

**AMA/Specialty RVS Update Committee
Meeting Minutes
September 30 – October 2, 2004**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, October 1, 2004 at 8:00am. The following RUC Members were in attendance:

William Rich, MD (Chair)	J. Leonard Lichtenfeld, MD
Michael D. Bishop, MD	Scott Manaker, MD
James Blankenship, MD	John E. Mayer, Jr., MD
James P. Borgstede, MD	Bill Moran, Jr., MD
Neil H. Brooks, MD	Bernard Pfeifer, MD
Norman A. Cohen, MD	Gregory Przybylski, MD
James Denneny, MD*	Sandra B. Reed, MD*
John Derr, Jr., MD	Chester W. Schmidt, Jr., MD
Mary Foto, OT	Daniel Mark Siegel, MD
John O. Gage, MD	J. Baldwin Smith, III, MD
William F. Gee, MD	Peter Smith, MD*
Robert S. Gerstle, MD*	Susan M. Strate, MD
David F. Hitzeman, DO	Trexler Topping, MD
Peter Hollmann, MD	Arthur Traugott, MD*
Charles F. Koopmann, Jr., MD	Richard Tuck, MD
George F. Kwass, MD*	Richard W. Whitten, MD
Barbara Levy, MD	Maurits J. Wiersema, MD
	Robert M. Zwolak, MD

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich welcomed the CMS Staff attending the meeting, which include:
 - Edith Hambrick, MD, CMS Medical Officer
 - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
 - Ken Simon, MD, CMS Medical Officer
 - Pam West, PT, CMS Health Insurance Specialist
 - Susan Nedza, MD - Observer, Chief Medical Officer, Chicago CMS Regional Office

- Doctor Rich welcomed the RUC Ad Hoc Practice Expense Workgroup Members attending. The members in attendance for this meeting are:

James Anthony, MD
Katherine Bradley, PhD, RN
Joel Brill, MD
Manuel Cerqueira, MD
Neal Cohen, MD
Richard Dickey, MD
Thomas Felger, MD
Gregory Kwasny, MD
Peter McCreight, MD
Tye Ouzounian, MD
James Regan, MD
Anthony Senagore, MD

- The following individuals were observers at the September 2004 meeting:

Michael	Bigby, MD	American Academy of Dermatology
Bruce	Cameron, MD	American College of Gastroenterology
James	Christmas, MD	American College of Obstetricians and Gynecologists
Bruce	Deitchman, MD	American Academy of Dermatology
Yolanda	Doss	American Osteopathic Association
Frank	Ehrlich, MD	American College of Surgeons
Pam	Ferraro	American College of Physicians
Tamara	Fountain, MD	American Academy of Ophthalmology
Kim	French	American College of Chest Physicians
Elizabeth	Hammond, MD	College of American Pathologists
Gerald	Hanson, MD	College of American Pathologists
Wayne	Holland, EdD	American Speech, Language, and Hearing Association
Mike	Itagaki	Guest of Dr. Traugott
Christopher	Kauffman, MD	North American Spine Society
Lane	Koenig, PhD	American Association of Hip and Knee Surgeons
Robert J.	Kossmann, MD	Renal Physicians Association
Nelly	Leon-Chisen, RHIA	American Hospital Association
Sheila	Madhani	Consultant
Pauline	Merrill, MD	American Academy of Ophthalmology
Eric	Muehlbauer	North American Spine Society
Brian	Parsley, MD	American Association of Hip and Knee Surgeons
Bernard	Patashnik	Consultants
Charles	Penley, MD	American Society of Clinical Oncology
William	Peters, MD	American College of Obstetricians and Gynecologists
Neil	Pliskin, MD	American Psychological Association
Tony	Puente, PhD	American Psychological Association
Bill	Robb, MD	American Association of Hip and Knee Surgeons

Tim	Shahbazian, DDS	American Dental Association
Mike	Sheppard	American Urological Association
Frank	Spinoza, DPM	American Podiatric Medical Association
Elizabeth	Tindall, MD	American College of Rheumatology
Patrick	Turski, MD	American Society of Neuroradiology
Laura	Wade	North American Spine Society
Frank	West	Society for Vascular Surgery

- Doctor Rich welcomed the Korean Medical Association (KMA) and presented them with gifts. The KMA observers include:

Name	Organization	Title(Position)
Hyo-Keel PARK	Korean Medical Association	Vice President, M.D
Jong-Ouck CHOI	Korean Medical Practitioners Association	Director of Health Insurance, MD
Young-Jae KIM	Korean Medical Association/Korean Academy of Family Medicine	Researcher, MD
Young-Joo JIN	Ministry of Health and Welfare	Deputy Director
Duck-Hee JIN	Health Insurance Review Agency	General Manager, RN
Wook, YOUNG	Korean Society for Vascular Surgery	Director of Health Insurance
Se-Jin JANG	The Korean Society of Pathologists	Member of Health Insurance, MD
Kyu-Ryong CHOI	Korean Ophthalmological Society	Member of Health Insurance, MD
Kee-Hwan KWON	Korean Society of otolaryngology	Member of Health Insurance, MD
Hyung-Jin SHIM	Korean Radiological Society	Director of Health Insurance, MD
Jung-Han SONG	Korean Society for Laboratory Medicine	Member of Health Insurance, MD
Jong-Nam JOH	Korean Society of Obstetrics and Gynecology	Director of Health Insurance, MD
Ki-Young CHO	Korean Dental Association	Director of Health Insurance, MD
Hee-Dai YOO	Korean Dental Association	Assistant Director, DDS
Chul-Soo KIM	Korean Hospital Association	Vice President, MD
Duk-Ju JEONG	Korean Hospital Association	Assistant manager
Seon-Kui Lee	Asian Institute for Bioethics and Health Law, Yonsei University	Researcher
Seoung-Gu PARK	Korean Medical Association	Head of a Medical & Health Insurance Affairs Office
Dong-Soo Lee	Korean Society of Nuclear Medicine	Director of Health Insurance, MD

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1

Peter Hollmann, MD (Chair)
James Blankenship, MD
James Borgstede, MD*
Jonathan Cooperman, PT, JD
Norman Cohen, MD
Meghan Gerety, MD
Gregory Kwasny, MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Scott Manaker, MD*
Bernard Pfeifer, MD
Richard Whitten, MD

Facilitation Committee #2

J. Baldwin Smith, III, MD (Chair)
Michael Bishop, MD
Neil Brooks, MD
John Gage, MD
David Hitzeman, DO
David Keepnews, RN, PhD
John E. Mayer, Jr., MD
Bill Moran, Jr., MD*
Greg Przybylski, MD*
Chester Schmidt Jr., MD
Richard Tuck, MD
John Wilson, MD

Facilitation Committee #3

Robert Zwolak, MD (Chair)
Keith Brandt, MD
John Derr, Jr., MD
Mary Foto, OTR*
Thomas Felger, MD*
William Gee, MD
Charles Koopmann, Jr., MD
Emil Paganini, MD
Daniel Mark Siegel, MD*
Susan Strate, MD
Trexler Topping, MD
Maurits Wiersema, MD

** Current RUC Ad Hoc Practice Expense Workgroup member or Former Practice Expense Advisory Committee (PEAC) member*

III. Approval of Minutes of the April 22-24, 2004

The minutes were reviewed and accepted by the RUC.

IV. CPT Editorial Panel Update

Doctor Peter Hollmann and Michael Beebe briefed the RUC on the following issues:

- The annual CPT meeting, November 4-6, 2004, Bal Harbour, Florida, will include sessions on:
 - Drafting vignettes
 - Team management and care management—caring for patients with high pre- and post-service work in relation to E/M codes
- The CPT Editorial Panel commends ophthalmology and otolaryngology on the deletion of the appropriate unused codes
- At the August 2004 CPT Editorial Panel meeting, significant introductory language on transcatheter procedures in vascular surgery and interventional radiology was approved. These codes will appear in the 2006 CPT book, they define what is considered to be the current coding practices.
- Conscious sedation codes introductory language has been changed and will appear in the 2005 CPT book.
- CPT goes to a three meeting a year cycle. This change should not highly impact the RUC. The Administrative Subcommittee will review the CPT/RUC calendar at the February 2005 RUC meeting.

