the public have the expertise to appropriately use the database information beyond the scope of the RUC?
- How would the information contained on the database be controlled?

After extensive discussion regarding the above questions, the RUC considered the following motion:

The RUC should release the database to the CMDs.

This motion failed.

RUC members discussed whether partial data could be released. Several suggestions were made including:

- Releasing the data as part of a legally binding contract, with defined penalties for misuse of the product
- Encrypting the data so that the information could not be mined
- Requiring a signed copyright agreement prior to releasing the database
- Requesting that CMDs to keep a record of whether the use of the information resulted in no change, an increase, or a decrease in the payment for services.

Doctor Gee suggested that the Administrative Subcommittee focus on determining the positive impact of releasing this information to physicians. Based on these suggestions and concerns, the following motion was approved:

The request to provide RUC database CD to Medicare Carrier Medical Directors should be referred back to the Administrative Subcommittee. The Administrative Subcommittee should consider 1) what portions of the database should be released; 2) how may it be safeguarded; and 3) legal advice from the AMA.

The motion was approved by the RUC.

The RUC agreed with the Administrative Subcommittee that the following statement should be removed from the Structure and Function document:

III. B. (4) Terms of Appointment – (a) Specialty Society representative and alternates shall hold terms of three (3) years, with a maximum tenure of six (6) years.

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

XVIII. RUC HCPAC Review Board Meeting Report

The RUC HCPAC met to review the recommendations for CNS Assessments and Tests, and also to discuss the future CPT/RUC HCPAC meeting. Ms. Nelda Spyres presented the HCPAC report to the RUC. The RUC was updated on the status of the CNS Assessments/Tests, the RUC HCPAC determined that the codes should be sent to back to psychology so that the Specialty Society can create new coding proposals which will include new code descriptors that recognize the differences in the modality of testing, (i.e. manual, automated and face-to-face) in order to define the work inherent in each of these different testing methodologies. In addition to new descriptors, The HCPAC recommended the creation of new vignettes and descriptions of pre, intra and post service work for each of these codes.

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

XIX. Other Issues

- The RUC reviewed a draft comment letter on the Proposed RUC for the 2004 Medicare Physician Payment Schedule, published in the August 15, 2003 Federal Register. The RUC considered several of the actions of its Subcommittees and Workgroups in finalizing the letter. A copy of the Final Comment Letter is attached to these minutes.

The meeting was adjourned at 7:20 pm on Saturday, September 20, 2003.

AMA/Specialty Society RVS Update Committee
Five-Year Review Workgroup
Friday, September 19, 2003

The following Five-Year Review Workgroup members met to review the previous Five-Year processes and to begin discussing the timeline, processes, and methodology for the next Five-Year Review : Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, Doug Leahy (alternate for J. Leonard Lichtenfeld), James Maloney, Arthur Traugott, Trexler Topping, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Review of Process, Methodology, and Timeline from Previous Five-Year Review

The Workgroup initially reviewed the timeline, methodology, and processes from the two previous Five-Year Review activities. Workgroup members shared their experience and identified a number of issues that should be further reviewed in developing procedures for the next Five-Year Review, including:

- Review compelling evidence – it was noted that the standard for compelling evidence may not have been consistent between the first two Five-Year Review activities. The Workgroup will review the current definition/standards for compelling evidence that is listed on page 7 of the current *Instructions for Specialty Societies Developing Work Relative Recommendations*.
- Develop a fair and standard appeals process – a number of specialty societies were afforded multiple opportunities to formulate and present compelling evidence in the last Five-Year Review. The Workgroup agreed that an appeals process is necessary for the next Five-Year Review. However, it is critical that this process be developed in advance, so that every specialty be afforded the same opportunity to present compelling evidence. A number of issues will be considered, including whether the utilization of facilitation committees remain appropriate in the Five-Year Review as the RUC received criticism in the past that it was difficult for specialties to re-present their rationale to a new group of individuals. The Workgroup will also develop criteria and a timeline for final appeals.
- IPUT – The Workgroup expressed hope that the issues surrounding the Intra-Work Per Unit Time (IPUT) will be addressed and resolved prior to Five-Year Review. The Workgroup suggests that the Research Subcommittee discuss the use of IPUT in the next Five-Year Review.

Timeline for Third Five-Year Review

The Workgroup reviewed the attached draft timeline for the third Five-Year Review that was prepared based on the timeline utilized in the previous two Five-Year Review processes. The workgroup agreed that the timeline is appropriate, and will consider any specialty society comments before final approval at the February 2004 RUC meeting. **The RUC reviewed the timetable and recommends that all approved methodologies in effect at the February 3-6, 2005 RUC meeting, including the RUC survey instrument, will be acceptable**

methodologies in the Five-Year Review. The RUC also understands that specialties must present any alternative methodologies by the April 28-May 1, 2005 meeting, but emphasized that it is in a specialty society's best interest to present this information as soon as possible.

Potential Modifications in Methodology and Processes for Third Five-Year Review

The Workgroup identified a number of methodological and procedural issues that need to be discussed further and resolved prior to finalizing the process for the next Five-Year Review. The follow issues were discussed:

- Review of Family of Services vs. Individual Services – In the previous Five-Year Review, several specialties identified large groups of codes and then developed relative value recommendations using unique methodology approved by the Research Subcommittee in advance of their presentations to the RUC. The Workgroup agreed to compile a list of previously accepted approaches to review families of services. If a specialty would like to vary from these methodologies, they must present this approach to the Research Subcommittee. The Workgroup agreed that innovation in the process is important, but that must be balanced with the need to retain fairness in the opportunities presented to all specialties. It was suggested that specialties should begin to discuss these approaches in early 2004 and present their ideas to the Research Subcommittee as soon as possible. The last opportunity to receive approval for a new methodology will be at the April 2005 RUC meeting.
- Screening Criteria – The workgroup agreed that it will need to review the screening criteria previously utilized to identify codes that should not be pursued further beyond the original comment (e.g., due to low utilization data or no expressed interest by a specialty society). It was noted that some screening criteria may no longer be appropriate, and other new criteria may surface.
- Direct Practice Expense Inputs – The Workgroup discussed the scope of the next Five-Year Review in regards to the work relative values and direct practice expense inputs. The Workgroup agreed that all codes presented at the Five-Year Review may be accompanied by practice expense and would be reviewed by the RUC. For example, if the number of level of office visits related to a CPT code is modified in reviewing physician work, this will lead to a similar revision in the direct practice expense inputs for the service. However, the Workgroup was less certain that a review of practice expense inputs, independent of a consideration of physician work, would be appropriate. It was noted that the Practice Expense Advisory Committee (PEAC) will have refined nearly all CPT codes and the opportunity for specialties to place a code on the PEAC agenda exists until the March 2004 PEAC meeting. CMS staff noted that the agency has not stated any plan to initiate a refinement of all practice expense inputs during this Five-Year Review, as the PEAC will just be concluding their work. The Workgroup, therefore, suggests that the proposal be developed to urge that the scope of the Five-Year Review be considered by the RUC at this meeting and recommends that codes should not be brought to the Five-Year Review solely on the basis of practice expense mis-valuation. The workgroup notes, however, that there is no established RUC mechanism by which

specialties may address codes whose practice expense alone is mis-valued. We recommend that the RUC develop a process and methodology by which anomalies in practice expense identified between the conclusion of the PEAC and the fourth Five-Year Review may be reviewed. The RUC recommends the following:

In developing the RUC proposal to CMS on the Five-Year Review, the RUC will propose that CPT codes identified for the third Five-Year Review should be based on potential mis-valuation of physician work. Refinements to direct practice expense inputs will occur as a result of changes in physician time, visit data, etc. The RUC will recommend to CMS that CPT codes should not be identified for this particular Five-Year Review based solely on concerns regarding the direct practice expense inputs only.

Development of Process and Identification of Objective Data to Identify Potentially Mis-valued CPT Codes

The Workgroup discussed the RUC's role in identifying potentially mis-valued codes. Documentation was reviewed outlining the previous attempts by the RUC and CMS to identify codes utilizing objective data. Use of data or comments by CMDs or others have been utilized in the past as it was acknowledged that specialties will bring perceived undervalued CPT codes to the Five-Year Review, but it is unlikely that specialties will identify overvalued services.

The Workgroup will continue to discuss this issue and review a list of suggestions developed by staff for review (e.g., 50 CPT codes that were valued as inpatient services that are now performed predominately in the office to determine if physician time and work remain appropriately valued). In addition, the workgroup suggests that **the RUC begin discussions with CMS regarding identification of mis-valued codes.**

DRAFT - Timetable for the Five-Year Review –For Discussion

December 30, 2004 Comment period closes on public solicitation of codes to be reviewed.
Assumes publication date of CMS Final Rule of November 1, 2004

February 1, 2005 CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.

February 3-6, 2005 Research Subcommittee to review any changes to the existing RUC survey instrument.

February 15, 2005 AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1.

April 1, 2005 Responses to the LOI due to the AMA.

April 28 – May 1, 2005 Initial screen of all codes at the April RUC meeting.
Research Subcommittee to review any alternative methodologies introduced.

May 9, 2005 Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.

August 2, 2005 Recommendations due to the AMA from specialty societies.

August 25-28, 2005 Five-year review workgroups meet and review recommendations.

September 14, 2005 Workgroup recommendations and consent calendars sent to the RUC.

September 29 – October 2, 2005 RUC meeting to review workgroup recommendations and consent calendars

October 31, 2005 RUC recommendations submitted to CMS.

November 2005-February 2006 CMS Review

March 2006 Notice of Proposed Rulemaking (NPRM) on Five-Year Review

November 2006 Final Rule on Five-Year Review

January 1, 2007 Implementation of new work relative value units.

**AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
Friday, September 19, 2003**

The following Professional Liability Insurance (PLI) Workgroup members met to review issues related to PLI and to develop the RUC's comments on the August 15, 2003 Proposed Rule: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith. Rick Ensor, CMS staff, participated via conference call.

Discussion of RUC Role in PLI

The PLI Workgroup acknowledged that the RUC's *Structure and Function* document currently states that "in the future the [RUC] Process may be used to establish the professional liability components of the RVS." The Workgroup agrees that the RUC should take a more active role in the establishment of PLI relative value units.

The Workgroup was informed that new and revised codes are temporarily assigned a PLI relative value based on CMS staff analysis of an appropriate crosswalk. This analysis usually includes a review of the frequency estimations on the RUC's *Summary of Recommendation* form and often the key reference service used to determine physician work. CMS staff also determine if the CPT code should be assigned a surgical or non-surgical risk factor.

The Workgroup discussed the opportunity for the RUC to provide recommendations to CMS for both an appropriate crosswalk and the appropriate risk factor determination. The Workgroup suggests that the Research Subcommittee consider the addition of question(s) to the survey instrument and/or *Summary of Recommendation* form to enable the RUC to begin providing this information to CMS.

The PLI Workgroup recommends that the RUC engage in the establishment of PLI relative values. The Research Subcommittee should add question(s) to the survey instrument and/or *Summary of Recommendation* form to enable the RUC to provide recommendations on an appropriate temporary crosswalk for the PLI relative value and the assignment of a surgical or non-surgical risk factor.

Review of PLI and the RBRVS and Discussion of August 15, 2003 Proposed Rule

A number of documents were provided to the PLI to review in advance of the meeting as resource material, including:

- Chapter 6 of Medicare Physicians' Guide on PLI Methodology
- RUC Comments on PLI from Sept. 1999, Dec. 1999, Feb. 2000, and Feb 2003
- February 2000 consultant presentation to the RUC

- June 2003 GAO Report on PLI- *Multiple Factors Have Contributed to Increased Premium Rates*
- August 2003 GAO Report on PLI – *Implications of Rising Premiums on Access to Health Care*
- August 15, 2003 Proposed Rule on 2004 Physician Payment Schedule
- May 8, 2003 Letter from surgical specialty societies to CMS regarding PLI

The Workgroup reviewed this material in preparation for the meeting and to assist in the development of RUC comments on the August 15, 2003 Proposed Rule.

Development of RUC Comments on August 15, 2003 Proposed Rule Relating to PLI

A draft of the RUC comment letter will be discussed at the conclusion of the RUC meeting. The PLI Workgroup extensively discussed topics that should be included in the RUC comment letter related to PLI. These points will be developed into specific comments and included in a second draft of the RUC comment letter to be circulated immediately following the RUC meeting.

The RUC will add the following recommendations in the RUC comment letter:

1. **CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years.**

The Workgroup expressed concern that the more recent data should be utilized for PLI premium data. CMS staff indicated that multiple attempts have been made to secure the most recent data, including discussions with the GAO, major consulting firms, other government agencies, and medical organizations. These data are utilized in application such as the PLI GPCI formula, requiring sufficient data at the county level for each specialty for which information is collected. Despite these efforts, the most complete set of data (70% complete) is 2002. CMS hopes to estimate 2003 PLI premium data for the 2004 Final Rule on the Physician Payment Schedule.

Several members of the Workgroup suggested that organized medicine may be able to generate more recent data. AMA staff indicated that these efforts have been ongoing by AMA and specialty societies, but issues remain with low response rates, etc. It was suggested that individuals responsible for PLI issues at the AMA present the most recent efforts to the PLI Workgroup at a future meeting. CMS welcomed the opportunity to review more comprehensive data than is currently available.

A second concern regarding the PLI premium data involves the weight averaging of multiple years of data. As recent PLI premiums have increased so greatly, it would be unfair to dilute these increases with data from earlier year(s), which are no longer reflective of today's costs.

2. CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.

The Workgroup argued that inclusion of these costs are critical as insurance carriers have left the market, it has required more and more physicians to change PLI coverage and therefore incur the costs of tail coverage. CMS has not included these costs in the past.

3. In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to Assistant at Surgery should be removed from this analysis.

The Workgroup is supportive of the letter submitted to CMS in May 2003 from a group of medical societies. This letter is included in the RUC agenda materials and outlines a methodology for CMS to employ in considering this recommendation. The Workgroup was concerned that the weighted averaging reduces the potential payment to higher-risk specialties and increases the potential payment to lower-risk specialties.

4. The RUC will reiterate its request for the PLI data discussed with Mr. Scully at the April 2003 RUC meeting. Page 3 and 4 of the current draft of the comment letter currently includes a paragraph related to this request.

Rick Ensor informed the Workgroup that the raw PLI premium data does include proprietary information. However, CMS is reviewing the data and determining mechanism to summarize the data so that CMS may share this information with the RUC.

5. The RUC will request a list of all CPT codes with their assigned category of risk (ie, surgical or non-surgical).

Mr. Ensor indicated that this information is available and CMS will share it with the RUC. He welcomes comments on the individual assignments of risk factor categories.

6. The RUC will comment that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable. That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

This issue is outlined on page eight of the draft RUC comment letter for discussion. The Workgroup unanimously agreed that the relative values should remain stable and re-scaling for budget neutrality should not be applied.