V. CMS Update

Doctor Ken Simon stated that:

- For the last nine months CMS has been working on implementing many of the elements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Currently CMS is in the comment period; most of the comments pertain to the Welcome to Medicare preventive physical examination benefit. The Physician Payment Schedule Final Rule and the Outpatient Prospective Payment System (OPPS) Final Rule are expected to be published November 1, 2004. CMS is trying to address many of the new benefits that relate to the cardiovascular disease

benefit, the diabetes preventive screening benefit and the welcome to Medicare preventive benefit.

Doctor Simon and Carolyn Mullen responded to several questions from the RUC members, including:

- A RUC member questioned if CMS added more money to Part B in order to cover the new benefit for the preventive physicals. Doctor Ken Simon responded that money was added to accommodate the new benefits. The estimated costs of these benefits are included in the August, 2004, Proposed Rule.
- A RUC member questioned where CMS stands in regard to its interest in funding quality improvement efforts. Doctor Ken Simon responded that since September 2001, Secretary Thompson has attempted to link quality to payment because he felt that health care is the one industry where there are no incentives in place, particularly as it pertains to the Medicare program, to reward those clinicians that consistently provide outstanding care to patients. Over the last three years there have been a host of two to three-year demonstration projects to assess the outcome of services that patients would receive under a payment for quality approach. To date, there are about 25 demonstration projects in place looking at various aspects of care provided to Medicare beneficiaries where there is a linkage of quality to payment.
- A RUC member questioned if CMS is looking at any methodologies that go beyond simple claims assessment when looking at quality measurements. Doctor Ken Simon said that the quality group is looking at many different approaches to augment the quality initiatives that the administrator would like to see put into place. Right now the quality initiative is engaged in outreach, speaking to specialty groups throughout the country on how best to develop and design methodologies to encourage physicians to meet the quality indicators for many of the different disease processes, in a prospective fashion instead of going through a chart review and making those determinations retrospectively.
- A RUC member questioned the requirement to perform an EKG as part of the new preventive physician exam benefit. Many primary care physicians perform the technical component and have the interpretation performed by someone else. Doctor Ken Simon responded that this is under active discussion. The statute indicated that that benefit entails a physical examination and an EKG. CMS received comments that some physicians do not have EKG capabilities in their office, yet they would like to provide a preventive examination to the patient. The coverage group, as well as the Centers for Medicare Management, the payment side of the agency, are

trying to sort out how to best interpret what is in the statute. CMS will publish its final decision in the Final Rule in November 2004.

- A RUC member questioned if CMS plans on setting up a study group to look at the impact of procedures that used to be performed in a hospital that are now performed in a physician's office in order to see if there is a financial impact on Medicare Part B. Doctor Ken Simon responded that there is awareness that there has been a shifting of landscape from services being performed from the inpatient setting to the outpatient setting. There has not been a formal process to get input on what steps the agency should take as it relates to reallocating funds from the Part A side to the Part B side in order to accommodate for the increase of services being performed in the outpatient setting. The RUC member then asked what would be the best mechanism to put forth an action to request a study on this. Doctor Ken Simon suggested that the Office of the Administrator would be a good place to start. The Administrator would have the authority and capability to challenge the Office of Research and Development within the Agency or other groups within the Agency to begin to take steps to address that problem.
- Sherry Smith indicated that the RUC wrote a letter to Doctor McClellan on March 31, 2004 regarding this specific issue. The RUC did not receive a response on this comment letter. Therefore, in the RUC comment letter, it referenced this March 31, 2004 request and asked that CMS respond to this in the Final Rule. The RUC anticipates that there will be discussion of this in the Final Rule. Carolyn Mullen stated a point of clarification that if something is moving from inpatient, directly to the office than that is Part A money that would have to be moved and that is something only Congress can do. A RUC Member commented that the RUC should request through the AMA House of Delegates, that congress should look into the matter of shifting Part A money to Part B money. Doctor Rich commented that the correct procedural approach would be for the society to go through the House of Delegates. Sharon McIlrath stated that the AMA already has policy in support of this analysis and is working to achieve CMS involvement in this review.

VI. CMD Update

Doctor William Mangold, Contractor Medical Director (CMD) for Arizona and Nevada, addressed that clarification on the welcome to Medicare examination is the most frequent question from local physicians regarding what level of examination these screenings will require of the physicians.

CMDs are gaining more and more opportunities to interact with specialty societies on how to inform members on how to appropriately bill Medicare. The CMD interaction with the RUC process has allowed such opportunities.

Doctor Mangold reported that CMDs are excited to be involved in the Five-Year Review process.

VII. Washington Update

Sharon McIlrath addressed the following issues:

- *Congressional Environment:* Congress will come back for a lame duck session on November 16, 2004. They need to perform other Omnibus Appropriations for the bills that did not pass.
- *Patient Safety:* Patient Safety may still be passed this year. Both the House and the Senate have passed bills. The bills are similar with the Senate bill leaning more to our liking on the confidentiality provisions. The AMA is part of a patient safety coalition that has generated many sign-on letters and worked hard on getting that bill through Congress this year.
- *2005 Three priorities for AMA:*
 1. Medical Liability Reform
 2. Medicare Physician Payment Reform
 3. Expanding Coverage for the Uninsured
- *Liability:* In the national scene, efforts are being made to limit protection to only physicians and hospitals. Democrats may back a lower liability capitation if the drug companies and other industries are removed from the legislation. The AMA is expanding the patient access network and finds that a call to action typically generates three responses per patient. Also working with the States on tort reform. Texas received \$100,000 in 2003 for their ballot initiative which led to rate reductions. Similar investments were given to four other states for tort reform initiatives: Florida, Wyoming, Nevada and Oregon.
- *SGR:* Will receive a 1.5% increase as a result of the MMA in 2005. After that CMS predicts cuts of 5% a year from 2006-2012, with a slightly smaller cut in 2013. This means that payment will fall by 31%, while at the same time by the government's conservative estimate of inflation, practice costs will increase by 19%. The good news is that no one believes that this is a viable situation. The bad news is that fixing the problem is going to be expensive. The AMA believes there are steps that the administration can do, such as take the drugs out of the SGR pool. Between 1996 and 2003, drug expenditures rose by 318% per patient, at

the same time actual physician services rose by 46% per patient. Drugs are becoming a larger part of the pool and the problem is exacerbated. Drugs were 3.7% when we started and by 2003 rose to 9.7% of the pool. The administration has the authority to take drugs out of the pool. Congress has made it clear that it wants that to happen. More than 70 Senators and more than 240 House members and all three of the Medicare committees have sent letters to CMS requesting that the drugs should be taken out. CMS is considering this but there are two problems: (1) CMS does not seem to feel that it needs to be done in 2005, because they were working on deadlines with the MMA. (2) The AMA believes that CMS's position would be that drugs would be taken out of the pool going forward. The AMA's contention is it is wrong to have them in today, it was wrong to have them in the pool in 1996. Since spending in the SGR is cumulative, the baseline and the pools need to be fixed. The AMA believes it is a disadvantage to wait another year, the hole will just get deeper and deeper.

- *The Balanced Budget Refinement Act (BBRA):* Legal analysis raises the objections that lawyers at HHS might have and what actions could be done legally. Fixing the actual and taking the drugs out could save \$35 billion. Another actuarial option could save over \$100 billion.
- AMA commission work from Medicare's former chief actuary to question one very costly assumption that both CBO and CMS have used in post estimates of the cost of replacing the SGR. One assumption said that if the SGR is eliminated then volume is going to go up one percent more than it would have if you still had the SGR. This added a great deal to the cost. CBO has changed their assumption and is not using that assumption.

Questions

- A RUC member posed a question what initiatives are there that are looking for ways to address the SGR problem other than focusing on technology driving the rate of expenditures for services? Sharon McIlrath responded that the workgroup is looking at proposals that MedPac has received. One option may be "pay for performance". MedPac is already headed down this path. MedPac has already done this for the plans and nursing homes. Another option is that the SGR should not be budget neutral. The RUC member then added that the notion that it is only economic incentives that are going to drive physician behavior is a myth that needs to be squashed. Ms. McIlrath agreed.

VIII. Directors Report

Sherry Smith made the following announcements:

- The RBRVS Symposium will be held in November and Doctors William Rich, Grant Bagley and Susan Nedza will be presenting on the MMA. Doctor Simon and Marc Hartstein will also be presenting on the 2005 Physician Payment Schedule.
- The August 25-28, 2005, Five Year Review meeting is the specific meeting where the workgroups will meet for the Five Year Review. The full RUC will then meet September 29-October 2, to review those workgroup reports. All details and timelines are in the agenda body.
- Welcomed the CPT staff, who will be observing the RUC process to see how their efforts flow through to the RUC
- There is an SGR document which includes the top 100 increases in allowed charges by code and top 100 decreases. This information is based on the 2003 utilization that was recently obtained from CMS.
- All of the work and practice expense recommendations from this meeting may impact the Final Rule. The AMA will have the recommendations to CMS by Friday, October 8, 2004.