7. The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume.

The Workgroup does not agree with the current CMS approach, which used national average premium data for twenty specialties, and uses crosswalk assumptions for the remaining medical specialties and other health care professionals. The Workgroup was also concerned that the 20 specialties with the highest volume used in the prior updates include only three high-risk specialties (orthopaedic surgery, general surgery, and emergency medicine).

8. The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.

Several RUC members urged the PLI Workgroup to “think outside the box” and work with CMS to develop a different methodology for paying physicians for their share of the individual physician’s professional liability insurance premium.

**AMA/Specialty Society RVS Update Committee
PEAC Transition Workgroup
Friday, September 19, 2003**

Doctors Moran (Chair), Brill, Borgstede, Kwasny, Reed, Siegel, Przybylski, and Whitten participated in the discussion.

Doctor Moran opened the workgroup's discussion of the PEAC's transition into the RUC process with a discussion of the following goals:

1. Obtain the quality of evaluating the PE for new codes as provided to existing codes
2. Use the expertise of the members of the PEAC
3. Be as cost efficient for both AMA and Specialty Societies
4. Both PE and physician work to be done by same group and/or at the same time

The workgroup believed that it was important that the direct practice expense inputs of new and revised codes are scrutinized by the RUC in a similar manner as the existing codes are through the PEAC. Sufficient time needed to be allotted for the review, of the practice expenses submitted by specialties. With this in mind, the workgroup discussed various times and dates when a Practice Expense Workgroup could meet to discuss or pre-facilitate the specialty's practice expense inputs for the new and revised codes. The workgroup agreed that to minimize the time and cost for the specialty societies and the AMA, that it would be best to meet concurrently with all RUC meetings.

Doctor Moran and workgroup members believed that the PEAC process has trained several advisors and RUC members over its existence, and believed that the knowledge gained should be maintained within the RUC process. Therefore, it was agreed that the talent of the PEAC should be utilized in the analysis of practice expense recommendations at the RUC. Most of the 30 current PEAC members had expressed interest in using their knowledge at the RUC, and therefore the workgroup recommended that a portion of these members should make up the Practice Expense Direct Input Workgroup. An exact number of these members was not specified, but it was agreed that having all 30 members at each RUC meeting was excessive. The workgroup felt that the RUC could ask specific members based on the RUC agenda items, their specialty society and availability, for an equal balance of representation.

The PEAC Transition Workgroup suggests to the RUC that:

1. The direct practice expense inputs for new and revised codes should be reviewed concurrently in a Practice Expense Direct Input Workgroup at each RUC meeting, to pre-facilitate the practice expense inputs of each new and revised CPT code on the RUC's agenda
2. The members of the Practice Expense Workgroup would initially be drawn from current PEAC members based on the RUC agenda items, specialty society, and availability

In these modifications, the PEAC would continue to function according to the directives and guidelines of the RUC. The current PEAC structure might be maintained, but the RUC would utilize approximately one-third of the committee at each meeting. It was believed that this would benefit small specialty society representation.

On a broader policy level, Carolyn Mullen from CMS stated, there are some additional practice expense methodological items that the Practice Expense Subcommittee may want to review in the near future. She listed four specific items that will be referred to the Practice Expense Subcommittee for review.

AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup Report
Friday, September 19, 2003

The following Multi-Specialty Points of Comparison (MPC) Workgroup members met to review proposed additions and deletions to the MPC: Doctors James Blankenship (Chair), John Derr, William Gee, John Mayer, Daniel Nagle, and Maurits J. Wiersema.

General Discussion Regarding MPC History/Criteria:

The Workgroup reviewed the RUC's *Annotated List of Actions* and discussed the historical revisions to the Multi-Specialty Points of Comparison (MPC). The workgroup understands that the following list of absolute criteria for the MPC were approved in February 2001:

- The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by CMS.
- The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

In February 2002, the RUC recommended that the MPC include the codes that meet all of the absolute criteria (designated with the key "A"), as well as additional codes recommended by specialties. Codes with the key B are codes that do not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians. Codes categorized as "C" are codes that do not have RUC time available, but the specialty would like the code included as a reference point.

The Workgroup questioned whether it was appropriate, going forward, to add codes to the MPC that have not been surveyed by the RUC and do not have RUC physician time available. The Workgroup concluded that this is not appropriate and recommends the following:

From this point forward, only A category codes shall be added to the MPC lists.

While the Workgroup did not feel comfortable suggesting a change in policy to now exclude all "B" and "C" codes from the MPC, the Workgroup expressed concern that specialties have the opportunity to replace these codes with "A" codes in the future. In particular, the Workgroup was concerned that specialties not be mandated to survey "B" or "C" codes on the MPC, if the RUC receives a request to review these codes in the future. The Workgroup recommends the following:

If external requests are imposed regarding the MPC list (ie, that all of the codes be considered validated by the RUC), specialty societies should be allowed to review codes on the list for addition and/or removal.

It was noted that the vote was not unanimous.

The Workgroup also considered whether there should be a formal request process by which requests for additions/deletions to the MPC list are brought to the RUC. The Workgroup that it would be inappropriate to require completion of a request form. The workgroup voted to request that:

- (a) Requests for additions/deletions be accompanied by a rationale, and;
- (b) The society making the request for addition/deletion should consult with other specialties performing the procedure to ascertain their agreement to the proposed change.

Review of Specialty Society Recommendations to Modify the Multi-Specialty Points of Comparison Document

In March 2002, the RUC recommended that the MPC list be reviewed (i.e., specialty societies would have the opportunity to solicit additions or deletions) on an annual basis, beginning at the September 2003 RUC meeting. The following requests for addition/deletions were considered at this meeting (Please refer to pages 784-788 of RUC agenda book for information on each CPT code listed below):

American Podiatric Medical Association - CPT codes 28485 and 28525

The Workgroup recommends that the CPT codes 28483 and 28525 are not level A codes and should not be included on the list.

American Association of Otolaryngology – Head and Neck Surgery-delete 31590.

CPT code 31590 from the MPC list because the service is no longer performed.

American Society of Colon and Rectal Surgery on codes 44202, 45110, 45113, 46060, and 46221

CPT code 45113 should be deleted and replaced with 45110. CPT code 45113 has a very low frequency and was a mini-survey during the second 5-yr review, while 45110 is a similar procedure, but has a higher frequency and was a full RUC survey.

CPT code 46060 should be deleted and be replaced with CPT code 46221. 46060 has a low IPUT because it was reduced as part of a family of reductions (during the second 5-yr review), without regard to the actual work of the code. Additionally, 46221 has a significantly higher frequency.

CPT code 44202 should be added to represent laparoscopic surgery in this section of the MPC.

American Society of Anesthesiology on CPT codes 62311 and 36489 36556

Code 62311 has a zero day global code and has an RVW of 1.54 and an IPUT value of -0.043. This code was one of the very first pain codes to go through the RUC. Since then, there have been changes in the methods used to evaluate codes which have resulted in a more sophisticated process. The specialty society does not feel that code 62311 is properly valued, therefore the Workgroup recommends that it be removed from the MPC list.

CPT code 36489 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2* has been deleted from CPT and replaced with code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older.* The MPC list should be updated accordingly.

American College of Radiology – delete code 75553

The Workgroup agreed with the American College of Radiology and the American College of Cardiology that code 75553, *Cardiac magnetic resonance imaging for morphology; with contrast material,* should be deleted from the MPC list due to changes in the technology for this service.

American Academy of Pediatrics - add 99294 and 99296

The Workgroup agreed with the American Association of Pediatrics that CPT code 99296 (subsequent neonatal critical care) should be reinstated on the MPC list, as it was initially included on the initial version of the MPC list. It was removed when the neonatal codes were revised and subsequently revalued in 2001-2002.

During the same time that the neonatal codes were being revised, new pediatric (for patients 31 days through 24 months of age) critical care codes were developed (99293 and 99294) and subsequently valued by the RUC. Given the parallel between 99294 (subsequent pediatric critical care) and 99296, it would be appropriate to include 99294 on the MPC list, as well.

The Workgroup noted that CPT codes 54150 and 62270 are currently on the Multi-Specialty Points of Comparison Document.

The Workgroup recommends the deletion and addition of CPT codes as requested by specialty societies. The only exception is in regard to CPT codes 28485 and 28525, which have not been reviewed by the RUC, and therefore, should not be added to the MPC.

Discussion of IPUT on MPC Issue

Regarding the addition of IPUT to the Multi-Specialty Points of Comparison List, the Workgroup acknowledged that while some specialties agreed with the addition of IPUT calculations, other specialty societies did not believe that this information should be added to the MPC list. The Research Subcommittee further discussed this issue on September 19, 2003.

Other Issues

Based on the discussion during the meeting, the Workgroup determined that the MPC workgroup should continue to meet for the purpose of revising the MPC list for use during the 5-year review. **The following motion was accepted:**

For the purpose of refining and validating the MPC list prior to the upcoming 5-year review, the MPC workgroup will continue to meet over the next few months via conference call.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee
Friday, September 19, 2003**

The Research Subcommittee met to discuss a variety of issues concerning the inclusion of IWPUT in the MPC list, the rebasing of the MEI and its effect on RVUs, and the definition of the pre-service time period for 000 and 010 day global periods. The following members were present: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Meghan Gerety, David Keepnews, M. Douglas Leahy (alternate for J. Leonard Lichtenfeld), Bernard Pfeifer, Sandra Reed, Trexler Topping, and Richard Tuck.

Inclusion of IWPUT on the MPC List

During the April 2003 RUC meeting, the Research Subcommittee discussed the possibility of including IWPUT calculations on the Multi-Specialty Points of Comparison (MPC) list. To determine if such a change in the format of the MPC list is appropriate, the RUC agreed to calculate an IWPUT for all type A codes for review by the Research Subcommittee and specialty societies. Category A codes are those codes that have meet all the criteria for inclusion on the MPC list such as having RUC survey time, and current work RVUs that the specialty(s) accept as valid. Specialty societies were sent the MPC list with IWPUT included and asked to identify specific codes that either should or should not have IWPUT included. The Subcommittee continued its discussion of the possible inclusion of IWPUT on the MPC. The Subcommittee discussed at length the pros and cons of including IWPUT on the MPC list. While some Subcommittee members were in favor of including the IWPUT on the MPC list, the Subcommittee concluded that additional issues needed to first be clarified. The following points were made by Subcommittee members:

- The inclusion of IWPUT on the MPC would enhance the usefulness of the MPC as a means to compare codes. The inclusion of IWPUT would be the inclusion of other type of data that would be used to help determine relativity.
- There may be other metrics that could be also included on the MPC list such as length of stay and site of service. These other data elements could be used to evaluate the new and revised codes.
- Including IWPUT on the MPC list would be premature primarily because all the data such as time and visits may not have been completely validated, even for category A codes. Since the physician data are used to calculate the IWPUT, a more careful examination of these data elements would first need to occur.
- Including IWPUT on the MPC could be misused by groups outside of the RUC. The list could then be used in the future to either devalue codes or force specialty societies to review codes. A number of subcommittee members were not aware that the MPC list is shared with CMS since the RUC developed the original list at the request of CMS. The role of the MPC and possible use was discussed in detail with a number of subcommittee members expressing concerns over allowing the MPC with IWPUT data to be shared

with groups other than RUC members. There was some discussion of having the MPC workgroup continue its review of the MPC list before adding IWPUT.

- There should also be further discussion of excluding certain global periods or excluding those codes reviewed by the RUC prior to a certain date when the RUC collected time data but never reviewed the data. This would exclude IWPUTs for codes with time data that may be inaccurate. Also, since there were concerns with using IWPUT for other than 90 day global period codes, the some Subcommittee members were in favor of including IWPUT only for the 90 day global period codes.

After much discussion of the pros and cons of including IWPUT on the MPC, the Subcommittee passed the a four part recommendation that recommends including IWPUT on the MPC for certain code categories but only after additional review of the use of the MPC list takes place. The Subcommittee also recognized that additional review of specific codes and the associated IWPUT will need to take place since some specialties may wish to exclude listing the IWPUT for certain codes. **The RUC recommends that:**

IWPUT be included on the MPC for category A codes with global periods of 90 days;

The MPC committee review the use of the MPC and assign uses for the list;

The MPC workgroup explore including other data elements for inclusion on the MPC list; and

The version of the MPC list with the IWPUT included only be used internally by the RUC.

Rebasing of the MEI and Impact on RVUs

The Research Subcommittee was asked by the RUC Chairman to develop a recommendation regarding the CMS proposal to revise the MEI and reduce the physician work and practice expense RVUs to maintain budget neutrality due to the increase in the PLI RVUs. This issue was raised by CMS in the recent Proposed Rule and the draft RUC comment letter will be discussed by the RUC at this meeting. There was widespread concern with changing physician work RVUs that are currently used as benchmarks for many codes, and any arbitrary changes would also affect benchmark IWPUT calculations used by many RUC members. Since the PLI Workgroup discussed this issue earlier in the day, the Research Subcommittee agreed to support the PLI Workgroup recommendation.

The Subcommittee recommends support for the PLI workgroup recommendation of not changing the physician work or practice expense RVUs to maintain budget neutrality. In addition, CMS should not decrease the conversion factor as a result of the increase in PLI RVU, however, if CMS insists on maintaining budget neutrality, this should occur through the conversion factor.

Pre-service time definition for 000 and 10 day global period codes

During the April RUC meeting, the RUC held a discussion regarding the pre-service time period definition of physician work for codes with 000 and 010 day global periods. The RUC definitions for the pre service time period for the 000 and 10 day global periods do not correspond to CMS definitions for these global periods. The Research Subcommittee continued its review of the issue and the discussion focused on the need to study the potential impacts of changing the RUC definition of pre-service time. The possible affects on the ability to separately bill for services provided before the day for surgery would have to be reviewed before making any change in the pre-service definition. After discussing various alternatives, the Research Subcommittee decided that the issue needed careful examination by a workgroup focused solely on pre-service time period definition. Addition, this workgroup would determine if CMS still is in favor of the RUC changing its definitions. The RUC recommends that:

The RUC form a workgroup to review the issue of the RUC pre-service definition of 000 and 10 day global period.

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
Friday, September 19, 2003**

The Practice Expense Subcommittee met during the September 2003 RUC meeting to continue its work on the allocation of physician time components, discuss the practice expense implications of shifts in site of service, and discuss components of the AWP proposed rule. The following Subcommittee members participated: Doctors Robert Zwolak (Chair), Bibb Allen, Neil Brooks, William Gee, Charles Koopmann, Bill Moran, Greg Przybylski, Daniel Siegel, Mauritis Wiersema, and Nelda Spyres.

Physician Time Components

Doctor Zwolak introduced the subcommittee to each of the items on the agenda starting with the continuation of the subcommittee's work on providing the PEAC with physician time components for its review of direct practice expense inputs. Doctor Zwolak explained that the RUC had asked specialty societies to provide all the necessary time components for each of their global period codes. Specialties for this meeting, were bringing forth fifteen 000 day global codes and that it was important to concentrate on intra-service portion of the time, as the PEAC uses physician intra-service time as one of their standards to determine clinical staff time in the office setting. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

- 1) If the specialty society agrees with the total Harvard physician time, specialty societies are asked to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post-operative hospital and office visits.
- 2) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is higher, specialty societies are required to conduct a full RUC physician time survey for the code.
- 3) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is lower, the predominate specialty who performs the service may provide a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel to develop the physician time components.

The subcommittee members were reminded that the RUC has expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs, and have no bearing on physician work.

Subcommittee members reviewed the time allocations to see if they seem accurate for the service being provided. The Subcommittee recommended the following RUC action:

The RUC recommends the following 15 physician time components be used for practice expense purposes:

CPT Code	Glob	Specialty	Pre-	Intra	Post	Time, Same	Total	Method	Hrvd Time	Time change	work rvu	IWPUT
			serv time	-Serv time	Day of Surgery	Time REC						
35470	000	SIR	*	82	128	210	Allocate	210	0	8.63	0.070	
35471	000	SIR	*	90	140	230	Allocate	230	0	10.07	0.077	
35472	000	SIR	*	85	93	178	Allocate	178	0	6.91	0.057	
35473	000	SIR	*	78	83	161	Allocate	161	0	6.04	0.054	
35474	000	SIR	*	80	106	186	Allocate	186	0	7.36	0.062	
35475	000	SIR	*	90	121	206	Allocate	206	0	9.49	0.075	
35476	000	SIR	*	75	70	145	Allocate	145	0	6.04	0.060	
36481	000	SIR	*	75	77	152	Allocate	152	0	6.99	0.070	
37203	000	SIR AGA,	*	80	61	141	Allocate	141	0	5.03	0.046	
43216	000	ASGE	12	33	20	65	Allocate	65	0	2.40	0.051	
43248	000	ASGE	16	32	15	63	Allocate	63	0	3.15	0.077	
44365	000	ASGE	22	48	16	86	Allocate	86	0	3.31	0.051	
93660	000	ACC	15	50	15	80	Survey	42	38	1.89	0.024	
93797	000	ACC	2	6	3	11	Allocate	11	0	0.18	0.011	
93798	000	ACC	2	7	3	12	Allocate	12	0	0.28	0.024	

*Pre and Post time have been combined for codes 35470-37203 into the Post Service Time Period.

The physician time for each code will be entered into the RUC database, and each code will be flagged in the RUC database to clearly identify that the physician time components are not to be considered when making work recommendations.

Facility to Non-Facility Procedures

The practice expense subcommittee agreed in January 2003 that there should be a mechanism to establish non-facility practice expense as practice patterns change, and the PEAC recently was asked to establish practice expense inputs for a set of percutaneous endovascular codes. The PEAC did establish a set of out of facility practice expense inputs at its August 2003 PEAC meeting, however the PEAC asked the practice expense subcommittee for assistance in asking CMS for an economic impact analysis of the pricing of this set percutaneous endovascular codes.

The PEAC was uncomfortable forwarding its recommendation for these codes to the RUC without an economic analysis and a review of that analysis. The PEAC believed that this type of analysis should be performed on other codes as well, and made the following recommendation in August 2003.

“The PEAC shall formulate in-office practice expense inputs for these percutaneous endovascular codes and refer them to a study group for an economic analysis and review. All other codes currently listed as “NA” in the office setting will also be studied by the workgroup. The PEAC will make its report to the RUC then at a later date. (August 2003 PEAC)”

It was clarified that although that there may be codes that could shift from the inpatient hospital setting to offices, however, the issue that the PEAC has discussed is regarding services shifting from other components of Part B spending into the spending in the SGR. Sherry Smith explained that an argument may be developed that this “shift” in site-of-service (ie, pricing in the office setting where the services not currently priced) may be addressed through the “law and regulation” factor in the SGR allowed spending formula. Therefore, a legislative action may not be required.

The Practice Expense Subcommittee and the RUC agreed that the RUC should work to resolve this issue and recommends the following approach:

- **The RUC should form a workgroup to address this issue, with involvement of PEAC members.**
- **The RUC will CMS to conduct an impact analysis on pricing these percutaneous endovascular codes and other services newly priced in the office, that have been proposed to shift major resources from facility to the non-facility setting.**
- **For services transitioning from the facility to the non-facility settings, the RUC will advocate that CMS consider a regulatory change in the SGR update formula to increase allowed expenditures.**

One RUC member pointed to a few examples of urological procedures being moved from the hospital to physician’s offices where the overall of the cost had decreased. Another RUC member pointed out that as the length of stay of typical inpatient services falls, and office visits rise, physicians are incurring the cost of care when the hospital is being reimbursed for the time the patient would have been in the hospital. He suggested that overvalued DRGs should be reviewed just as the work and practice expense relative values are. AMA staff clarified that the RUC had communicated with CMS several years ago and at that time, CMS was not interested in conducting a review regarding the shift of costs from the inpatient to outpatient setting. Nevertheless, the RUC would like to urge CMS to conduct such a review at this time.

The RUC agreed that the issue of shifting services from the I/P setting to the O/P setting (i.e., hospital visits to office visits) is an issue that needs focus and encourages CMS to continue to consider this issue.

August 20, 2003 Proposed Rule of Payment Reform for Part B Drugs and Increased Payments Related to the Costs of Furnishing or Administering Drugs

The Subcommittee reviewed August 20, 2003 Proposed Rule in which CMS has developed various options regarding the issue of drug pricing. The Subcommittee focused its attention on modifications that will be made to enhance the payment for drug administration. Specifically, the issues surrounding the CMS proposal to adopt ASCO supplemental practice expense survey. This proposal will:

- Increase oncology practice expense per hour data from \$99.30 to \$189.00.
- Adopt ASCO supplemental survey data without blending with previous SMS data.
- Revise Cardiothoracic surgery practice expense data without blending with previous SMS data.
- Move drug administration codes from non-physician pool to top down methodology.
- Revise non-physician work pool practice expense per hour to \$82.60 from \$69.00 to reflect a weighted average of specialties remaining in this pool (radiology, cardiology, internal medicine, and therapeutic radiation oncology).
- Change hematology specialty crosswalk to oncology.
- Revise CMS policy to allow payment for multiple pushes.

The Subcommittee's concerns include a discussion of the following:

- Oncology practice expense per hour will increase to almost three times the current "all physician" practice expense per hour, which is \$69.00.
- Staff and administrative salaries appear excessive in comparison with CMS's own staff pricing utilized in the direct practice expense inputs.
- The other expense category for oncologists is 396% higher than all physicians.
- CMS failed to exclude extreme outliers in the data.

The Subcommittee agreed that the above concerns warranted a RUC comment on this Proposed Rule, and accordingly, recommended the following:

The RUC should submit a comment on the AWP rule stating that the RUC can not support adoption of the ASCO practice expense supplemental survey at this time, but welcomes the opportunity for further review of this data should the society choose to do so.

Although a number of issues are included in this Proposed Rule, this single topic was the only issue that the Subcommittee had time to address at this meeting. Although a formal motion is not included in this Subcommittee report, the discussion generally supported the CMS effort to ascertain an accurate drug pricing approach and to ensure appropriate payment for drug administration.

Other Issues

Doctor Gee expressed his continued dismay that CMS does not require greater documentation directly from industry in regards to the pricing of medical supplies and equipment. He offered the following motion, approved by the Subcommittee:

The RUC should encourage CMS to use all available avenues to gain accurate equipment and supply prices.

Carolyn Mullen from CMS stated during the PEAC Transition Workgroup, that with the conclusion of the PEAC there are some additional practice expense methodological items that the Practice Expense Subcommittee may want to review in the near future:

1. There are several variables considered when the useful life of an equipment item is established. A specific useful life methodology was established by ABT Associates long ago, and it may be in the best interest of the subcommittee to review the methodology in light of any existing data and possibly make comment
2. Current CMS policy disallows maintenance contracts as a direct practice expense input. It was suggested that some specific maintenance contracts may be anomalies, and should be allowed because of their similarities to other high cost equipment items
3. CMS currently has a specific amortization methodology for large or expensive pieces of equipment. It may be in the best interest of the subcommittee to review the amortization methodology used by CMS and possibly make comment
4. CMS's current methodology assigns all staff equipment and supply costs for services with professional and technical components (PC and TC) to the technical portion of the service. CMS has done this because it was believed that generally all of these direct cost inputs are associated with obtaining the diagnostic information and there is no direct costs associated with the physician interpretation. However, they now believe that there may be limited, exceptions where it is appropriate to assign direct inputs to a PC service. The PEAC recommended that CMS include clinical staff in certain codes that both a PC and TC component for activities such as scheduling the procedure and educating the patient when the procedure is done in the facility setting. CMS accepted these recommendations, but because of the practice expense methodology currently does not assign direct inputs to the PC services and the TC is not paid in the facility setting, these procedures were not credited with the recommended practice expense inputs. CMS is proposing to modify the practice expense methodology to allow direct inputs to be added to PC services when these inputs are clearly associated with the professional service, including when the PEAC makes such recommendations. Carolyn is suggesting that the subcommittee review other situations where this is occurring.

**AMA/Specialty RVS Update Committee
Administrative Subcommittee
Friday, September 19, 2003**

Members Present: Doctors John Derr (Chair) Sherry Barron-Seabrook, Michael Bishop, David F. Hitzeman, Peter A. Hollmann, John E. Mayer, Charles Mick, J. Baldwin Smith, III, Richard W. Whitten, and Robert Fifer, PhD

I. RUC Alternates

At the last RUC meeting, there were several alternates for RUC members who were unable to attend the sessions. Consequently, there were unanticipated substitutions for RUC members during presentations. The following motion was approved:

In the instance that neither the RUC Member nor the RUC Alternate are able to attend the RUC meeting, the specialty society shall notify the Chair of substitutions for representation in the form of a letter, in advance of the RUC Meeting. Approval of this substitute representative shall be at the discretion of the RUC Chair. In addition, the substitute representative shall be required to return a signed copy of the Conflict of Interest Statement to AMA Staff prior to the start of the RUC meeting.

The motion was approved by the RUC.

II. Criteria for Membership/Election Rules Document

The following editorial changes were made to the document under the Internal Medicine Subspecialty heading:

Bullet 2, line 1: “Internal Medicine subspecialties not included on the RUC approve list of **internal medicine** specialties are allowed to petition the RUC...”

Bullet 3: “The “other rotating seat” on the RUC ~~should~~ shall not be open to internal medicine subspecialty.

The committee reviewed the Criteria for Membership/Election Rules Document. The following motion was approved by the Subcommittee:

Pending a review by the AMA legal department, to ensure that the voting rules are in line with Sturgis parliamentary procedure, the document be approved.

The RUC extracted this item for discussion and determined that the Criteria for Membership/Election Rules Document should be tabled until the ballot issue is reviewed by the AMA legal department. This issue will be discussed at the next Administrative Subcommittee Meeting.

III. Request to provide RUC database CD to Medicare Carrier Medical Directors (CMD)

The RUC has received numerous requests from Medicare Carrier Medical Directors to obtain the RUC database, currently utilized in the RUC process. Doctor Bill Mangold, Carrier Medical Director, provided the perspective of CMDs by stating that RUC Database would be used as a resource to mediate payment for Medicare services. Doctor Mangold also stated his belief that the RUC Database is an excellent tool, which he could use to improve communication between Carrier Medicare Directors and physicians.

The committee queried Doctor Mangold on the potential use of the database and voiced concerns that it may be inappropriately utilized. Specifically, would payment be denied or reduced based on information included in the RUC database? Doctor Mangold commented that CMDs would use the database to improve the accuracy of reimbursement, especially when the services provided were reported with a -22 modifier. Sherry Smith verified this perspective by stating that many of the CMDs who have contacted her regard the database are interested in obtaining the rationale, vignettes, and descriptions of work to enhance their ability to evaluate claims reported with the -22 modifier.

The extent to which RUC database information is currently available was questioned by the RUC. Currently, vignettes are available, through the CPT product Code Manager. In addition, the RUC rationale is forwarded to CMS and under the Freedom of Information Act is technically available to the public; however, this information is not electronically available in an efficient and effective format. The quantitative data included in the RUC database, including the payment schedule information, utilization data, physician time, and practice expense inputs are all data that are currently available on the CMS website. However, the format of the RUC database compiles this information into one program, easier to utilize than accessing these individual databases.

Sherry Smith clarified that upon the approval by the RUC, the AMA would work to determine the licensing agreements that would properly safeguard the proprietary information contained in the database. She also suggested that a face-to-face orientation with CMDs, along with a thorough explanation of the licensing terms, would facilitate proper use of the database. Committee members suggested that the written materials clearly state that the description of the typical patient should not be used to solely represent the intent of the CPT code as the descriptor itself is should be the primary guide to appropriate coding.

The Administrative Subcommittee recommended that with the provision that the AMA will properly safeguard and discriminately distribute the information contained in the RUC database, the RUC database be distributed to Medicare Carrier Medical Directors.

This issue was extracted for discussion. The RUC had several questions regarding the report. The RUC questioned how the AMA would benefit from the release of the

information. Sherry Smith clarified that the request to release the information came from a public forum of the CMD's, not from the AMA.

The RUC also questioned the completeness of the database. While the Administrative Subcommittee agreed that the database is not perfected, the committee determined that it could be useful for those with the expertise to evaluate the information contained by the CD. A RUC member reminded the committee of previous Administrative Subcommittee recommendations that the database was not previously released to CMDs on the basis that it has gaps and omissions. While there have been improvements to the RUC database, the overall consensus of the RUC was that the database is not ready for release.

In addition to the readiness of the CD, the RUC questioned whether CMD's or other members of the public have the expertise to appropriately use the database information beyond the scope of the RUC. Some members felt that the information could be valuable for teaching, however, the amount of information should be controlled. The following motion was considered:

The RUC should release the database to the CMDs.

This motion failed.

RUC members continued to discuss whether partial data could be released. Several suggestions included releasing the data as part of a legally binding contract, with defined penalties for misuse of the product. In addition, it was suggested that the database be encrypted so that the information could not be mined. Others recommended that copyright agreements be signed prior to releasing the database. One suggestion included asking CMDs to keep a record of whether the use of the information resulted in no change, an increase, or a decrease in the payment for services. As part of future discussions by the Administrative Subcommittee, Doctor Gee suggested that the Subcommittee focus on determining the positive impact of releasing this information to physicians. The following motion was approved:

The request to provide RUC database CD to Medicare Carrier Medical Directors should be referred back to the Administrative Subcommittee. The Administrative Subcommittee should consider 1) what portions of the database should be released; 2) how may it be safeguarded; and 3) legal advice from the AMA.

The motion was approved by the RUC.