IX. Relative Value Recommendations for CPT 2005

Tissue Debridement of Genitalia for Gangrene (Tab 4)

Charles Mabry, MD, FACS, American College of Surgeons (ACS)

Facilitation Committee #2

The CPT Editorial Panel in February 2004 created four new codes for performing a debridement for Fournier's Gangrene. Existing excision and debridement codes were not specific to the urogenital system where debridements are extensive and involve removal/transplantation of the genital organs such as the penis or testes. In addition, these procedures are usually performed emergently in high risk patients with over 50% mortality rates. Two of the four codes were brought forth by specialties in April 2004 and re-reviewed in September 2004 and the other two codes were reviewed by the RUC in September 2004. CPT codes 11004, 11005 and 11006 have each been assigned a global period of 000 because the post-operative link is so variable. The RUC reviewed the typical patient scenario for all four codes and understood that the new codes would never be performed in the physician's office due to fact that these patients were at high risk and emergent.

11004

In April 2004, the RUC reviewed and compared the work of 000 day global codes 11012 *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone* (RUC Surveyed, MPC listed, Work RVU=6.87) and 43242 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)* (RUC Surveyed, Work RVU = 7.30). Both codes have an intra-service work time of 90 minutes which is identical to new code 11004. The RUC believed that code 11004 is significantly more intense than code 11012 and at a higher risk. It was explained that for these new codes the physician is actually filleting the skin. In addition, the RUC believed the intensity of code 43242 was similar for this emergency room procedure. The RUC then used the intra-service work intensity of 43242 to establish a work RVU for code 11004. The RUC believed that the pre-service time associated with these codes should reflect the existence of an extensive E/M code prior to the service, and recommended decreasing the pre-service evaluation time by 15 minutes. The pre and immediate post service time for 11004 and 11006 was justified to the RUC as being longer and more involved than the time needed for code 43242. The RUC used the building block approach using the intensity of 43242, with the understanding that the work of 11004 is more involved. The RUC used an intra-service work per unit of time (IWPUT) of .077 to establish a work RVU for 11004 of 8.80.

However, at the September 2004 meeting, the RUC identified that a separate E/M visit does occur with 11004 and 11006. The RUC addressed that the post-operative service time should be revised to demonstrate accuracy. Therefore, a 99233 (RVU=1.51) post-operative visit should be added to 11004 and 11006 without affecting the IWPUT. **The RUC recommends adding 1.51 RVUs to 11004 The RUC recommends a work RVU of 10.31 (8.80+1.51) for 11004.**

11005

The RUC reviewed the survey data of 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of abdominal wall, with or without fascial closure*. The survey responses indicated a significantly higher intensity of technical skill and physical effort; psychological stress and pre-service, intra-service and post-service time segments for 11005 as compared to the reference service code of 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children* (RVU=3.99). The RUC also compared 11005 to reference code 34833 *Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular*

prosthesis, by abdominal or retroperitoneal incision, unilateral (RVU=11.98). The sum of 34833 plus the 99233 post-op visit equals 13.49 (11.98+1.51). Therefore, since the operative intensity of 11005 has a greater intensity than 34833, the survey median RVU of 13.75 appeared appropriate. The facilitation committee reviewed the AUA survey data from 2003 for 11005 and compared it to the ACS survey data for the September, 2004 RUC meeting. The pre-, intra- and post- service times of the two codes were almost identical, however it was noted that 11005 is often associated with removal of infected synthetic mesh necessitating a formal closure of the peritoneal cavity. Although there is an add-on code for removal of the infected mesh, the added work of the abdominal/peritoneal closure after removing the mesh was felt by the committee to justify a slightly higher RVU of 13.75 (an additional 1.14 RVUs), thereby resulting in a slightly higher intensity for 11005. **The RUC recommends the survey median work RVU of 13.75 for code 11005.**

11006

In April 2004, the RUC used the same building block approach used in 11004 to develop a work RVU for code 11006. The RUC used the IPUT of code 43242 (0.077) to establish a work RVU of 11.10 for 11006. In addition, the RUC also believed the intra-time associated with these procedures was not sufficiently reflected in the specialty's survey results. The RUC understood that the intra-service physician time for 11006 had to be more than the intra-service time for code 11004 and accepted the specialty's recommendation for the 75th percentile surveyed results of 120 minutes. The RUC also reviewed 000 day global code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording* (RUC Surveyed, MPC listed, Work RVU =11.57) for its complexity and work in relation to this new service. Code 93620 has a RUC surveyed pre-service time of 60 minutes, intra-service time of 120 minutes, and 60 minutes of post service time.

However, at the September 2004 meeting, the RUC identified that a separate E/M visit does occur with 11004 and 11006. The RUC addressed that the post-operative service time should be revised to demonstrate accuracy. Therefore, a 99233 (RVU=1.51) post-operative visit should be added to 11004 and 11006 without affecting the IPUT. **The RUC recommends adding 1.51 RVUs to 11006. The RUC recommends a work RVU of 12.61 (11.10+1.51) for 11006.**

11008

The RUC reviewed the survey data for 11008 *Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)*. The survey responses indicated a higher intensity of mental effort and judgment; technical skill and physical

effort; psychological stress and median intra-service time for 11008 as compared to the reference service code of 49568 *Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)* (RVU = 4.88). **The RUC recommends the median Work RVU of 5.00 for code 11008.**

The RUC recommends the following physician time and relative work values:

CPT Code	Pre-Service Evaluation Time	Pre-Service Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	Post-Operative Visit	Recommended RVU
11004	30	15	20	90	30	1 - 99233	10.31
11005	30	15	15	120	30	1 - 99233	13.75
11006	30	15	20	120	30	1 - 99233	12.61
11008	0	0	0	60	0		5.00

Practice Expense for 11004, 11005, 11006 and 11008

The RUC agreed that these procedures are performed on an emergent basis in the facility setting only, and would not have any direct practice expense inputs.

Gastric Reconstructive Procedure (Tab 5)

Michael Edye, MD, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

Christine Ren, MD, American Society of Bariatric Surgeons (ASBS)

AMA staff communicated with the specialty societies and this issue was deferred and will be presented at the February 2005 RUC meeting.

Endometrial Cryoablation Therapy (Tab 6)

George Hill, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)

William Peters, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)

Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)

CPT created a new code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed to describe endometrial cryoablation with ultrasonic guidance* since there are no existing codes that accurately describe the clinical distinctions of uterine cryoablation.

Given the survey results that were based on a comparison with code 58563, *Hysteroscopy, surgical; with endometrial ablation (egg, endometrial resection, electrosurgical ablation, thermoablation)* (work RVU = 6.16), the RUC and the presenters concluded that the intra-service intensity of the two codes were equal, however the RUC also agreed that the physician time estimates from the survey were incorrect. The RUC made a number of adjustments to the time for code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed*. Pre-service time was reduced by 10 minutes and the RUC assigned a half discharge day rather than a full discharge day. The presenters explained that the survey respondents underestimated the intra-service time and while the survey median was 40 minutes, the presenters felt that the 75th percentile of 45 minutes more accurately reflected the intra-service time. The presenters also stated that this time would be a more accurate comparison with the reference service's intra-service time of 60 minutes. The committee agreed that an IPUT of .076 which is the intensity measure of the reference service should also be applied to code 58356 as well as 45 minutes of intra-service time. The committee discussed these changes in detail and agreed to the following adjustments and recommended value.

Pre evaluation time	30
Positioning time	10
Scrub time	10
Intra-service time	45 @ IPUT 0.076
Immediate post time	30
Discharge day	.5 of 99238
Office visits	1 X 99213

An analysis of this time and intensity results in an RVU of 6.36. The RUC agreed that the rank order between 58356 (recommended work RVU = 6.36) and the reference service 58563 (work RVU = 6.16) would be correct. The RUC also noted that this work RVU is equivalent to code 46260 *Hemorrhoidectomy, internal and external, complex or extensive* (work RVU = 6.36), which is included on the RUC's MPC list.

The RUC recommends a work RVU of 6.36 for code 58356.

Practice Expense

The RUC reviewed the direct practice expense inputs and made changes to the clinical staff inputs in the service period as well as applied standard post op visit time for follow-up phone calls. A cryoablation machine was also added as equipment. The details of the practice expense inputs are attached to the recommendations.

Doppler Velocimetry, Umbilical and Middle Cerebral Arteries (Tab 7)

James T. Christmas, MD, American College of Obstetricians and Gynecologists (ACOG)

George Hill, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)

Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)

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

Jonathan Berlin, MD, American College of Radiology (ACR)

Facilitation Committee #3

CPT created two new codes to describe doppler velocimetry of fetal umbilical artery and middle cerebral artery. These are codes that are needed to describe the work involved in adequately assessing and timing the delivery of a growth restricted fetus. These procedures are typically performed by physicians, not clinical staff.

Code 76820 Doppler velocimetry; umbilical artery

The RUC agreed that the median RVU of 0.50 was appropriate for code 76820 *Doppler velocimetry; umbilical artery*. The RUC reviewed the survey data and the comparison with the reference code 76827 *Echo exam of fetal heart* (Work RVU=0.58). Given a slightly lower total time and intensity the RUC agreed that a work RVU of 0.50 would place the code in proper rank order with similar codes such as the reference code. **The RUC recommends a work RVU of 0.50 for code 76820.**

Code 76821 Doppler velocimetry, fetal; middle cerebral artery

The RUC discussed code 76821 *Doppler velocimetry, fetal; middle cerebral artery* in much greater detail. The RUC was concerned that the survey results indicated that the time and intensity measures would indicate a value the same as 76820, however, the presenters recommended a higher value at the 75th percentile value. The presenters explained that the survey results that were based on responses from radiologists and maternal-fetal medicine physicians may have resulted in an anomaly. The presenters explained that the procedure is performed 90% of the time by maternal-fetal medicine physicians and 10% of the time by radiologists. However, the majority of the survey respondents were radiologists and the presenters felt that the survey data by the radiologists skewed the overall survey responses. Since the maternal-fetal medicine physicians will be providing the vast majority of the services, the RUC agreed with the presenters that it would be appropriate to give greater weight to the maternal medicine survey data that resulted in a median RVU of 0.70. The presenters assured the committee that physicians and not clinical staff will be performing the procedure. The committee also felt that this value of 0.70 would place the code in proper rank order with 76820 *doppler velocimetry, fetal; umbilical artery* (recommended work RVU = 0.50) The

presenters explained that there is a significant difference between Doppler velocimeter of the umbilical artery and the middle cerebral artery and a 0.20 RVU difference is warranted. Due to the anomalies in the data from the two societies the RUC agreed that the practice pattern of the maternal-fetal medicine physician was appropriate. It is likely that radiologists who valued the code considered they were performing this examination in conjunction with another obstetrical ultrasound examination such as *76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation* (work RVU = 1.90) and *76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99) In contrast, when maternal fetal medicine physicians perform 76821, it will typically be performed as a stand alone code.

The RUC recommends a work RVU of 0.70 for code 76821.

The committee also made several adjustments to the practice expense inputs such as changing the staff type to the standard staff blend of RN/LPN/MT and specifying that code 76820 uses an ultrasound room and 76821 uses an ultrasound color Doppler. The details of the practice expense inputs are attached to the recommendations.

Flow Cytometry (Tab 8)

Susan Spires, MD, American Society of Cytopathology (ASC)

Gerald Hanson, MD, College of American Pathologists (CAP)

David Hoak, MD, American Society of Cytopathology (ASC)

Facilitation Committee #2

The number of clinical flow cytometric applications has grown significantly in the past few years, as has the number of antibodies used to evaluate hematologic conditions. In response to this growth and concerns of the Centers for Medicare and Medicaid Services, the CPT Editorial Panel in May 2004 further clarified its flow cytometric section by deleting one code and adding five. This revision separated the work between the laboratory technologist and the physician. Two of the five new codes involve the technical component of morphologic correlation, and the three other codes involve the physician interpretation of flow cytometry.

The RUC understands that the new coding structure for flow cytometry (CPT codes 88184-88189) will result in an overall savings. We request that CMS consider these savings, much like you often consider budget increases for CPT codes which represent unbundled services. This savings should be considered to offset other increases resulting from coding changes and refinements to one

of the components of the RBRVS. If the savings for this new coding structure for flow cytometry are greater than the increases for other coding changes or relative value refinements, a positive adjustment should be made to the conversion factor.

The RUC reviewed the specialty society physician work recommendations for flow cytometry codes:

88187 *Flow cytometry, interpretation; 2 to 8 markers*

88188 *Flow cytometry, interpretation; 9 to 15 markers*

88189 *Flow cytometry, interpretation; 16 or more markers*

The RUC reviewed the specialty recommended reference codes and the pre, intra, and post physician time for the family of new codes, in developing its recommendation. The RUC first reviewed the specialty's reference codes:

88331 Pathology consultation during surgery; first tissue block, with frozen section (s), single specimen (Work RVU = 1.19); 88307 Surgical pathology, gross and microscopic examination, Level V (Work RVU = 1.59); 88325 Consultation, comprehensive, with review of records and specimens, with report on referred material (Work RVU = 2.22), in relation to the new codes in terms of physician time and work.

The RUC then discussed the specialty recommendation in detail, and agreed with the physician time and the descriptions of work in the intra-service time period for all the codes. However the pre and post service physician work time needed adjustment to represent the typical patient. The pre-service time was determined by the RUC and the specialty to be typically identical for each of the codes (5 minutes). These five minutes would include discussing the potential analysis with the clinician and other professionals prior to the receipt of the specimen. The RUC recommendation for code 88189 was then appropriately adjusted for this change in time.

In addition, the post-service time in the survey results was believed to be overstated by the survey respondents. The RUC and the specialty believed that the post-service physician time should be lowered to reflect the typical patient encounter. Therefore, by using an intra-work per unit of time methodology used by the RUC, 0.16 RVUs were extracted from the specialty society recommendation for codes 88187 and 88188, reflecting a reduction of 7 minutes of post-service work. 88189 was adjusted for 5 minutes of post-service work to account for the discussion between the pathologist and the clinician. Below are the RUC recommended relative values for codes 88187, 88188, and 88189 with the time changes taken into account.

88187

Specialty Society Recommendation:	1.52
Removal of the equivalent of the work associated with 7 minutes of Post Service Time (7 x 0.0224)	- 0.16
RUC Relative Value Recommendation for 88187	1.36

88188

Specialty Society Recommendation:	1.85
Removal of the equivalent of the work associated with 7 minutes of Post Service Time (7 x 0.024)	- 0.16
RUC Relative Value Recommendation for 88188	1.69

88189

Specialty Society Recommendation:	2.45
Removal of the equivalent of the work associated with 5 minutes of pre-service Time (5 x 0.0224)	- 0.11
Removal of the equivalent of the work associated with 5 minutes of post-service Time (5 x 0.0224)	- 0.11
RUC Relative Value Recommendation for 88189	2.23

The amended times for 88187, 88188 and 88189 are as follows:

	88187	88188	88189
Pre-Service Time	5	5	5
Intra-Service Time	30	35	40
Post-Service Time	3	3	5

Practice Expense:

The RUC carefully reviewed the attached practice expense recommendations for the technical component of the flow cytometry codes (88184 and 88185) so that there would not be duplication in any clinical labor, medical supplies, or equipment in the non-facility setting. The RUC recommends no practice expense inputs in the facility setting. In addition, there are no practice expense inputs recommended for codes 88187, 88188, and 88189.

In Situ Hybridization (eg FISH) Procedures (Tab 9)

Susan Spires, MD, American Society of Cytopathology (ASC)

Elizabeth Hammond, MD, College of American Pathologists (CAP)

David Hoak, MD, American Society of Cytopathology (ASC)

Facilitation Committee #2

Fluorescent in situ hybridization (FISH) has rapidly gained acceptance in the pathology and oncology communities as a definitive diagnostic marker for certain cancers. In response to this gained acceptance, the Centers for Medicare and Medicaid Services and specialty societies sought clarity in the coding structure. The CPT Editorial Panel created two new codes and revised one code, in order to provide further specificity in these FISH procedures. The panel also revised a code and added a code for Immunohistochemistry (IHC) procedures to clarify whether the procedure is performed manually or with the assistance of a computer.

The RUC had the opportunity to have a detailed discussion of the entire set of FISH and ICH procedures, independently and as a group, concerning the physician work and intensity. RUC members understood from the specialty society representatives that the FISH procedures are not billed together.