IV. Other Issues

The current term of the Advisory Committee, listed in the Structure and Functions document, states that the maximum term limit for an RUC advisor should be limited to 6 years. However, this has not been reinforced and it is not consistent with the lack of term limits for RUC members and HCPAC members. The Subcommittee determined that the

statement should be removed from the Structure and Function document. **The Subcommittee recommends the following:**

The RUC's Structure and Functions document should be revised as follows:

III. B. (4) Terms of Appointment – (a) Specialty Society representative and alternates shall hold terms of three (3) years, ~~with a maximum tenure of six (6) years.~~

AMA/Specialty Society RVS Update Process **Rotating Seat Policies and Election Rules**

Societies Eligible for Nomination

- Only those specialty societies which have appointed a physician Advisor to the RUC should be eligible. Any specialty society seated in the AMA House of Delegates may choose to appoint an advisor.
- The solicitation for nominations for the three rotating seats should be sent to the Executive Director of each specialty society represented on the RUC Advisory Committee, including those represented on the RUC. Those specialty societies in the AMA House of Delegates that have chosen not to appoint a physician representative to the RUC Advisory Committee will not receive an invitation.
- Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle.
- A specialty cannot run for both an Internal Medicine rotating seat and an “any other seat”.

Individual/Coalition Seats on the RUC

A specialty society may only be listed once on the ballot, either individually or as a part of a coalition. The RUC Staff will review the nominations and work with the nominated specialty societies to revise the ballot as necessary to avoid duplicate nominations and resolve other problems that may arise.

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, internal medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.
- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.
- The “other rotating seat” on the RUC shall not be open to internal medicine subspecialties.

Candidate Eligibility

The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.

Election Process

- All eligible specialty societies should be notified that they should attend the RUC meeting to make their presentation.
- Candidates will be allowed to present a two page biographical sketch or abbreviated CV. In addition to the biographical sketch, candidates will have two minutes, or less (at the discretion of the RUC Chair depending on the number of candidates) to present their qualifications before the entire RUC.
- There must be a quorum to hold the election and **a majority is considered 50 percent plus one vote** of the total number of valid ballots cast.

- In the case of **four or more candidates**, there could be up to three ballots. The first ballot will list all contending candidates. Voters will rank the candidates by assigning points to their choices as follows:

First choice	= 3 points
Second choice	= 2 points
Third choice	= 1 points

No points will be assigned for unranked candidates. A candidate with a majority vote (i.e. greater than 50 percent of the RUC members indicate the candidate as the first choice) will be awarded the seat. In the case of no majority vote, the three candidates garnering the highest number of points will be placed on a second ballot. Voters will then use the process described above to rank the candidates. The candidate with a majority vote will be awarded the seat. In the case of no majority vote, the two candidates garnering the highest points will be placed on a third ballot. From that ballot, the candidate with the majority vote will be elected to the seat.

- In the case of **three candidates**, there will be two ballots. The first ballot will use the ranking process described above and the second ballot will identify the two candidates with the most points from the first ballot.
- In the case of **two candidates**, the candidate with the majority vote will be elected to the seat.
- An election will be unnecessary in the case that there is an **unchallenged seat** and the seat will be awarded to the unchallenged candidate by voice vote.

Voter Eligibility

All current members of the RUC with voting seats are eligible to vote.

Ballot Validity

Names will be placed on the ballot to ensure that AMA staff can return the invalid ballot to the voter.

RUC HCPAC Review Board Report
Chicago, Illinois
Friday, September 19, 2003

On September 19, 2003, the RUC HCPAC Board met to assess the recommendations for CNS Assessment/Tests (96100, 96105, 96115 and 96117). The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair
Nelda Spyres, LCSW, Alternate Co-Chair
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C

David Keepnews, PhD, JD, RN, FAAN
Marc Lenet, DPM
Bernard Pfeifer, MD
Christopher Quinn, OD
Karen Smith, MS, RD, FADA
Arthur Traugott, MD

I. Call to Order

Ms. Spyres, LCSW called the meeting to order at 4:05 pm.

II. Introduction

Ms. Spyres, LCSW introduced the new RUC HCPAC Review Board member:

- Christopher Quinn, OD, American Optometry Association

III. Assessment of the CNS Assessment/Tests (96100, 95105, 96115, 96117)

The CNS assessment/tests (96100, 96105, 96115 and 96117) presented by the James Georgoulakis, PhD of the American Psychological Association were reviewed by the RUC HCPAC Review Board. After reviewing the Summary of Recommendation forms for these codes, it is the recommendation of the RUC HCPAC that the specialty society develop new coding proposals to be reviewed by the CPT Editorial Panel entailing new codes with descriptors that recognize the difference in the modality of testing, i.e. manual, automated and face-to-face in order to define the work inherent in each of these different testing methodologies. In addition to new descriptors, new vignettes would be created as well as new descriptions of pre, intra and post service work for each of these codes.

IV. Other Issues

The Joint CPT/RUC HCPAC Meeting is scheduled to be held during the November CPT Meeting. RUC HCPAC members are encouraged to attend and to forward any agenda topics to Desiree Rozell, CPT Staff or Roseanne Eagle, RUC Staff.

V. Adjournment

Ms. Spyres adjourned the meeting at 5:20 pm

September 30, 2003

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1476-P
P.O. Box 8013
Baltimore, Maryland 21244-8013
Hubert H. Humphrey Building

Re: Medicare Programs; Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004; Proposed Rule

Dear Administrator Scully:

The American Medical Association (AMA)/ Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for Medicare Programs; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004, published in the August 15, 2003 Federal Register.

Practice Expense Refinement

The RUC appreciates the remarks made in the Proposed Rule regarding the significant effort and the remarkable progress made by the members of the Practice Expense Advisory Committee (PEAC) in the refinement of direct practice expense inputs for individual CPT codes. We agree that this process has led to improvements in these data. We would also commend the CMS staff who have been committed to the refinement process and who have made significant contributions throughout the PEAC process.

The RUC offers the following specific comments on direct practice expense inputs:

- We agree that the practice expense methodology should be modified to allow direct inputs to be added to professional component services when these expenses have been identified by the PEAC to be linked to the physician service. Clinical staff time has been recommended for the professional component for cardiac catheterization CPT codes 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, and 93624. In addition, we request that you include CPT codes 93619, 93620, and 93642, which were reviewed at the

January 2003 PEAC meeting. Additional codes may be identified at future PEAC meetings.

- The proposal to re-price the medical supplies utilized in the practice expense methodology is well organized and comprehensive. We appreciate the enormity of this project and agree that these data must be refined periodically. We agree that the assignment of supply categories would be helpful in future refinement activities. The RUC understands that specialties may find more appropriate resources and prices for certain supply items and we urge CMS to consider these specific comments.
- CMS has made interim revisions to the direct practice expense inputs for 99183 *Physician attendance and supervision of hyperbaric oxygen therapy, per session* and to *Holter monitoring* CPT codes 93225, 93226, 93231, and 93232. CMS has proposed to make these revisions interim until the PEAC has the opportunity to review the direct inputs for these services. The PEAC is scheduled to review each of these CPT codes at the January or March 2004 meeting and we will submit these recommendations to you following this meeting. We appreciated your continued interest in guidance from the PEAC on these issues where interim refinements have been proposed.
- During the course of reviewing the CPEP database for the application of PEAC approved standards for CPT codes with 090 day global periods, AMA and CMS staff identified a few anomalies within the clinical time for a few codes with 000 day global periods. The PEAC has reviewed these anomalies and requests that CMS refine these codes in the Final Rule for the 2004 Physician Payment Schedule.

Percutaneous Abscess Drainage

In 1997, CPT created new codes to differentiate between open and percutaneous abscess drainage. Unlike their open procedure counterparts, all of the percutaneous codes were assigned a global period of 000 days. The work relative value for each of these codes is based on a 000 day global and does not incorporate any follow-up visits as it was determined that these visits are most typically performed by other physicians. As the codes were added to CPT after the CPEP process and prior to the PEAC/RUC process, CMS used a crosswalk to determine the practice expense inputs. It appears that CMS crosswalked the direct inputs from the open codes to the percutaneous codes. This crosswalk is inappropriate as the codes have different global periods.

Each of the following codes are currently priced in the facility setting only and are predominately performed in the inpatient setting. The specialty and the PEAC agree that there should be **zero direct practice expense inputs** in the facility setting for the following services:

Current Staff Time in CPEP File:					
<u>Code</u>	<u>Short Descriptor</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>% I/P</u>
32201	Drain, percutaneous, lung lesion	110	0	170	85%
44901	Drain app abscess, percutaneous	15	0	244	87%
47011	Percutaneous drain, liver lesion	15	0	207	78%
48511	Drain pancreatic pseudocyst	15	0	154	79%
49021	Drain peritoneal abscess	15	0	292	84%
49041	Drain, precut, abdominal abscess	15	0	292	85%
49061	Drain, precut, retroperitoneal abscess	15	0	292	81%
50021	Renal abscess, precut drain	74	60	377	69%
58823	Drain pelvic abscess, percutaneous	33	0	67	79%

Closure of Eyelid by Suture

The only other unexplained anomaly in the post-service time for a 000 day global code is related to CPT code 67875. This code has an assigned global period of 000 and includes no post-op visits in the work relative value. However, the CPEP process appears to have assigned the code clinical staff time, supplies, and equipment related to a follow up visit:

67875 Closure of eyelid by suture 31 minutes post-time for both non-facility and facility. Also includes many supplies and equipment related to post-op visit.

This CPT code was refined by the PEAC in March 2003 and approved by the RUC in May 2003. The attached RUC recommendation submitted to CMS in May, reflects a 000 day global and no longer includes inappropriate post-time.

Practice Expense Proposals for Calendar Year 2004

In the December 31, 2002 Final Rule, CMS indicated that the American Society of Clinical Oncology (ASCO) submitted a supplemental survey. The Lewin Group reviewed the survey and indicated that it met the criteria CMS established for supplemental practice expense data. However, Lewin expressed their concern with the results stating, "We believe that such high practice expense per hour values require further consideration." CMS articulates their concern with the data in detail in this December 2002 Final Rule. CMS chose not to incorporate this data in the 2003 Medicare Physician Payment Schedule, but indicated that CMS would confer with ASCO regarding the rationale for the high increases in costs from the SMS survey data, and in addition to

the variance with other specialty data, particularly in categories such as administrative staff salaries and other expenses.

In the August 15, 2003 Proposed Rule, CMS states, "We have discussed the oncology survey together with the Lewin Group and ASCO. These discussions were useful in providing us with more information which to make a final decision regarding the incorporation of the oncology survey into the practice expense methodology." CMS then refers to the August 20, 2003 Proposed Rule for Payment for Part B Drugs in regards to their proposed implementation of these data. In this separate Proposed Rule, CMS proposes to use the oncology survey data in the practice expense formula, if modifications are also made for payment of Part B drugs.

The RUC has not reviewed the ASCO survey or the Lewin Group report. The Proposed Rule includes a statement from CMS that, "We have subsequently held such discussions with ASCO and understand that the high values for average compensation for clinical and administrative staff are largely due to a limited number of practices with very high values that raise the average values calculated across all respondents to the survey." The RUC notes that detailed information regarding the CMS meeting in which ASCO provided additional rationale is not publicly available. Our committee did discuss the results of the survey as outlined in the *Federal Register* and concluded that the RUC would like to explore this issue further. However, we understand that our opportunity to comment concludes in October and our next scheduled meeting is not until February 2004. Accordingly, we cannot support the use of the oncology practice expense supplemental survey data at this time.

At the November 21, 1998 RUC meeting, the RUC assigned each element of the practice expense methodology to a subcommittee to review. The RUC's Research Subcommittee has been assigned the responsibility of reviewing issues related to the SMS survey and specialty supplemental survey data. The RUC would welcome the opportunity to review these data and rationale, if oncology chooses to present this information to the Research Subcommittee.

Professional Liability Insurance

CMS has announced that 2000 decennial census data, 2000 HUD fair market rental data for residential rents, and 1999 through 2003 professional liability insurance (PLI) premium data will be utilized to update geographic practice cost indices (GPCIs). However, since CMS has not yet received the 2000 decennial census data, refinements to the work and practice expense GPCIs will not be included in the Final Rule, but rather in the Proposed Rule for the 2005 Physician Payment Schedule. CMS is also in the process of collecting more recent PLI data and will publish new PLI GPCIs in the Final Rule for the 2004 Physician Payment Schedule, expected to be released in November 2004. These new PLI GPCIs will be considered interim and be subject to public comment.

The RUC understands that CMS is collecting actual 1999 through 2002 PLI premium data and will then project the PLI premium rates for 2003. At our April 2003 meeting, the RUC indicated an interest in reviewing these data. You had indicated that once these data had been summarized to prevent any confidentiality issues, CMS would share these data with the RUC. **We continue to be interested in this information and would request that these PLI premium data be made available to the RUC early in the comment period on the Final Rule, so that we have an opportunity to review the information prior to developing our comments.**

The RUC has recently formed a Professional Liability Insurance (PLI) Workgroup. This Workgroup met at our September 18-20, 2003 meeting. The PLI Workgroup reviewed the Proposed Rule and the current process for establishing PLI relative values for new and revised codes and recommended several actions items for the RUC. The RUC has approved the PLI Workgroup actions and has included these recommendations in this comment letter. The RUC looks forward to a continuing dialogue with CMS regarding of appropriate valuation of expense related to PLI in the RBRVS payment system.

The RUC will begin to engage in the establishment of PLI relative values recommendations to CMS. Our Research Subcommittee will begin exploring revisions to our survey instrument and/or *Summary of Recommendation* form to enable the RUC to provide recommendations on an appropriate temporary crosswalk for the PLI relative value and the assignment of a surgical or non-surgical risk factor. The RUC understands that currently new and revised codes are temporarily assigned a PLI relative value based on CMS staff analysis of an appropriate crosswalk. This analysis usually includes a review of the frequency estimations on the RUC's *Summary of Recommendation* form and often the key reference service used to determine physician work. CMS staff also determine if the CPT code should be assigned a surgical or non-surgical risk factor.

CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years. The RUC urges CMS to use the most recent data available for PLI payments. We also oppose weight averaging of multiple years of data. As recent PLI premiums have increased so greatly, it would be unfair to dilute these increases with data from earlier year(s), which are no longer reflective of today's costs.

CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data. The inclusion of these costs are critical as insurance carriers have left the market, requiring more and more physicians to change PLI coverage and therefore incur the costs of tail coverage. We understand that CMS has not included these costs in the past.

In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to assistant at surgery services should be removed from this analysis. The RUC is supportive of the letter submitted to CMS in May 2003 from a group of medical societies. This letter outlines a methodology for CMS to employ in considering this recommendation. The RUC is concerned that the weighted averaging reduces the potential payment to higher-risk specialties and increases the potential payment to lower-risk specialties.

The RUC requests a list of all CPT codes with their assigned category of risk (ie, surgical or non-surgical). We would like to review this list and potentially submit comments on the individual assignments of risk factor categories.