88361

The RUC reviewed the RUC action from April 2003 for code 88361

Morphometric analysis; tumor immunohistochemistry

(eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative (Work RVU = 0.94). In April 2003, CAP received 17 responses to its survey for 88361 and recommended 1.35 Work RVUs. The RUC believed the survey response rate was too low and made no recommendation. The RUC believed that the more current survey results (with 32 respondents) were more reliable and represented the typical physician work, but only at the 25th percentile Work RVU of 1.18. The RUC also reviewed the specialty's key reference code 88112 *Cytopathology, selective cellular enhancement techniques with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Work RVU 1.18)*, and believed it was similar work. **The RUC recommends a relative work value of 1.18 for revised code 88361** *Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology.*

88360

Similar to code 88361, code 88360 *Morphometric analysis; tumor*

immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual

was reviewed in detail, and it was agreed that the 25th percentile more accurately

reflected intensity associated with the physician work involved. The RUC believed that the survey results were accurate, but did not believe the work was greater than the specialty's MPC reference code 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19). **The RUC recommends a relative work value of 1.10 for code 88360.**

88365

The RUC viewed code 88365 *In situ hybridization (eg. FISH), each probe* as having a physician work intensity equal to code 88361. The RUC believed however, after clarification from the specialty, that the survey median work RVU was appropriate, and the work was similar to its reference code, 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19). **The RUC recommends the specialty's median survey results representing a relative work value of 1.20 for code 88365.**

88367

Code 88367 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; using computer-assisted technology* was considered by the RUC to be much more intensive and time consuming for the physician in relation to the other codes in the family discussed above. In addition, the RUC believed the physician work was between the specialty's chosen MPC reference code, 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27) and the median survey results of 1.35 work RVUs. **The RUC recommends a relative work value of 1.30 for code 88367.**

88368

The specialty and the RUC discussed code 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; manual* in detail regarding the physician intensity. The physician work intensity was agreed to be approximately the same as code 88365, however the procedure is more time consuming. The RUC agreed with the surveyed median physician time of 45 minutes and the work intensity of 88365 to develop its recommendation. **The RUC recommends a relative work value of 1.40 for code 88368.**

The RUC and the specialty also understood that the survey results indicated that there was no physician work associated with the pre-service and post-service time period for any of the codes. Therefore, **the RUC recommends that the RUC exclude the pre-service and post-service physician work descriptions in the RUC database.**

Practice Expense Inputs

The RUC reviewed the inputs line by line, and made revisions in the clinical labor time to reflect the typical patient. **The RUC recommends the attached practice expense inputs for this family of codes.**

X. Relative Value Recommendations for CPT 2006

Anesthesia for Incomplete or Missed Abortion (Tab 10)

James D. Grant, MD, American Society of Anesthesiologists (ASA)
Brenda S. Lewis, MD, American Society of Anesthesiologists (ASA)

The CPT Editorial Panel created two new codes, 0196X1 *Anesthesia for incomplete or missed abortion procedures* and 0196X2 *Anesthesia for induced abortion procedures*, to differentiate between anesthesia for two distinct categories of abortion procedures - induced and spontaneous. CPT Code 01964 *Anesthesia for abortion procedures* (Base Unit = 4), was valued by the RUC in April 2001.

0196X1 and 0196X2

The RUC reviewed survey data from nearly 40 anesthesiologists who indicated that the services described in 0196X1 and 0196X2 have a similar intensity to that of code 01964. The survey responses on the intensity/complexity measures indicated little variance, with mental effort and judgment; technical skill and physical effort; and psychological stress for reference service code 01964. The society recommended the survey median of 4 base units for both 0196X1 and 0196X2. **The RUC recommends a base unit of 4 for CPT codes 0196X1 and 0916X2.**

Practice Expense

These anesthesia services are performed in a facility setting only and, therefore, no direct practice expense inputs are applicable.

Laryngeal Function Studies (Tab 11)

American Academy of Otolaryngology – Head and Neck Surgery
American Speech-Language-Hearing Association

The specialty society notified AMA staff that this issue will be deferred until the 2005 February RUC meeting.

Drug Administration Services (Tab 12)

Elizabeth Tindall, MD, American College of Rheumatology (ACRh)
Joel Brill, MD, American Gastroenterological Association (AGA)
David Regan, MD, American Society of Clinical Oncology (ASCO)
W. Charles Penley, MD, American Society of Clinical Oncology (ASCO)
Samuel H. Silver, MD, PhD, American Society of Hematology (ASH)
Lawrence Martinelli, MD, Infectious Diseases Society of America (IDSA)
William F. Gee, MD, American Urological Association (AUA)

Facilitation Committee #1

The RUC reviewed work relative value recommendations and direct practice expense inputs presented by a coalition of six specialties: oncology, hematology, infectious disease, rheumatology, gastroenterology, and urology. The specialty societies informed the RUC that the survey results were only valid in reviewing the levels of intensity between services, as the respondents were not able to differentiate between the supervision of drug administration and evaluation and management services. The specialty societies developed their recommendations via a consensus panel approach, basing their recommendations on a comparison to 99211 *Level 1 office visits* (Work RVU = 0.17) and other services evaluated by the RUC.

The RUC reviewed all twenty new codes by first allocating them into three categories (hydration, TX/DX and chemotherapy). For each of these categories, anchors were developed in order to create relativity amongst the codes. The RUC first assessed the relationship between 90760 *Intravenous infusion, hydration; initial, up to one hour*, 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour*, and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 99211 serves as an appropriate anchor for CPT code 90760 *hydration*. The RUC reviewed existing code 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) and determined that it was an appropriate reference code for 96413 *Chemotherapy* as the physician supervision requirements are equivalent and the patient acuity and risk of adverse outcomes are similar. The RUC then based all of the recommendations for these twenty codes within a range between 0.17 and 0.28, accounting for differences in time and intensity for each service.

The RUC considered only those codes that were approved by the CPT Editorial Panel and did not include other activities, such as physician time related to treatment management or clinical staff activities related to nutrition or psychological counseling in these specific drug administration services.

A number of supporting documents are attached to this recommendations including: 1) a summary of the RUC review of drug administration; 2) an

overview of the CPT coding changes for *CPT 2006*; 3) an excel spreadsheet that summarizes the RUC recommendations; 4) an excel spreadsheet predicting the utilization of the new CPT codes; 5) excel spreadsheets with direct practice expense inputs; and 6) separate documents summarizing the specialties work recommendations for each of the 20 new codes.

Hydration

90760 (H1)

The RUC examined 90760 *Intravenous infusion, hydration; initial, up to one hour*. The RUC agreed that this service had similar complexity and intensity as a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU = 0.17). In addition, the RUC agreed that the time associated with this code (7 minutes of total service time) was equal to the physician supervision time of the reference code (7 minutes of total service time). **The RUC recommends a work relative value of 0.17 for 90760.**

90761 (H2)

The RUC reviewed the recommendation for 90761 *Intravenous infusion, hydration; each additional hour, up to eight (8) hours*. Although this code is the second hour of hydration, the RUC agreed that there would be a need for some nurse/physician interaction. The RUC agreed that the work related to 90761 was about half of the work associated with 90760. The RUC recommends that the total physician time is 3 minutes. **The RUC recommends a work relative value of 0.09 for 90761**

Therapeutic/Diagnostic Infusions and Injections

90765 (H3)

The RUC assessed 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* and decided that in order to maintain relativity between the codes, the work RVUs for this code should be placed between the work RVUs for 90760 (recommended work RVU of 0.17) and 96413 (recommended work RVU of 0.28). After discussing the differences between all three codes, the RUC agreed that the service provided in 90765 was more closely related to 90760 than 96413 when considering the intensity and complexity of the patient, risk of complications, and likelihood that the physician would be asked to intervene during the course of an infusion. The RUC recommends that the total physician time is 9 minutes. **The RUC recommends a work relative value of 0.21 for 90765.**

90766 (H5)

The RUC examined the recommendations for 90766 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)*.

The RUC agreed that the agents being administered for this code would not only require additional hours of administration but also would be very different from the agents that would be administered when 90765 would be reported alone. Due to the higher levels of toxicity of these agents, there would be more nurse/physician interaction. The RUC recommends 3 minutes of total physician time. The RUC believes that the intensity of this increment of physician involvement is greater than the increment between the first and subsequent hours of hydration, and therefore, recommends only a .03 reduction in physician work between the first and second hour of infusions for therapeutic agents. **The RUC recommends a work RVU of 0.18 for 90766.**

90767 (H4)

The RUC reviewed the recommendations for 90767 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure.*

After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that complications may occur with administering a second drug and there is a greater likelihood of additional nurse/physician interaction as compared to 90766 (recommended work RVUs of 0.18). The RUC recommends 6 minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 90767.**

90768 (H6)

The RUC examined the recommendations for 90768 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration).* After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving two drugs at the same time, which would account for some nurse/physician interaction but less interaction than that of 90766 or 90767. Therefore the RUC agreed that the work and intensity associated with this service would be similar to 90760, the first hour of hydration, or 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU=0.17). The RUC recommends 4 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90768.**

90772 (H7)

The RUC assessed the recommendations for 90772 *Therapeutic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.* The RUC identified a reference code for this service, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time) which is similar in intensity, work and time. The

RUC recommends 7 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90772.**

The RUC reaffirms its recommendations for vaccination codes (90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid), 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure), 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) and 90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)) of 0.17, 0.15, 0.17 and 0.15; respectively. All of these codes are currently valued at 0.00 work RVUs. However, the RUC urges CMS to publish work values for these services as part of the drug administration review. The RUC also acknowledges that the direct practice expense inputs for immunization administration may need to be re-reviewed. The RUC recommendations for these services are attached.

90774 (H9)

The RUC assessed the RUC recommendations for 90774 *Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.* The RUC used magnitude estimation to determine the appropriate work RVU for this procedure. The RUC agreed that an appropriate reference code would be 90760 *Intravenous infusion, hydration; initial, up to one hour* (RUC Recommended Work RVU=0.17) The RUC deemed 90774 to be more intense and require additional time to perform (7 minutes total time for 90760 and 9 minutes of total time for 90774) as compared to 90760. **The RUC recommends a work RVU of 0.18 for 90774.**

90775 (H10)

The RUC examined the recommendations for 90775 *Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure).* The RUC identified a reference code for 90775 that was similar in work and intensity, 90761 *Intravenous infusion, hydration; each additional hour, up to eight (8) hours* (RUC Recommended Work RVU=0.09). However, 90775 requires more time to perform (4 minutes total service time) than 90761 (3 minutes total service time). The RUC agreed that in order to maintain relativity, a 0.01 increment should be added to the work RVU of 90761. **The RUC recommends a work RVU of 0.10 for 90775.**

Chemotherapy Infusions and Injections

96401 (H11)

The RUC examined the recommendations for 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*. The RUC agreed that the service identified with this CPT code is more complex, has higher risk and has higher probability of nurse/physician interaction than 90772 (RUC Recommended Work RVU of 0.17). In addition, the RUC observed that 96401 requires more time than 90772, 9 and 7 minutes respectively. In addition, the RUC agreed that the work described in 96401 is similar to 90765, initial therapeutic/diagnostic infusion, up to one hour. **The RUC recommends a work RVU of 0.21 for 96401.**

96402 (H12)

The RUC reviewed the RUC recommendations for 96402 *Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic*. Upon reviewing the recommendations for this code, the RUC identified a reference service code for this procedure, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time). The RUC recommends 9 minutes of physician time related to 96402. The RUC agreed that this code should be valued between 90772 *therapeutic injection* (RUC recommended Work RVU= 0.17) and 96401 *chemotherapy injection* (RUC Recommended Work RVU=0.21). **The RUC recommends a work RVU of 0.19 for 96402.**

96409 (H13)

The RUC examined the recommendations for 96409 *Chemotherapy administration, subcutaneous or intramuscular; intravenous push technique, single or initial substance/drug*. The RUC agreed that in order to maintain relativity between the chemotherapy administration codes, this procedure should be relatively placed between 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic* (RUC Recommended Work RVU=0.21) and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug* (RUC Recommended Work RVU=0.28). The RUC agreed that because 96409 had 2 minutes less intra service time than 96413 and 2 minutes more intra service time than 96401, the work relative value recommendation should be placed directly between the work relative value recommendations for the other two codes, in order to maintain relativity. The total physician time for 96409 is 11 minutes. **The RUC recommends a work RVU of 0.24 for 96409.**

96411(H14)

The RUC examined the recommendations for 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)*. When examining the recommendation for 96411, the RUC agreed that the work associated with this code was twice the amount of work associated with 90775 due to differences in intensity, complexity and total service times (4 minutes total service time for 90775 and 7 minutes total service time for 96411). **The RUC recommends a work RVU of 0.20 for 96411.**

96413 (H15)

The RUC examined 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) was an appropriate reference code for 96413. The RUC agreed that 93798 was a good reference code for 96413 because both services have similar intensity, complexity and involve similar physician direct supervision times (12 minutes total service time for 93798 and 13 minutes total service time for 96413). Both of these codes require supervision that may occur for more than one patient at a time. The RUC agreed that the patient acuity and risk adverse outcomes are similar for both services. **The RUC recommends a work relative value of 0.28 for 96413.**

96415 (H16)

The RUC examined the 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)*. The RUC agreed that an increment of physician work (.01) above 90766 *therapeutic/diagnostic infusion, subsequent hour* would be appropriate. The RUC agreed that the work of 96415 is equivalent to 90767 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)* (RUC Recommended Work RVU=0.19). The RUC recommends five minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 96415.**

96416 (H17)

The RUC reviewed 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump* and agreed that an appropriate reference code would be 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21) because both codes have similar intensity, complexity and nurse/physician interaction. In addition, both codes

have similar total service times, 9 minutes total service time for 90765 and 10 minutes total service time for 96416. **The RUC recommends a work RVU of 0.21 for 96416.**

96417 (H18)

The RUC reviewed the recommendations for 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)*. After reviewing the service, the RUC agreed that when this service was reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that because of the complications that may occur with administering a second drug, there would be additional nurse/physician interaction as compared to 96415 (recommended work RVU of 0.19). The RUC agreed that 96417 is equivalent to 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21). The RUC recommends a total of 8 minutes of physician time. **The RUC recommends a work RVU of 0.21 for 96417.**

96521 (H24)

The RUC reviewed 96521 *Refilling and maintenance of portable pump* and determined that this service has similar complexity, work and total service time as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96521.**

96522 (H26)

The RUC reviewed CPT code 96522 *Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* and determined that this service has similar complexity, work and total service times as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96522.**

96523 (H25)

The RUC examined 96523 *Irrigation of implanted venous access device for drug delivery systems*. The RUC observed that this service had no intra-service or post service activities and only required 2 minutes on pre-service to perform. Therefore the RUC agreed with using an IWP/UT analysis to establish a work relative value recommendation for this code. By using IWP/UT analysis, the RUC determined that 2 minutes of pre-service same day evaluation would equate to 0.04 work RVUs (2 minutes x 0.0224 = 0.04 RVUs). **The RUC recommends a work RVU of 0.04 for 96523.**

Physician Time

The RUC recommends that all times associated with these codes, when placed in the RUC database, include a notation to clarify that the physician times associated with these codes are direct supervision and interactions with clinical staff, rather than face-to-face with the patient.

Practice Expense

The RUC reviewed the practice expense inputs for the existing codes which were approved by the PEAC and subsequently by the RUC in 2002. The RUC observed that when these codes were first reviewed, a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* was billed with the majority of these codes over fifty percent of the time. However, because the current CMS rules and CCI edits do not allow a 99211 to be billed with this series of codes, the RUC noted that some of the activities that were eliminated in 2002 are not appropriate to add back to these codes. In addition, the RUC's recommendations incorporate the new coding structure and the ability to capture practice expense for subsequent drug infusions. The revised practice expense inputs are attached to this recommendation.

XI. Other Relative Value Recommendations

Intracranial Aneurysm Repair (Tab 13)

Frederick Boop, MD, Congress of Neurological Surgeons (CNS)

John Wilson, MD, American Association of Neurological Surgeons (AANS)

The specialty societies sent a letter dated September 15, 2004, to AMA staff indicating that this issue will be brought to the Five Year Review.

XII. RUC Ad Hoc Practice Expense Advisory Committee Report (Tab 14)

Doctor Bill Moran, Jr., Chair of the RUC Ad Hoc Practice Expense Committee presented its report. The Committee refined 58 existing CPT codes at its September 2004 meeting, and postponed the remaining existing codes to its February 2005 meeting. In addition, the committee reviewed and made suggestions concerning the new chemotherapy administration codes and other new codes up for review at the RUC meeting.