The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume. The RUC does not agree with the current CMS approach, which used national average premium data for twenty specialties, and uses crosswalk assumptions for the remaining medical specialties and other health care professionals. The RUC is also concerned that the 20 specialties with the highest volume used in the prior updates include only three high-risk specialties (orthopaedic surgery, general surgery, and emergency medicine).

The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized. Several RUC members urged the PLI Workgroup to “think outside the box” and work with CMS to develop a different methodology for paying physicians for their share of the individual physician’s professional liability insurance premium. This is a concept that we will explore at future RUC meetings and would welcome dialogue with CMS on this concept.

Payment Policy for CPT Tracking Codes

CMS proposes to create a national payment policy and develop relative values for CPT tracking codes when you discover a “significant programmatic need” to do so, such as when receiving a request from a carrier medical director. In our comments on the Final Rule for the 2003 Physician Payment Schedule, we offered guidance on any CPT Level III tracking code, or G code, for which you are considering the establishment of relative values. We continue to offer this guidance on developing work relative values or direct practice expense inputs for any services included on the physician payment schedule.

Excision of Benign and Malignant Lesions

In *CPT 2003*, the CPT Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646 utilizing the size of the actual skin removed, rather than the size of the lesion only. The RUC then reviewed a proposal from the specialties who perform these services to adjust the work relative values for work neutrality only. CMS agreed with this approach and published the RUC's recommendations in the Final Rule for the 2003 Physician Payment Schedule.

However, in this Proposed Rule, CMS has indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS has proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units.

The RUC understands that despite the former opinion of both the CPT Editorial Panel and our committee, CMS staff continue to view the physician work in the excision of benign and malignant lesions to be equivalent. We urge CMS to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. There are a number of issues that should be addressed related to this proposal. For example, the physician time for each of these code pairs of excision of benign and malignant lesions currently varies, with total physician time for excision of malignant lesion code 18% higher on average than the similar excision of benign lesion code.

Flow Cytometry

CMS has concluded that a coding scheme for flow cytometry, currently coded as CPT code 88180 *Flow cytometry, each cell surface, cytoplasmic or nuclear marker* that pays per marker for the technical component and per panel for the professional component would more accurately reflect the actual practice of flow cytometry. CMS indicates that they have discussed this issue with the laboratory community and understands that CPT coding changes are under consideration. CMS further states that in the event that the specialty does not submit a coding proposal, CMS would consider creating a HCPCS Level II G code(s) instead.

The RUC urges CMS to continue to work with the specialty society, as they work through the CPT Editorial Panel and RUC processes, to determine the appropriate coding and relative values for this service.

End Stage Renal Disease

Without any discussion with the nephrology community, the CPT Editorial Panel, or the RUC, CMS has proposed to alter the way physicians report and are paid for their services

related to End Stage Renal Disease (ESRD). Specifically, CMS has proposed to make CPT codes 90918, 90919, 90920, and 90921 invalid for Medicare and to create G codes to replace these CPT codes. CMS proposes to create three G codes in place of each CPT code to differentiate payment based on the number of “face-to-face physician visits” per month. Each age category would have a code for 1 visit per month, 2-3 visits per month, and 4 or more visits per month. CMS assumes that most physicians will perform 4 or more visits per patient and a smaller number will perform three or fewer visits. Using this assumption and 2002 Medicare utilization data, CMS developed relative value units for the new G codes that are to be equivalent to the pool of relative values from the existing CPT codes for ESRD services.

In principle, we express our disappointment and frustration that CMS continues to select one or two issues each year and make such decisions without any consultation from the medical community and outside the usual CPT and RUC processes. We note that this approach is contrary to most of our interactions with CMS on coding and payment policies. These issues are usually handled in an open manner with dialogue amongst all parties affected by the proposals.

We urge CMS to consider the many avenues of communication that were available once concern about these services were identified. Working with the specialty society and/or directly with the CPT Editorial Panel, a CPT coding proposal may have been developed. If your concern relates to the relative values currently assigned to these services, you may have asked the RUC to review the assumptions that were made when the codes were valued in 1994 to determine if they were still valid. We note that the RUC originally reviewed these existing codes in 1994 after CMS specifically requested the RUC’s input. The RUC urges you to not finalize this proposal and instead work with the specialty, CPT Editorial Panel, and the RUC toward a long-term solution that involves the input of all appropriate entities.

Adjustments to Relative Value Units to Match New MEI Weights

CMS has proposed to re-weight the components of the MEI based on updated data. Medical Economic Index (MEI). Changes in the MEI weights are as follows:

Component	Proposed MEI Weight	2003 Relative Value Units
Physician work	52.466%	52.649%
Practice expense	43.669%	44.175%
PLI	3.865%	3.176%

CMS is considering two options to match the new MEI weights to the relative values:

1. CMS may make no adjustment to the physician work relative values and adjust only the practice expense (.9885) and PLI relative values (1.217). CMS acknowledges that the medical community has expressed a desire to retain the stability of the work relative values. However, they note that an additional 0.3% reduction to the conversion factor would then be necessary.
2. CMS may adjust all three components by reducing physician work relative value units by 0.35% (0.9965) and the practice expense relative values by 1.15% (0.9885) and increase the PLI relative values by 21.7% (1.217) to match the rebased MEI weights. This option would not require a further adjustment to the conversion factor.

The RUC has consistently urged CMS to retain the stability of the work relative values in the RBRVS. We have discussed this issue extensively, in light of the continuing threat to the Medicare conversion factor, and unanimously continue to support our policy. **The RUC recommends that the work relative values remain stable and across-the-board adjustments should never be applied to this component of the RBRVS payment system.** CMS must consider that these work relative values are utilized by private payors, physician compensation systems, and in productivity analysis. The RUC depends upon the stability in these values as it reviews new and revised codes, both in magnitude estimation and in any calculations regarding intra-work per unit of time (IWPUT).

In our comments on the December 31, 2002 Final Rule, the RUC commented as follows:

During the course of the transition to the resource-based practice expense relative values and the refinement of its methodology, CMS has implemented changes and maintained budget neutrality via a re-scaling of all practice expense relative values. This has been a necessary step in the methodology and refinement as the relativity between CPT codes is still under development.

As the PEAC completes its efforts in the spring of 2004 and CMS finalizes policies related to practice expense, we believe that CMS should consider providing the same stability to the practice expense relative values as is seen in the work relative values. CMS should consider keeping the practice expense relative values stable at the conclusion of the refinement process. Much like what is done with work relative values, any code-level refinements due to annual coding changes that result in a non-budget neutral impact should not result in a reduction of all practice expense relative values. The RUC requests that CMS present an analysis of this issue in an upcoming Proposed Rule.

After discussion at our latest meeting, the RUC also recommends that adjustments related to the MEI rebasing not be applied to the practice expense relative values.

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We understand that CMS believes that if they adjust the work, practice expense and malpractice relative value units to match the new MEI weights, they are required to ensure that the adjustments do not increase or decrease Medicare expenditures by more than \$20 million. Although the total relative value units for some codes will increase slightly and the total relative value units for others will decrease slightly, the adjustment of the relative value units for budget neutrality means that the total payments after the revising and rebasing the relative value units will be no different in 2004 than in 2003. Thus, any suggestion that rebasing and revising the MEI will be an important means of addressing the PLI crisis is simply not true. Unless Medicare payments are increased to offset the increased costs of PLI, the crisis will remain and worsen over time.

We urge CMS to review section 1848(c)(4) of the Social Security Act to determine whether this section of the law would provide CMS the statutory authority keep the proposed PLI relative value units in place without reducing the work and practice expense relative value units. This section of the law is referred to as "Ancillary Policies." It states: "The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section." If that is not possible then we support making the necessary budget neutrality adjustments through the conversion factor, rather than the relative value units.

We appreciate your consideration of these comments. If you have any specific questions regarding our recommendations, please contact Sherry Smith at the AMA at (312) 464-5604 or via e-mail at Sherry_Smith@ama-assn.org.

Sincerely,

William Rich, MD

cc: RUC Participants
Attachment

Physician Time Components Accepted by the RUC - September 2003

RUC HCPAC Review Board Report
Chicago, Illinois
Friday, September 19, 2003

On September 19, 2003, the RUC HCPAC Board met to assess the recommendations for CNS Assessment/Tests (96100, 96105, 96115 and 96117). The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair
Nelda Spyres, LCSW, Alternate Co-Chair
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C

David Keepnews, PhD, JD, RN, FAAN
Marc Lenet, DPM
Bernard Pfeifer, MD
Christopher Quinn, OD
Karen Smith, MS, RD, FADA
Arthur Traugott, MD

I. Call to Order

Ms. Spyres, LCSW called the meeting to order at 4:05 pm.

II. Introduction

Ms. Spyres, LCSW introduced the new RUC HCPAC Review Board member:

- Christopher Quinn, OD, American Optometry Association

III. Assessment of the CNS Assessment/Tests (96100, 95105, 96115, 96117)

The CNS assessment/tests (96100, 96105, 96115 and 96117) presented by the James Georgoulakis, PhD of the American Psychological Association were reviewed by the RUC HCPAC Review Board. After reviewing the Summary of Recommendation forms for these codes, it is the recommendation of the RUC HCPAC that these codes be sent to the CPT Editorial Panel to create new codes with descriptors that recognize the difference in the modality of testing, i.e. manual, automated and face-to-face in order to define the work inherent in each of these different testing methodologies. In addition to new descriptors, new vignettes would be created as well as new descriptions of pre, intra and post service work for each of these codes.

IV. Other Issues

The Joint CPT/RUC HCPAC Meeting is scheduled to be held during the November CPT Meeting. RUC HCPAC members are encouraged to attend and to forward any agenda topics to Desiree Rozell, CPT Staff or Roseanne Eagle, RUC Staff.

V. Adjournment

Ms. Spyres adjourned the meeting at 5:20 pm

**AMA/Specialty RVS Update Committee
Administrative Subcommittee
Friday, September 19, 2003**

Members Present: Doctors John Derr (Chair) Sherry Barron-Seabrook, Michael Bishop, David F. Hitzeman, Peter A. Hollmann, John E. Mayer, Charles Mick, J. Baldwin Smith, III, Richard W. Whitten, and Robert Fifer, PhD

I. RUC Alternates

At the last RUC meeting, there were several alternates for RUC members who were unable to attend the sessions. Consequently, there were unanticipated substitutions for RUC members during presentations. The following motion was approved:

In the instance that neither the RUC Member nor the RUC Alternate are able to attend the RUC meeting, the specialty society shall notify the Chair of substitutions for representation in the form of a letter, in advance of the RUC Meeting. Approval of this substitute representative shall be at the discretion of the RUC Chair. In addition, the substitute representative shall be required to return a signed copy of the Conflict of Interest Statement to AMA Staff prior to the start of the RUC meeting.

The motion was approved by the RUC.

II. Criteria for Membership/Election Rules Document

The following editorial changes were made to the document under the Internal Medicine Subspecialty heading:

Bullet 2, line 1: “Internal Medicine subspecialties not included on the RUC approve list of **internal medicine** specialties are allowed to petition the RUC...”

Bullet 3: “The “other rotating seat” on the RUC ~~should~~ shall not be open to internal medicine subspecialty.

The committee reviewed the Criteria for Membership/Election Rules Document. The following motion was approved by the Subcommittee:

Pending a review by the AMA legal department, to ensure that the voting rules are in line with Sturgis parliamentary procedure, the document be approved.

The RUC extracted this item for discussion and determined that the Criteria for Membership/Election Rules Document should be tabled until the ballot issue is reviewed by the AMA legal department. This issue will be discussed at the next Administrative Subcommittee Meeting.

III. Request to provide RUC database CD to Medicare Carrier Medical Directors (CMD)

The RUC has received numerous requests from Medicare Carrier Medical Directors to obtain the RUC database, currently utilized in the RUC process. Doctor Bill Mangold, Carrier Medical Director, provided the perspective of CMDs by stating that RUC Database would be used as a resource to mediate payment for Medicare services. Doctor Mangold also stated his belief that the RUC Database is an excellent tool, which he could use to improve communication between Carrier Medicare Directors and physicians.

The committee queried Doctor Mangold on the potential use of the database and voiced concerns that it may be inappropriately utilized. Specifically, would payment be denied or reduced based on information included in the RUC database? Doctor Mangold commented that CMDs would use the database to improve the accuracy of reimbursement, especially when the services provided were reported with a -22 modifier. Sherry Smith verified this perspective by stating that many of the CMDs who have contacted her regard the database are interested in obtaining the rationale, vignettes, and descriptions of work to enhance their ability to evaluate claims reported with the -22 modifier.

The extent to which RUC database information is currently available was questioned by the RUC. Currently, vignettes are available, through the CPT product Code Manager. In addition, the RUC rationale is forwarded to CMS and under the Freedom of Information Act is technically available to the public; however, this information is not electronically available in an efficient and effective format. The quantitative data included in the RUC database, including the payment schedule information, utilization data, physician time, and practice expense inputs are all data that are currently available on the CMS website. However, the format of the RUC database compiles this information into one program, easier to utilize than accessing these individual databases.

Sherry Smith clarified that upon the approval by the RUC, the AMA would work to determine the licensing agreements that would properly safeguard the proprietary information contained in the database. She also suggested that a face-to-face orientation with CMDs, along with a thorough explanation of the licensing terms, would facilitate proper use of the database. Committee members suggested that the written materials clearly state that the description of the typical patient should not be used to solely represent the intent of the CPT code as the descriptor itself is should be the primary guide to appropriate coding.

The Administrative Subcommittee recommended that with the provision that the AMA will properly safeguard and discriminately distribute the information contained in the RUC database, the RUC database be distributed to Medicare Carrier Medical Directors.

This issue was extracted for discussion. The RUC had several questions regarding the report. The RUC questioned how the AMA would benefit from the release of the

information. Sherry Smith clarified that the request to release the information came from a public forum of the CMD's, not from the AMA.

The RUC also questioned the completeness of the database. While the Administrative Subcommittee agreed that the database is not perfected, the committee determined that it could be useful for those with the expertise to evaluate the information contained by the CD. A RUC member reminded the committee of previous Administrative Subcommittee recommendations that the database was not previously released to CMDs on the basis that it has gaps and omissions. While there have been improvements to the RUC database, the overall consensus of the RUC was that the database is not ready for release.

In addition to the readiness of the CD, the RUC questioned whether CMD's or other members of the public have the expertise to appropriately use the database information beyond the scope of the RUC. Some members felt that the information could be valuable for teaching, however, the amount of information should be controlled. The following motion was considered:

The RUC should release the database to the CMDs.

This motion failed.

RUC members continued to discuss whether partial data could be released. Several suggestions included releasing the data as part of a legally binding contract, with defined penalties for misuse of the product. In addition, it was suggested that the database be encrypted so that the information could not be mined. Others recommended that copyright agreements be signed prior to releasing the database. One suggestion included asking CMDs to keep a record of whether the use of the information resulted in no change, an increase, or a decrease in the payment for services. As part of future discussions by the Administrative Subcommittee, Doctor Gee suggested that the Subcommittee focus on determining the positive impact of releasing this information to physicians. The following motion was approved:

The request to provide RUC database CD to Medicare Carrier Medical Directors should be referred back to the Administrative Subcommittee. The Administrative Subcommittee should consider 1) what portions of the database should be released; 2) how may it be safeguarded; and 3) legal advice from the AMA.

The motion was approved by the RUC.

IV. Other Issues

The current term of the Advisory Committee, listed in the Structure and Functions document, states that the maximum term limit for an RUC advisor should be limited to 6 years. However, this has not been reinforced and it is not consistent with the lack of term limits for RUC members and HCPAC members. The Subcommittee determined that the

statement should be removed from the Structure and Function document. **The Subcommittee recommends the following:**

The RUC's Structure and Functions document should be revised as follows:

III. B. (4) Terms of Appointment – (a) Specialty Society representative and alternates shall hold terms of three (3) years, ~~with a maximum tenure of six (6) years.~~

AMA/Specialty Society RVS Update Process Rotating Seat Policies and Election Rules

Societies Eligible for Nomination

- Only those specialty societies which have appointed a physician Advisor to the RUC should be eligible. Any specialty society seated in the AMA House of Delegates may choose to appoint an advisor.
- The solicitation for nominations for the three rotating seats should be sent to the Executive Director of each specialty society represented on the RUC Advisory Committee, including those represented on the RUC. Those specialty societies in the AMA House of Delegates that have chosen not to appoint a physician representative to the RUC Advisory Committee will not receive an invitation.
- Specialty societies that have been appointed to a rotating seat in the previous cycle shall not be eligible for nomination to the three rotating seats for the subsequent cycle.
- A specialty cannot run for both an Internal Medicine rotating seat and an “any other seat”.

Individual/Coalition Seats on the RUC

A specialty society may only be listed once on the ballot, either individually or as a part of a coalition. The RUC Staff will review the nominations and work with the nominated specialty societies to revise the ballot as necessary to avoid duplicate nominations and resolve other problems that may arise.

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, internal medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.
- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.
- The “other rotating seat” on the RUC shall not be open to internal medicine subspecialties.

Candidate Eligibility

The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.

Election Process

- All eligible specialty societies should be notified that they should attend the RUC meeting to make their presentation.
- Candidates will be allowed to present a two page biographical sketch or abbreviated CV. In addition to the biographical sketch, candidates will have two minutes, or less (at the discretion of the RUC Chair depending on the number of candidates) to present their qualifications before the entire RUC.
- There must be a quorum to hold the election and **a majority is considered 50 percent plus one vote** of the total number of valid ballots cast.
 - In the case of **four or more candidates**, there could be up to three ballots. The first ballot will list all contending candidates. Voters will rank the candidates by assigning points to their choices as follows:

First choice	= 3 points
Second choice	= 2 points
Third choice	= 1 points

No points will be assigned for unranked candidates. A candidate with a majority vote (i.e. greater than 50 percent of the RUC members indicate the candidate as the first choice) will be awarded the seat. In the case of no majority vote, the three candidates garnering the highest number of points will be placed on a second ballot. Voters will then use the process described above to rank the candidates. The candidate with a majority vote will be awarded the seat. In the case of no majority vote, the two candidates garnering the highest points will be placed on a third ballot. From that ballot, the candidate with the majority vote will be elected to the seat.

- In the case of **three candidates**, there will be two ballots. The first ballot will use the ranking process described above and the second ballot will identify the two candidates with the most points from the first ballot.
- In the case of **two candidates**, the candidate with the majority vote will be elected to the seat.
- An election will be unnecessary in the case that there is an **unchallenged seat** and the seat will be awarded to the unchallenged candidate by voice vote.

Voter Eligibility

All current members of the RUC with voting seats are eligible to vote.

Ballot Validity

Names will be placed on the ballot to ensure that AMA staff can return the invalid ballot to the voter.

**AMA.Specialty Society RVS Update Committee
Five-Year Review Workgroup
Friday, September 19, 2003**

The following Five-Year Review Workgroup members met to review the previous Five-Year processes and to begin discussing the timeline, processes, and methodology for the next Five-Year Review : Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, Doug Leahy (alternate for J. Leonard Lichtenfeld), James Maloney, Arthur Traugott, Trexler Topping, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Review of Process, Methodology, and Timeline from Previous Five-Year Review

The Workgroup initially reviewed the timeline, methodology, and processes from the two previous Five-Year Review activities. Workgroup members shared their experience and identified a number of issues that should be further reviewed in developing procedures for the next Five-Year Review, including:

- Review compelling evidence – it was noted that the standard for compelling evidence may not have been consistent between the first two Five-Year Review activities. The Workgroup will review the current definition/standards for compelling evidence, that is listed on page 7 of the current *Instructions for Specialty Societies Developing Work Relative Recommendations*.
- Develop a fair and standard appeals process – a number of specialty societies were afforded multiple opportunities to formulate and present compelling evidence in the last Five-Year Review. The Workgroup agreed that an appeals process is necessary for the next Five-Year Review. However, it is critical that this process be developed in advance, so that every specialty be afforded the same opportunity to present compelling evidence. A number of issues will be considered, including whether the utilization of facilitation committees remain appropriate in the Five-Year Review as the RUC received criticism in the past that it was difficult for specialties to re-present their rationale to a new group of individuals. The Workgroup will also develop criteria and a timeline for final appeals.
- IWPUT – The Workgroup expressed hope that the issues surrounding the Intra-Work Per Unit Time (IWPUT) will be addressed and resolved prior to Five-Year Review. The Workgroup suggests that the Research Subcommittee discuss the use of IWPUT in the next Five-Year Review.

Timeline for Third Five-Year Review

The Workgroup reviewed the attached draft timeline for the third Five-Year Review that was prepared based on the timeline utilized in the previous two Five-Year Review processes. The workgroup agreed that the timeline is appropriate, and will consider any specialty society comments before final approval at the February 2004 RUC meeting.

The RUC reviewed the timetable and recommends that all approved methodologies in effect at the February 3-6, 2005 RUC meeting, including the RUC survey instrument, will be acceptable methodologies in the Five-Year Review. The RUC also understands that specialties must present any alternative methodologies by the April 28-May 1, 2005 meeting, but emphasized that it is in a specialty societies best interest to present this information as soon as possible.

Potential Modifications in Methodology and Processes for Third Five-Year Review

The Workgroup identified a number of methodological and procedural issues that need to be discussed further and resolved prior to finalizing the process for the next Five-Year Review. The follow issues were discussed:

- Review of Family of Services vs. Individual Services – In the previous Five-Year Review, several specialties identified large groups of codes and then developed relative value recommendations using unique methodology approved by the Research Subcommittee in advance of their presentations to the RUC. The Workgroup agreed to compile a list of previously accepted approaches to review families of services. If a specialty would like to vary from these methodologies, they must present this approach to the Research Subcommittee. The Workgroup agreed that innovation in the process is important, but that must be balanced with the need to retain fairness in the opportunities presented to all specialties. It was suggested that specialties should begin to discuss these approaches in early 2004 and present their ideas to the Research Subcommittee as soon as possible. The last opportunity to receive approval for a new methodology will be at the April 2005 RUC meeting.
- Screening Criteria – The workgroup agreed that it will need to review the screening criteria previously utilized to identify codes that should not be pursued further beyond the original comment (eg, due to low utilization data or no expressed interest by a specialty society). It was noted that some screening criteria may no longer be appropriate, and other new criteria may surface.
- Direct Practice Expense Inputs – The Workgroup discussed the scope of the next Five-Year Review in regards to the work relative values and direct practice expense inputs. The Workgroup agreed that all codes presented at the Five-Year Review may be accompanied by practice expense and would be reviewed by the RUC. For example, if the number of level of office visits related to a CPT codes is modified in reviewing physician work, this will lead to a similar revision in the direct practice expense inputs for the service. However, the Workgroup was less certain that a review of practice expense inputs, independent of a consideration of physician work, would be appropriate. It was noted that the Practice Expense Advisory Committee (PEAC) will have refined nearly all CPT codes and the opportunity for specialties to place a code on the PEAC agenda exists until the March 2004 PEAC meeting. CMS staff noted that the agency has not stated any plan to initiate a refinement of all practice expense inputs during this Five-Year

Review, as the PEAC will just be concluding their work. The Workgroup, therefore, suggests that the proposal be developed to urge that the scope of the Five-Year Review be considered by the RUC at this meeting and recommends that codes should not be brought to the Five-Year Review solely on the basis of practice expense mis-valuation. The workgroup notes, however, that there is no established RUC mechanism by which specialties may address codes whose practice expense alone is mis-valued. We recommend that the RUC develop a process and methodology by which anomalies in practice expense identified between the conclusion of the PEAC and the fourth Five-Year Review may be reviewed. The RUC recommends the following:

In developing the RUC proposal to CMS on the Five-Year Review, the RUC will propose that CPT codes identified for the third Five-Year Review should be based on potential mis-valuation of physician work. Refinements to direct practice expense inputs will occur as a result of changes in physician time, visit data, etc. The RUC will recommend to CMS that CPT codes should not be identified for this particular Five-Year Review based solely on concerns regarding the direct practice expense inputs only.

Development of Process and Identification of Objective Data to Identify Potentially Mis-valued CPT Codes

The Workgroup discussed the RUC's role in identifying potentially mis-valued codes. Documentation was reviewed outlining the previous attempts by the RUC and CMS to identify codes utilizing objective data. Use of data or comments by CMDs or others have been utilized in the past as it was acknowledged that specialties will bring perceived undervalued CPT codes to the Five-Year Review, but it is unlikely that specialties will identify overvalued services.

The Workgroup will continue to discuss this issue and review a list of suggestions developed by staff for review (eg, 50 CPT codes that were valued as inpatient services that are now performed predominately in the office to determine if physician time and work remain appropriately valued). In addition, the workgroup suggests that **the RUC begin discussions with CMS regarding identification of mis-valued codes.**

Timetable for the Five-Year Review – DRAFT - For Discussion

March 2004	Submission of RUC Proposal on Five-Year Review to CMS
December 30, 2004	Comment period closes on public solicitation of codes to be reviewed. <i>Assumes publication date of CMS Final Rule of November 1, 2004</i>
February 1, 2005	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
February 3-6, 2005	Research Subcommittee to review any changes to the existing RUC survey instrument.
February 15, 2005	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS on February 1.
April 1, 2005	Responses to the LOI due to the AMA.
April 28 – May 1, 2005	Initial screen of all codes at the April RUC meeting. Research Subcommittee to review any alternative methodologies introduced.
May 9, 2005	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.
August 2, 2005	Recommendations due to the AMA from specialty societies.
August 25-28, 2005	Five-year review workgroups meet and review recommendations.
September 14, 2005	Workgroup recommendations and consent calendars sent to the RUC.
September 29 – October 2, 2005	RUC meeting to review workgroup recommendations and consent calendars
October 31, 2005	RUC recommendations submitted to CMS.
November 2005- February 2006	CMS Review
March 2006	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2006	Final Rule on Five-Year Review
January 1, 2007	Implementation of new work relative value units.

Approved at the September 18-20, 2003 RUC Meeting.

AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup Report
Friday, September 19, 2003

The following Multi-Specialty Points of Comparison (MPC) Workgroup members met to review proposed additions and deletions to the MPC: Doctors James Blankenship (Chair), John Derr, William Gee, John Mayer, Daniel Nagle, and Maurits J. Wiersema.

General Discussion Regarding MPC History/Criteria:

The Workgroup reviewed the RUC's *Annotated List of Actions* and discussed the historical revisions to the Multi-Specialty Points of Comparison (MPC). The workgroup understands that the following list of absolute criteria for the MPC were approved in February 2001:

- The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by CMS.
- The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

In February 2002, the RUC recommended that the MPC include the codes that meet all of the absolute criteria (designated with the key "A"), as well as additional codes recommended by specialties. Codes with the key B are codes that do not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians. Codes categorized as "C" are codes that do not have RUC time available , but the specialty would like the code included as a reference point.

The Workgroup questioned whether it was appropriate, going forward, to add codes to the MPC that have not been surveyed by the RUC and do not have RUC physician time available. The Workgroup concluded that this is not appropriate and recommends the following:

From this point forward, only A category codes shall be added to the MPC lists.

While the Workgroup did not feel comfortable suggesting a change in policy to now exclude all "B" and "C" codes from the MPC, the Workgroup expressed concern that specialties have the opportunity to replace these codes with "A" codes in the future. In particular, the Workgroup was concerned that specialties not be mandated to survey "B" or "C" codes on the MPC, if the RUC receives a request to review these codes in the future. The Workgroup recommends the following:

If external requests are imposed regarding the MPC list (ie, that all of the codes be considered validated by the RUC), specialty societies should be allowed to review codes on the list for addition and/or removal.

It was noted that the vote was not unanimous.

The Workgroup also considered whether there should be a formal request process by which requests for additions/deletions to the MPC list are brought to the RUC. The Workgroup felt it would be inappropriate to require completion of a request form. The workgroup voted to request that:

- (a) Requests for additions/deletions be accompanied by a rationale, and;
- (b) The society making the request for addition/deletion should consult with other specialties performing the procedure to ascertain their agreement to the proposed change.

Review of Specialty Society Recommendations to Modify the Multi-Specialty Points of Comparison Document

In March 2002, the RUC recommended that the MPC list be reviewed (i.e., specialty societies would have the opportunity to solicit additions or deletions) on an annual basis, beginning at the September 2003 RUC meeting. The following requests for addition/deletions were considered at this meeting (Please refer to pages 784-788 of RUC agenda book for information on each CPT code listed below):

American Podiatric Medical Association - CPT codes 28485 and 28525

The Workgroup recommends that the CPT codes 28483 and 28525 are not level A codes and should not be included on the list.

American Association of Otolaryngology – Head and Neck Surgery-delete 31590.

CPT code 31590 from the MPC list because the service is no longer performed.

American Society of Colon and Rectal Surgery on codes 44202, 45110, 45113, 46060, and 46221

CPT code 45113 should be deleted and replaced with 45110. CPT code 45113 has a very low frequency and was a mini-survey during the second 5-yr review, while 45110 is a similar procedure, but has a higher frequency and was a full RUC survey.

CPT code 46060 should be deleted and be replaced with CPT code 46221. 46060 has a low IWP/PUT because it was reduced as part of a family of reductions (during the second 5-yr review), without regard to the actual work of the code. Additionally, 46221 has a significantly higher frequency.

CPT code 44202 should be added to represent laparoscopic surgery in this section of the MPC.

American Society of Anesthesiology on CPT codes 62311 and 36489 36556

Code 62311 has a zero day global code and has an RVW of 1.54 and an IWP/PUT value of -0.043. This code was one of the very first pain codes to go through the RUC. Since then, there have been changes in the methods used to evaluate codes which have resulted in a more sophisticated process. The specialty society does not feel that code 62311 is properly valued, therefore the Workgroup recommends that it be removed from the MPC list.