The RUC agreed with the committee's practice expense recommendations for the 58 existing codes. The full RUC Ad Hoc Practice Expense Committee report is attached to these minutes.

XIII. RUC HCPAC Review Board Report (Tab 15)

Ms. Mary Foto, OTR, RUC HCPAC Co-Chair, welcomed the National Association of Social Workers' (NASW) new member Doris Tomer, LCSW.

The HCPAC then reviewed the CPT codes on the HCPAC MPC List. The HCPAC identified that further edits to the list need to occur. The HCPAC specialty societies will submit codes to be added or deleted to this list. The revised list will be reviewed at the February 2005 HCPAC Meeting.

Robert C. Fifer, PhD, American Speech-Language-Hearing Association, was elected as the HCPAC Alternate Co-Chair. Dr. Fifer will fulfill Nelda Spyres', LCSW term by serving as the HCPAC Alternate Co-Chair until September 2005.

Additionally, Antonio Puente, PhD, American Psychological Association, presented an educational session on the services provided in the CNS Assessments/Tests (96100-96117). The psychological testing codes are scheduled to be presented to CPT in November 2004 and thereafter, if accepted, will be presented to the RUC HCPAC for relative value assignment.

The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.

XIV. Ad Hoc Pre-Time Workgroup Report (Tab 16)

Doctor Topping presented the report of the Ad Hoc Pre-Service Time Workgroup. The workgroup looked at various options for developing pre-service physician time standards. Doctor Topping explained that the workgroup had concerns with establishing standards since it would considerably change RUC methodology that compares new/revised codes to an existing code. The workgroup therefore agreed not to develop a recommendation for developing pre-service time standards. Also, the workgroup felt that summary pre-service times should not be provided to the RUC survey respondents as this would adversely affect survey responses. The RUC passed the following recommendation:

The RUC approved pre-service time data should not be provided to RUC survey respondents.

The workgroup also discussed how the RUC should use existing RUC approved physician times. Since the data is already included in the RUC database, providing data would not be a substantial change and may be a

useful reference source for RUC members to consider as part of an individual code review. The RUC passed the following recommendation:

The RUC members will receive a summary of RUC approved pre-service times on a periodic basis.

XV. Multi-Specialty Points of Comparison Workgroup Report (Tab 17)

Doctor James Blankenship reported that the Multi-Specialty Points of Comparison (MPC) Workgroup had met and considered requests to add or remove services from the MPC. **The RUC approved the MPC Workgroup recommendation to make the following changes to the MPC:**

<u>CPT Code</u>	<u>Action</u>	<u>Requesting Society</u>	<u>Dominant Specialty</u>
<u>Agreement</u>			
11040	Remove	APMA	
11043	Remove	ACS	
11200	Add	AAP	Yes, Dermatology
20551	Add	APMA	Yes, Family Medicine
28080	No action	APMA	<i>RUC time not validated, do not add</i>
28296	Remove	APMA	
33249	Add	ACC	
35082	Remove	SVS	Yes, General Surgery
35301	Remove	SVS	Yes, General Surgery
35585	Remove	SVS	Yes, General Surgery
36200	Remove	ACC	Yes, Radiology
36405	Add	AAP	
37205	Remove	ACC	Yes, Radiology
51595	Remove	AUA	
52000	Remove	AUA	
54150	Remove	AAP	
55700	Remove	AUA	
55845	Remove	AUA	
62270	Remove	AAP	Yes, Neurology and Radiology
92982	Remove	ACC	
93018	Remove	ACC	
93501	Remove	ACC	
93751	Add	ACC	
99202	Remove	AAFP/AAN	Yes, Podiatry
99203	Remove	AAFP/AAN	Yes, Orthopaedic Surgery
99204	Remove	AAFP/AAN	Yes, Internal Medicine
99205	Remove	AAFP/AAN	Yes, Internal Medicine
99211	Remove	AAFP/AAN	Yes, Internal Medicine

99212	Remove	AAFP/AAN	
99213	Remove	AAFP/AAN	Yes, Internal Medicine
99214	Remove	AAFP/AAN	Yes, Internal Medicine
99215	Remove	AAFP/AAN	Yes, Internal Medicine
99222	Remove	AAFP/AAN	Yes, Internal Medicine
99223	Remove	AAFP/AAN	Yes, Internal Medicine
99232	Remove	AAFP/AAN	Yes, Internal Medicine
99233	Remove	AAFP/AAN	Yes, Internal Medicine
99238	Remove	AAFP/AAN	Yes, Internal Medicine
99242	Remove	AAN	Yes, General Surgery
99243	Remove	AAN	Yes, Orthopaedic Surgery
99244	Remove	AAN	Yes, Cardiology
99245	Remove	AAN	
99253	Remove	AAN	Yes, Cardiology
99254	Remove	AAN	Yes, Cardiology
99255	Remove	AAN	Yes, Cardiology

The MPC Workgroup noted and the RUC agreed that the Evaluation and Management codes may be removed from the MPC list because some societies believe they are mis-valued and plan to propose them for inclusion in the Five Year Review. The RUC agreed that these services serve as important reference points and should be added back to the MPC list upon completion of the Five-Year Review process.

The RUC also agreed with the MPC Workgroup that the inclusion of a code on the MPC list does not preclude its identification for the Five-Year Review.

The approved MPC Workgroup report is attached to these minutes.

XVI. Professional Liability Insurance Workgroup Report (Tab 18)

Doctor Gregory Przybylski reported that the Professional Liability Insurance (PLI) Workgroup met to discuss the Five-Year Review of the PLI relative value units. The Workgroup again expressed concern regarding the methodology and outcome of the risk factor assignment outlined in the *Proposed Rule*. Mr. Ensor indicated that the comments submitted by the RUC were not specific enough to consider actual changes to the proposal. He indicated that Bearing Point utilized their own physicians to review the appropriateness of these risk factors. Mr. Ensor noted that CMS welcomes continued input from the RUC on the crosswalks and risk factor assignments.

The RUC agreed that these risk factor assignments should be reviewed and recommends that the PLI Workgroup review the assignment of non-surgical and surgical risk factors at the February RUC meeting.

Direct Payment of PLI Premiums

Several members of the Workgroup argued that the current system of compensating physicians for Medicare's portion of their professional liability insurance premiums is broken. It was suggested that PLI should not be a component of the RBRVS payment system. A suggestion was made that a coalition of specialties submit a resolution to the AMA House of Delegates requesting that the AMA pursue legislation mandating a more direct way to pay physicians for their actual premium costs. **The PLI Workgroup requested and the RUC agreed that AMA staff forward all resolutions and reports on the PLI issue to the RUC.**

The approved PLI Workgroup Report is attached to these minutes.

XVII. Practice Expense Subcommittee Report (Tab 19)

Doctor Robert Zwolak presented the Practice Expense Subcommittee Report. The Practice Expense Subcommittee met to discuss the practice expense inputs for Protein Electrophoresis, allocation of physician time components, and hear an update in the AMA's plans for practice expense data collection.

Practice Expense Inputs for Protein Electrophoresis

At its April 2004 meeting, the RUC discussed the work and practice expense recommendations proposed by the College of American Pathologists (CAP) for codes involving Protein Electrophoresis. The RUC's discussions involved the appropriateness of cross-walking the work, and practice expense inputs from existing codes rather than performing a RUC survey for work recommendations, and surveying or convening a consensus panel for practice expense recommendations as required. The RUC agreed with the specialty society to cross-walk the work components and asked the practice expense subcommittee to further review the appropriateness of the practice expense recommendation for these pathology codes.

Subcommittee members discussed and agreed that these codes were distinct and required the CAP recommended 8 minutes of clinical staff time for the codes.

The Practice Expense Subcommittee recommends that the RUC accept the practice expense inputs recommended by CAP for new and revised codes: 84165, 84166, 86334, and 86335.

Physician Time Allocations

For this meeting, AMA staff obtained physician time allocations for 2 CPT codes. Subcommittee members carefully reviewed a physician time recommendation from the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Academy of Family Physicians (AAFP), and believed the recommended times were reasonable and should be accepted. The subcommittee was also informed that ACEP supports the following reductions in physician time.

The Practice Expense Subcommittee recommends the following physician time components be used for practice expense purposes only, these times will be flagged in the RUC database as not to be used for physician work purposes by the RUC or by CMS.