CPT code 36489 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2* has been deleted from CPT and replaced with code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older.* The MPC list should be updated accordingly.

American College of Radiology – delete code 75553

The Workgroup agreed with the American College of Radiology and the American College of Cardiology that code 75553, *Cardiac magnetic resonance imaging for morphology; with contrast material,* should be deleted from the MPC list due to changes in the technology for this service.

American Academy of Pediatrics - add 99294 and 99296

The Workgroup agreed with the American Association of Pediatrics that CPT code 99296 (subsequent neonatal critical care) should be reinstated on the MPC list, as it was initially included on the initial version of the MPC list. It was removed when the neonatal codes were revised and subsequently revalued in 2001-2002.

During the same time that the neonatal codes were being revised, new pediatric (for patients 31 days through 24 months of age) critical care codes were developed (99293 and 99294) and subsequently valued by the RUC. Given the parallel between 99294 (subsequent pediatric critical care) and 99296, it would be appropriate to include 99294 on the MPC list, as well.

The Workgroup noted that CPT codes 54150 and 62270 are currently on the Multi-Specialty Points of Comparison Document.

The Workgroup recommends the deletion and addition of CPT codes as requested by specialty societies. The only exception is in regard to CPT codes 28485 and 28525, which have not been reviewed by the RUC, and therefore, should not be added to the MPC.

Discussion of IWPUT on MPC Issue

Regarding the addition of IWPUT to the Multi-Specialty Points of Comparison List, the Workgroup acknowledged that while some specialties agreed with the addition of IWPUT calculations, other specialty societies did not believe that this information should be added to the MPC list. The Research Subcommittee further discussed this issue on September 19, 2003.

Other Issues

Based on the discussion during the meeting, the Workgroup determined that the MPC workgroup should continue to meet for the purpose of revising the MPC list for use during the 5-year review. **The following motion was accepted:**

For the purpose of refining and validating the MPC list prior to the upcoming 5-year review, the MCP workgroup will continue to meet over the next few months via conference call.

Approved at the September 18-20, 2003 RUC Meeting.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
Friday, September 19, 2003

The Practice Expense Subcommittee met during the September 2003 RUC meeting to continue its work on the allocation of physician time components, discuss the practice expense implications of shifts in site of service, and discuss components of the AWP proposed rule. The following Subcommittee members participated: Doctors Robert Zwolak (Chair), Bibb Allen, Neil Brooks, William Gee, Charles Koopmann, Bill Moran, Greg Przybylski, Daniel Siegel, Mauritis Wiersema, and Nelda Spyres.

Physician Time Components

Doctor Zwolak introduced the subcommittee to each of the items on the agenda starting with the continuation of the subcommittee's work on providing the PEAC with physician time components for its review of direct practice expense inputs. Doctor Zwolak explained that the RUC had asked specialty societies to provide all the necessary time components for each of their global period codes. Specialties for this meeting, were bringing forth fifteen 000 day global codes and that it was important to concentrate on intra-service portion of the time, as the PEAC uses physician intra-service time as one of their standards to determine clinical staff time in the office setting. Below are the established guidelines created by the RUC for the specialties to follow when submitting their physician time components:

- 1) If the specialty society agrees with the total Harvard physician time, specialty societies are asked to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post-operative hospital and office visits.
- 2) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is higher, specialty societies are required to conduct a full RUC physician time survey for the code.
- 3) If the specialty society disagrees with the total Harvard physician time, and believes the total physician time is lower, the predominate specialty who performs the service may provide a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel to develop the physician time components.

The subcommittee members were reminded that the RUC has expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs, and have no bearing on physician work. Subcommittee members reviewed the time allocations to see if they seem accurate for the service being provided. The Subcommittee recommended the following RUC action:

The RUC recommends the following 15 physician time components be used for practice expense purposes:

CPT Code	Glob	Specialty	Pre-	Intra	Post	Time, Same	Total	Method	Hrvd Time	Time change	work rvu	IWPUT
			serv time	-Serv time	Day of Surgery	Time REC						
35470	000	SIR	*	82	128	210	Allocate	210	0	8.63	0.070	
35471	000	SIR	*	90	140	230	Allocate	230	0	10.07	0.077	
35472	000	SIR	*	85	93	178	Allocate	178	0	6.91	0.057	
35473	000	SIR	*	78	83	161	Allocate	161	0	6.04	0.054	
35474	000	SIR	*	80	106	186	Allocate	186	0	7.36	0.062	
35475	000	SIR	*	90	121	206	Allocate	206	0	9.49	0.075	
35476	000	SIR	*	75	70	145	Allocate	145	0	6.04	0.060	
36481	000	SIR	*	75	77	152	Allocate	152	0	6.99	0.070	
37203	000	SIR AGA,	*	80	61	141	Allocate	141	0	5.03	0.046	
43216	000	ASGE AGA,	12	33	20	65	Allocate	65	0	2.40	0.051	
43248	000	ASGE AGA,	16	32	15	63	Allocate	63	0	3.15	0.077	
44365	000	ASGE	22	48	16	86	Allocate	86	0	3.31	0.051	
93660	000	ACC	15	50	15	80	Survey	42	38	1.89	0.024	
93797	000	ACC	2	6	3	11	Allocate	11	0	0.18	0.011	
93798	000	ACC	2	7	3	12	Allocate	12	0	0.28	0.024	

*Pre and Post time have been combined for codes 35470-37203 into the Post Service Time Period.

The physician time for each code will be entered into the RUC database, and each code will be flagged in the RUC database to clearly identify that the physician time components are not to be considered when making work recommendations.

Facility to Non-Facility Procedures

The practice expense subcommittee agreed in January 2003 that there should be a mechanism to establish non-facility practice expense as practice patterns change, and the PEAC recently was asked to establish practice expense inputs for a set of percutaneous endovascular codes. The PEAC did establish a set of out of facility practice expense inputs at its August 2003 PEAC meeting, however the PEAC asked the practice expense subcommittee for assistance in asking CMS for an economic impact analysis of the pricing of this set percutaneous endovascular codes.

The PEAC was uncomfortable forwarding its recommendation for these codes to the RUC without an economic analysis and a review of that analysis. The PEAC believed that this type of analysis should be performed on other codes as well, and made the following recommendation in August 2003.

“The PEAC shall formulate in-office practice expense inputs for these percutaneous endovascular codes and refer them to a study group for an economic analysis and review. All other codes currently listed as “NA” in the office setting will also be studied by the workgroup. The PEAC will make its report to the RUC then at a later date. (August 2003 PEAC)”

It was clarified that although that there may be codes that could shift from the inpatient hospital setting to offices, however, the issue that the PEAC has discussed is regarding services shifting from other components of Part B spending into the spending in the SGR. Sherry Smith explained that an argument may be developed that this “shift” in site-of-service (ie, pricing in the office setting where the services not currently priced) may be addressed through the “law and regulation” factor in the SGR allowed spending formula. Therefore, a legislative action may not be required.

The Practice Expense Subcommittee and the RUC agreed that the RUC should work to resolve this issue and recommends the following approach:

- **The RUC should form a workgroup to address this issue, with involvement of PEAC members.**
- **The RUC will ask CMS to conduct an impact analysis on pricing these percutaneous endovascular codes and other services newly priced in the office, that have been proposed to shift major resources from facility to the non-facility setting.**
- **For services transitioning from the facility to the non-facility settings, the RUC will advocate that CMS consider a regulatory change in the SGR update formula to increase allowed expenditures.**

One RUC member pointed to a few examples of urological procedures being moved from the hospital to physician’s offices where the overall of the cost had decreased. Another RUC member pointed out that as the length of stay of typical inpatient services falls, and office visits rise, physicians are incurring the cost of care when the hospital is being reimbursed for the time the patient would have been in the hospital. He suggested that overvalued DRGs should be reviewed just as the work and practice expense relative values are. AMA staff clarified that the RUC had communicated with CMS several years ago and at that time, CMS was not interested in conducting a review regarding the shift of costs from the inpatient to outpatient setting. Nevertheless, the RUC would like to urge CMS to conduct such a review at this time.

The RUC agreed that the issue of shifting services from the I/P setting to the O/P setting (ie, hospital visits to office visits) is an issue that needs focus and encourages CMS to continue to consider this issue.

August 20, 2003 Proposed Rule of Payment Reform for Part B Drugs and Increased Payments Related to the Costs of Furnishing or Administering Drugs

The Subcommittee reviewed August 20, 2003 Proposed Rule in which CMS has developed various options regarding the issue of drug pricing. The Subcommittee focused its attention on modifications that will be made to enhance the payment for drug administration. Specifically, the issues surrounding the CMS proposal to adopt ASCO supplemental practice expense survey. This proposal will:

- Increase oncology practice expense per hour data from \$99.30 to \$189.00.
- Adopt ASCO supplemental survey data without blending with previous SMS data.
- Revise Cardiothoracic surgery practice expense data without blending with previous SMS data.
- Move drug administration codes from non-physician pool to top down methodology.
- Revise non-physician work pool practice expense per hour to \$82.60 from \$69.00 to reflect a weighted average of specialties remaining in this pool (radiology, cardiology, internal medicine, and therapeutic radiation oncology).
- Change hematology specialty crosswalk to oncology.
- Revise CMS policy to allow payment for multiple pushes.

The Subcommittee's concerns include a discussion of the following:

- Oncology practice expense per hour will increase to almost three times the current "all physician" practice expense per hour, which is \$69.00.
- Staff and administrative salaries appear excessive in comparison with CMS's own staff pricing utilized in the direct practice expense inputs.
- The other expense category for oncologists is 396% higher than all physicians.
- CMS failed to exclude extreme outliers in the data.

The Subcommittee agreed that the above concerns warranted a RUC comment on this Proposed Rule, and accordingly, recommended the following:

The RUC should submit a comment on the AWP rule stating that the RUC can not support adoption of the ASCO practice expense supplemental survey at this time, but welcomes the opportunity for further review of this data should the society choose to do so.

Although a number of issues are included in this Proposed Rule, this single topic was the only issue that the Subcommittee had time to address at this meeting. Although a formal motion is not included in this Subcommittee report, the discussion generally supported the CMS effort to ascertain an accurate drug pricing approach and to ensure appropriate payment for drug administration.

Other Issues

Doctor Gee expressed his continued dismay that CMS does not require greater documentation directly from industry in regards to the pricing of medical supplies and equipment. He offered the following motion, approved by the Subcommittee:

The RUC should encourage CMS to use all available avenues to gain accurate equipment and supply prices.

Carolyn Mullen from CMS stated during the PEAC Transition Workgroup, that with the conclusion of the PEAC there are some additional practice expense methodological items that the Practice Expense Subcommittee may want to review in the near future:

1. There are several variables considered when the useful life of an equipment item is established. A specific useful life methodology was established by ABT Associates long ago, and it may be in the best interest of the subcommittee to review the methodology in light of any existing data and possibly make comment
2. Current CMS policy disallows maintenance contracts as a direct practice expense input. It was suggested that some specific maintenance contracts may be anomalies, and should be allowed because of their similarities to other high cost equipment items
3. CMS currently has a specific amortization methodology for large or expensive pieces of equipment. It may be in the best interest of the subcommittee to review the amortization methodology used by CMS and possibly make comment
4. CMS's current methodology assigns all staff equipment and supply costs for services with professional and technical components (PC and TC) to the technical portion of the service. CMS has done this because it was believed that generally all of these direct cost inputs are associated with obtaining the diagnostic information and there is no direct costs associated with the physician interpretation. However, they now believe that there may be limited exceptions where it is appropriate to assign direct inputs to a PC service. The PEAC recommended that CMS include clinical staff in certain codes that both a PC and TC component for activities such as scheduling the procedure and educating the patient when the procedure is done in the facility setting. CMS accepted these recommendations, but because of the practice expense methodology currently does not assign direct inputs to the PC services and the TC is not paid in the facility setting, these procedures were not credited with the recommended practice expense inputs. CMS is proposing to modify the practice expense methodology to allow direct inputs to be added to PC services when these inputs are clearly associated with the professional service, including when the PEAC makes such recommendations. Carolyn is suggesting that the subcommittee review other situations where this is occurring.

**AMA/Specialty Society RVS Update Committee
PEAC Transition Workgroup
Friday, September 19, 2003**

Doctors Moran (Chair), Brill, Borgstede, Kwasny, Reed, Siegel, Przybylski, and Whitten participated in the discussion.

Doctor Moran opened the workgroup's discussion of the PEAC's transition into the RUC process with a discussion of the following goals:

1. Obtain the quality of evaluating the PE for new codes as provided to existing codes
2. Use the expertise of the members of the PEAC
3. Be as cost efficient for both AMA and Specialty Societies
4. Both PE and physician work to be done by same group and/or at the same time

The workgroup believed that it was important that the direct practice expense inputs of new and revised codes are scrutinized by the RUC in a similar manner as the existing codes are through the PEAC. Sufficient time needed to be allotted for the review, of the practice expenses submitted by specialties. With this in mind, the workgroup discussed various times and dates when a Practice Expense Workgroup could meet to discuss or pre-facilitate the specialty's practice expense inputs for the new and revised codes. The workgroup agreed that to minimize the time and cost for the specialty societies and the AMA, that it would be best to meet concurrently with all RUC meetings.

Doctor Moran and workgroup members believed that the PEAC process has trained several advisors and RUC members over its existence, and believed that the knowledge gained should be maintained within the RUC process. Therefore, it was agreed that the talent of the PEAC should be utilized in the analysis of practice expense recommendations at the RUC. Most of the 30 current PEAC members had expressed interest in using their knowledge at the RUC, and therefore the workgroup recommended that a portion of these members should make up the Practice Expense Direct Input Workgroup. An exact number of these members was not specified, but it was agreed that having all 30 members at each RUC meeting was excessive. The workgroup felt that the RUC could ask specific members based on the RUC agenda items, their specialty society and availability, for an equal balance of representation.

The PEAC Transition Workgroup suggests to the RUC that:

1. The direct practice expense inputs for new and revised codes should be reviewed concurrently in a Practice Expense Direct Input Workgroup at each RUC meeting, to pre-facilitate the practice expense inputs of each new and revised CPT code on the RUC's agenda
2. The members of the Practice Expense Workgroup would initially be drawn from current PEAC members based on the RUC agenda items, specialty society, and availability

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In these modifications, the PEAC would continue to function according to the directives and guidelines of the RUC. The current PEAC structure might be maintained, but the RUC would utilize approximately one-third of the committee at each meeting. It was believed that this would benefit small specialty society representation.

On a broader policy level, Carolyn Mullen from CMS stated, there are some additional practice expense methodological items that the Practice Expense Subcommittee may want to review in the near future. She listed four specific items that will be referred to the Practice Expense Subcommittee for review.

**AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
Friday, September 19, 2003**

The following Professional Liability Insurance (PLI) Workgroup members met to review issues related to PLI and to develop the RUC's comments on the August 15, 2003 Proposed Rule: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith. Rick Ensor, CMS staff, participated via conference call.

Discussion of RUC Role in PLI

The PLI Workgroup acknowledged that the RUC's *Structure and Function* document currently states that "in the future the [RUC] Process may be used to establish the professional liability components of the RVS." The Workgroup agrees that the RUC should take a more active role in the establishment of PLI relative value units.

The Workgroup was informed that new and revised codes are temporarily assigned a PLI relative value based on CMS staff analysis of an appropriate crosswalk. This analysis usually includes a review of the frequency estimations on the RUC's *Summary of Recommendation* form and often the key reference service used to determine physician work. CMS staff also determine if the CPT code should be assigned a surgical or non-surgical risk factor.

The Workgroup discussed the opportunity for the RUC to provide recommendations to CMS for both an appropriate crosswalk and the appropriate risk factor determination. The Workgroup suggests that the Research Subcommittee consider the addition of question(s) to the survey instrument and/or *Summary of Recommendation* form to enable the RUC to begin providing this information to CMS.

The PLI Workgroup recommends that the RUC engage in the establishment of PLI relative values. The Research Subcommittee should add question(s) to the survey instrument and/or *Summary of Recommendation* form to enable the RUC to provide recommendations on an appropriate temporary crosswalk for the PLI relative value and the assignment of a surgical or non-surgical risk factor.

Review of PLI and the RBRVS and Discussion of August 15, 2003 Proposed Rule

A number of documents were provided to the PLI to review in advance of the meeting as resource material, including:

- Chapter 6 of Medicare Physicians' Guide on PLI Methodology
- RUC Comments on PLI from Sept. 1999, Dec. 1999, Feb. 2000, and Feb 2003
- February 2000 consultant presentation to the RUC

- June 2003 GAO Report on PLI- *Multiple Factors Have Contributed to Increased Premium Rates*
- August 2003 GAO Report on PLI – *Implications of Rising Premiums on Access to Health Care*
- August 15, 2003 Proposed Rule on 2004 Physician Payment Schedule
- May 8, 2003 Letter from surgical specialty societies to CMS regarding PLI

The Workgroup reviewed this material in preparation for the meeting and to assist in the development of RUC comments on the August 15, 2003 Proposed Rule.

Development of RUC Comments on August 15, 2003 Proposed Rule Relating to PLI

A draft of the RUC comment letter will be discussed at the conclusion of the RUC meeting. The PLI Workgroup extensively discussed topics that should be included in the RUC comment letter related to PLI. These points will be developed into specific comments and included in a second draft of the RUC comment letter to be circulated immediately following the RUC meeting.

The RUC will add the following recommendations in the RUC comment letter:

1. **CMS should determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. CMS should utilize this predicted 2004 data only and not weight average these data with data from previous years.**

The Workgroup expressed concern that the more recent data should be utilized for PLI premium data. CMS staff indicated that multiple attempts have been made to secure the most recent data, including discussions with the GAO, major consulting firms, other government agencies, and medical organizations. These data are utilized in application such as the PLI GPCI formula, requiring sufficient data at the county level for each specialty for which information is collected. Despite these efforts, the most complete set of data (70% complete) is 2002. CMS hopes to estimate 2003 PLI premium data for the 2004 Final Rule on the Physician Payment Schedule.

Several members of the Workgroup suggested that organized medicine may be able to generate more recent data. AMA staff indicated that these efforts have been ongoing by AMA and specialty societies, but issues remain with low response rates, etc. It was suggested that individuals responsible for PLI issues at the AMA present the most recent efforts to the PLI Workgroup at a future meeting. CMS welcomed the opportunity to review more comprehensive data than is currently available.

A second concern regarding the PLI premium data involves the weight averaging of multiple years of data. As recent PLI premiums have increased so greatly, it would be unfair to dilute these increases with data from earlier year(s), which are no longer reflective of today's costs.

2. CMS should utilize data on the cost of tail coverage in the determination of PLI annual premium data.

The Workgroup argued that inclusion of these costs are critical as insurance carriers have left the market, it has required more and more physicians to change PLI coverage and therefore incur the costs of tail coverage. CMS has not included these costs in the past.

3. In evaluating individual CPT codes, CMS should use the typical specialty (50% or greater), rather than a weighted average of all specialties who perform the service. If a single specialty does not perform the service at least 50% of the time, then a weighted average of the specialties (with greatest volume of service provided whose sum equals or exceeds 50%) would be necessary. In addition, any claims related to Assistant at Surgery should be removed from this analysis.

The Workgroup is supportive of the letter submitted to CMS in May 2003 from a group of medical societies. This letter is included in the RUC agenda materials and outlines a methodology for CMS to employ in considering this recommendation. The Workgroup was concerned that the weighted averaging reduces the potential payment to higher-risk specialties and increases the potential payment to lower-risk specialties.

4. The RUC will reiterate its request for the PLI data discussed with Mr. Scully at the April 2003 RUC meeting. Page 3 and 4 of the current draft of the comment letter currently includes a paragraph related to this request.

Rick Ensor informed the Workgroup that the raw PLI premium data does include proprietary information. However, CMS is reviewing the data and determining mechanism to summarize the data so that CMS may share this information with the RUC.

5. The RUC will request a list of all CPT codes with their assigned category of risk (ie, surgical or non-surgical).

Mr. Ensor indicated that this information is available and CMS will share it with the RUC. He welcomes comments on the individual assignments of risk factor categories.

6. The RUC will comment that the work relative values and eventually the practice expense values (once refinement is complete for 2005) should remain stable. That is, any CMS budget neutrality adjustments should not be applied to the work and practice expense relative value units. CMS indicates that adjustments to the conversion factor will be required if the relative values are not re-scaled. The RUC, of course, maintains that additional funding should be advocated, rather than applying budget neutrality to any component of the payment system.

This issue is outlined on page eight of the draft RUC comment letter for discussion. The Workgroup unanimously agreed that the relative values should remain stable and rescaling for budget neutrality should not be applied.

7. The RUC recommends that PLI data for all specialties should be considered rather than only 20 specialties with the highest volume.

The Workgroup does not agree with the current CMS approach, which used national average premium data for twenty specialties, and uses crosswalk assumptions for the remaining medical specialties and other health care professionals. The Workgroup was also concerned that the 20 specialties with the highest volume used in the prior updates include only three high-risk specialties (orthopaedic surgery, general surgery, and emergency medicine).

8. The RUC recommends that the PLI Workgroup work with CMS to explore how PLI premium data provided by individual physicians can be utilized.

Several RUC members urged the PLI Workgroup to “think outside the box” and work with CMS to develop a different methodology for paying physicians for their share of the individual physician’s professional liability insurance premium.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee
Friday, September 19, 2003**

The Research Subcommittee met to discuss a variety of issues concerning the inclusion of IWPUT in the MPC list, the rebasing of the MEI and its effect on RVUs, and the definition of the pre-service time period for 000 and 010 day global periods. The following members were present: Doctors James Borgstede, (Chair), James Blankenship, Norman Cohen, John Gage, Meghan Gerety, David Keepnews, M. Douglas Leahy (alternate for J. Leonard Lichtenfeld), Bernard Pfeifer, Sandra Reed, Trexler Topping, and Richard Tuck.

Inclusion of IWPUT on the MPC List

During the April 2003 RUC meeting, the Research Subcommittee discussed the possibility of including IWPUT calculations on the Multi-Specialty Points of Comparison (MPC) list. To determine if such a change in the format of the MPC list is appropriate, the RUC agreed to calculate an IWPUT for all type A codes for review by the Research Subcommittee and specialty societies. Category A codes are those codes that have meet all the criteria for inclusion on the MPC list such as having RUC survey time, and current work RVUs that the specialty(s) accept as valid. Specialty societies were sent the MPC list with IWPUT included and asked to identify specific codes that either should or should not have IWPUT included. The Subcommittee continued its discussion of the possible inclusion of IWPUT on the MPC. The Subcommittee discussed at length the pros and cons of including IWPUT on the MPC list. While some Subcommittee members were in favor of including the IWPUT on the MPC list, the Subcommittee concluded that additional issues needed to first be clarified. The following points were made by Subcommittee members:

- The inclusion of IWPUT on the MPC would enhance the usefulness of the MPC as a means to compare codes. The inclusion of IWPUT would be the inclusion of other type of data that would be used to help determine relativity.
- There may be other metrics that could be also included on the MPC list such as length of stay and site of service. These other data elements could be used to evaluate the new and revised codes.
- Including IWPUT on the MPC list would be premature primarily because all the data such as time and visits may not have been completely validated, even for category A codes. Since the physician data are used to calculate the IWPUT, a more careful examination of these data elements would first need to occur.
- Including IWPUT on the MPC could be misused by groups outside of the RUC. The list could then be used in the future to either devalue codes or force specialty societies to review codes. A number of subcommittee members were not aware that the MPC list is shared with CMS since the RUC developed the original list at the request of CMS. The role of the MPC and possible use was discussed in detail with a number of subcommittee members expressing concerns over allowing the MPC with IWPUT data to be shared

Approved at the September 18-21, 2003 RUC meeting.

with groups other than RUC members. There was some discussion of having the MPC workgroup continue its review of the MPC list before adding IWPUT.

- There should also be further discussion of excluding certain global periods or excluding those codes reviewed by the RUC prior to a certain date when the RUC collected time data but never reviewed the data. This would exclude IWPUTs for codes with time data that may be inaccurate. Also, since there were concerns with using IWPUT for other than 90 day global period codes, the some Subcommittee members were in favor of including IWPUT only for the 90 day global period codes.

After much discussion of the pros and cons of including IWPUT on the MPC, the Subcommittee passed the a four part recommendation that recommends including IWPUT on the MPC for certain code categories but only after additional review of the use of the MPC list takes place. The Subcommittee also recognized that additional review of specific codes and the associated IWPUT will need to take place since some specialties may wish to exclude listing the IWPUT for certain codes. **The RUC recommends that:**

IWPUT be included on the MPC for category A codes with global periods of 90 days;

The MPC committee review the use of the MPC and assign uses for the list;

The MPC workgroup explore including other data elements for inclusion on the MPC list; and

The version of the MPC list with the IWPUT included only be used internally by the RUC.

Rebasing of the MEI and Impact on RVUs

The Research Subcommittee was asked by the RUC Chairman to develop a recommendation regarding the CMS proposal to revise the MEI and reduce the physician work and practice expense RVUs to maintain budget neutrality due to the increase in the PLI RVUs. This issue was raised by CMS in the recent Proposed Rule and the draft RUC comment letter will be discussed by the RUC at this meeting. There was widespread concern with changing physician work RVUs that are currently used as benchmarks for many codes, and any arbitrary changes would also affect benchmark IWPUT calculations used by many RUC members. Since the PLI Workgroup discussed this issue earlier in the day, the Research Subcommittee agreed to support the PLI Workgroup recommendation.

The Subcommittee recommends support for the PLI workgroup recommendation of not changing the physician work or practice expense RVUs to maintain budget neutrality. In addition, CMS should not decrease the conversion factor as a result of the increase in PLI RVU, however, if CMS insists on maintaining budget neutrality, this should occur through the conversion factor.

Pre-service time definition for 000 and 10 day global period codes

During the April RUC meeting, the RUC held a discussion regarding the pre-service time period definition of physician work for codes with 000 and 010 day global periods. The RUC definitions for the pre service time period for the 000 and 10 day global periods do not correspond to CMS definitions for these global periods. The Research Subcommittee continued its review of the issue and the discussion focused on the need to study the potential impacts of changing the RUC definition of pre-service time. The possible affects on the ability to separately bill for services provided before the day for surgery would have to be reviewed before making any change in the pre-service definition. After discussing various alternatives, the Research Subcommittee decided that the issue needed careful examination by a workgroup focused solely on pre-service time period definition. Addition, this workgroup would determine if CMS still is in favor of the RUC changing its definitions. The RUC recommends that:

The RUC form a workgroup to review the issue of the RUC pre-service definition of 000 and 10 day global period.

Facilitation Committee # 3

Percutaneous RF Ablation of Bone Tumor Lesion – Tab 5

September 20, 2003

Doctors Lichtenfeld (Chair), Gee, Hitzmann, Kwass, Pfeifer, Wiersema, and Simon from CMS facilitated during lunch on the work relative value, practice expense, and sites of service for new CPT code 20XXX *Ablation, bone tumor(s) (eg, osteoid osteoma, metatasis) radiofrequency, percutaneous; including computerized tomographic guidance*

The facilitation committees initially heard from the presenters who agreed that the physician work value could be reduced and still reflect the amount of time and intensity required to perform the procedure. Facilitation members discussed several codes over a variety of comparable specialties. Specifically, the facilitation committee agreed with the specialty societies' surveyed physician time, and used a building block approach to compare the relative value units across specialties to establish the proper work value.

The committee believed that the intra-service work intensity could be compared to code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (010 day global, Work RVU = 15.19). Therefore the committee used this code to establish the following building block approach to develop the proper work RVU for 20XXX. With this building block, the CT scan physician work is included in the intra-service time period.

Calculation of IPUT for 20XXX using the Intra-Service Work Intensity from 47382: Pre-Service

23 minutes of evaluation time with an intensity of 0.0224 = 0.515

15 minutes of positioning time with an intensity of 0.0224 = 0.336

10 minutes of scrub, dress, and wait with intensity of 0.0080 = 0.080

Intra-Service time of 80 minutes with an intensity of 0.0710 = 5.68

Post Service time of 30 minutes with an intensity of 0.0224 = 0.660

Total Recommended Relative Work Value for code = **7.28**

The facilitation committee believed that the recommended value of 7.28 was an accurate work recommendation in relation to code 62287, *Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy)* (090 day global, Work RVU = 8.08) after backing out the post-service discharge day management and office visit information. In addition, the specialty societies' survey results indicated that the responders would agree with the recommended value.

Furthermore, the committee members reviewed codes 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (000 day global,

work RVU = 7.39), and 45383 *Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (000 day global, work RVU = 5.87). Committee members believed that the similarities in the global periods, physician work, and time placed this new code within its proper rank order among these codes.

Practice Expense Recommendation

The Facilitation Committee reviewed the recommended practice expense inputs and determined that several modifications should be made to align the recommendations with PEAC standards. The time for preparing the patient was reduced from 3 minutes to 2 minutes. In addition, the staff type for cleaning the room was revised from CT tech to a RN/LPN/MA blend, and the time for this staff was reduced by 3 minutes to 2 minutes. In addition, the Committee was concerned about the request for 15 minutes of time allotted for cleaning the RFA equipment, and requests that the specialty society work with CMS to determine the appropriate value. Supplies and equipment were revised to reflect that an Evaluation and Management visit is billed with this code, and as a result the facilitation committee recommends removal of the patient education booklet. In addition, the cardio-respiratory monitor should be added to the recommended supplies to reflect use of a conscious sedation pack.