CPT	Descriptor	glob	"PR" Time	pre time	intra time	Im-SD	Total Time Recommended
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	000	106	25	25	21	71
21310	Closed treatment of nasal bone fracture without manipulation	000	100	20	15	10	45

Update on AMA's Plans for Practice Expense Data Collection

Kathy Kuntzman, Vice President of the AMA's Health Policy Department provided an update on SMS activities to the Practice Expense Subcommittee. She indicated that the AMA staff proposed to reinitiate an SMS-like survey in 2005, however staff were not able to secure funding for this activity in the budget planning process. Subcommittee members expressed their dismay regarding this news. Subcommittee members believed the data from the survey is critical for the development of practice expense relative values, MEI updates, and other research and made the following recommendation to the RUC.

The practice expense subcommittee recommends that the RUC request the AMA reconsider the funding of the SMS survey, in order to obtain updated practice expense data. Attached to these minutes is a letter dated November 3, 2004, in which the RUC requests that the AMA reconsider the funding of the SMS survey, in order to obtain updated practice expense data.

The full Practice Expense Subcommittee Report is attached to these minutes.

XVIII. Research Subcommittee Report (Tab 20)

Doctor Borgstede highlighted the topics that the Research subcommittee discussed and invited RUC members to pose questions. The RUC discussed the review of ultrasound codes and Doctor Borgstede clarified that research subcommittee will be looking at all ultrasound codes and the issues that were identified at the April RUC meeting. Also, AMA staff asked societies to inform AMA staff of any codes missing from the lists included in the agenda material.

The RUC passed the following recommendations:

AMA staff will provide the Research Subcommittee with a list of ultrasound codes and the corresponding physician work data so that value of the ultrasound component of codes can be estimated along with an IPUT calculation.

The RUC also passed the following recommendation, however, the RUC has requested that specialty societies review the new set of Reference Service List guidelines so that it can be finalized at the February, 2005 RUC meeting.

The Subcommittee approved the following set of guidelines for development of reference service lists. This includes reaffirmation of existing guidelines and new guidelines to be added to the existing guidelines.

Existing Guidelines:

- **Include a broad range of services and work RVUs for the specialty.**
Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.
- **Services on the list should be those which are well understood and commonly provided by physicians in the specialty.**
- **Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)**

New Guidelines

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**

- **Include several high volume codes typically performed by the specialty.**

XIX. Administrative Subcommittee Report (Tab 21)

Doctor Chester Schmidt presented the Administrative Subcommittee Report to the RUC. The Administrative Subcommittee met to discuss several issue: 1.) CPT/RUC Meeting Dates, 2.) Clarification of RUC Membership Criterion, 3.) Re-Review of RUC Recommendations, 4.) Update on the Medicare Contractor Medical Director's Request.

In its discussion of the CPT/RUC Meeting Dates, the Administrative Subcommittee agreed that the June 2-June 5 CPT Meeting would allow adequate time for the specialty societies to complete the RUC Survey process before the September 29-October 2, 2005 RUC Meeting. Once CPT has finalized its annual calendar, the Administrative Subcommittee will review the timeline between all CPT and RUC Meetings

In its discussion of the Clarification of RUC Membership Criterion, the members of the Administrative Subcommittee, discussed this request and approved the following motion:

A workgroup will be formed to assess the current criteria for a permanent seat on the RUC.

Upon review of this motion, the RUC amended the Administrative Subcommittee's motion to request the full Subcommittee to review the issue, rather than creating a special workgroup. **The RUC approved the following motion:**

The Administrative Subcommittee will assess the first criteria for RUC membership, related to ABMS specialties, at the February 2005 meeting.

The Administrative Subcommittee also reviewed a request made by a RUC member at the April 2004 RUC meeting, that a formal process should be instated to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. Doctor Schmidt stated that he would work with RUC staff to create a proposal to develop and formalize this process. The proposal will be shared with the Administrative Subcommittee at the February 2005 RUC Meeting for further discussion

The Administrative Subcommittee received an update on the Medicare Contractor Medical Directors' request for the RUC database. The Administrative Subcommittee agreed with this request and approved the following motion:

1. The RUC database will be distributed to CMDs with appropriate confidentiality agreements, and amendments to the CMS license with CPT.
2. The RUC will use the CMDs experience and advice for future product development and continuance of release.
3. The licenses for use would be limited to one year and would limit the CMDs to use the RUC database for the RBRVS/CPT process and Medicare related issues only.
4. During the span of their one year use, the CMDs will be required to quarterly complete a survey questioning their use and overall impact of the RUC Database release.
5. The release of the database would be concurrent with the distribution of the RUC databases to the RUC members with all of the CPT 2005 related information

The RUC extracted this item. After more deliberation, a vote was taken.

The motion failed. The RUC will not release the database at this time.

In addition, to discussing the RUC database distribution to the Contractor Medical Directors, the workgroup recommended that the RUC Database be released to the Specialty Societies for use outside of the CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims). After discussing this recommendation, the Administrative Subcommittee approved the following motion:

1. The RUC database will be distributed to the current distribution list of specialty societies with appropriate confidentiality agreements and amendments to their license with CPT.
2. The RUC will use these specialty societies experience and advice for future product development and continuance of release.
3. The licenses for use would be limited to one year and would limit these specialty societies to use the RUC database for the RBRVS/CPT processes and Medicare related issues only.
4. During the span of their one year use, these specialty societies will be required to quarterly complete a survey questioning their use and overall impact of the RUC Database release.

5. The release of the database would be concurrent with the distribution of the RUC databases to the RUC members with all of the CPT 2005 related information.

The RUC extracted this item for discussion and determined that the release of the RUC database should be tabled until this issue is reviewed by the AMA legal counsel and other AMA staff.

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

XX. Other Issues

The meeting was adjourned on Saturday, October 2, 2004 at 12:00 p.m.

**AMA/Specialty RVS Update Committee
RUC Ad Hoc Practice Expense Committee
September 29, 2004**

Bill Moran, MD (Chair)	Thomas A. Felger, MD
James Anthony, MD	Gregory Kwasny, MD
Katherine Bradley, PhD, RN	Peter McCreight, MD
Joel Brill, MD	Tye Ouzounian, MD
Manuel D. Cerqueira, MD	James B. Regan, MD
Neal Cohen, MD	Anthony Senegore, MD

Call to Order

Doctor Moran called the group to order and explained to the members that this committee was created to conclude the Practice Expense Advisory Committee (PEAC)'s activities of refining the practice expense inputs of existing codes, and begin to review new and revised codes on the RUC's agenda. Doctor Moran stated that the final PEAC codes for review had been split between this meeting and the February 2005 meeting. Doctor Moran then welcomed a group of visiting physicians from the Korean Medical Association.

Specialty Society Requests and Specific Committee Recommendations

The committee discussed and made decisions on the following Specialty Society Requests:

1. The American Academy of Dermatology Association (AADA) requested that code 17307 be deferred to the January 2005 meeting as the meeting date conflicted with annual meetings of their key presenters. AMA staff stated that code 17307, and its family had been deferred from refinement several times in the past, and that there is a RUC action from September 2002 referring the practice expense inputs be refined by this committee. An AADA advisor agreed to refine the family of codes during the February 2005 RUC meeting. In addition, members believed that there should be no further delay for this family of codes. The codes to be refined are: 17304, 17305, 17306, 17307, and 17310.
2. The American Psychological Association Practice Organization requested that the Central Nervous System Assessment/Tests family of codes be deferred from the February 2005 RUC meeting to the April 2005 meeting, as they are to be reviewed by the CPT Editorial Panel in November 2004 (Code 96105 was extracted from this request, see next request). Committee members agreed to the specialty society request pending the CPT Editorial Panel's actions in November 2004. In addition, if there is no action taken by the CPT Editorial Panel in November 2004, the codes are recommended to be refined in February 2005 by this committee.
3. The American Speech-Language Hearing Association (ASHA) and the American Academy of Neurology (AAN) requested code 96195 be refined at this meeting

rather than at the February 2005 meeting. The committee members agreed with this request.

4. AADA representatives stated that hair transplant codes 15775 and 15776 are obsolete and that the International Society for Hair Restoration Surgeons are currently working with the CPT Editorial Panel to revise the codes. These codes will be placed on the February 2005 agenda pending CPT Editorial Panel action.
5. The following codes were postponed to the February 2005 meeting so that specialty societies performing these services would jointly bring the entire family of codes forward for refinement: 42160, 41250, 41251. These families include:
 - 42100 – 42140
 - 41250 - 41252
6. Unclaimed code 69300 was scheduled for refinement at this meeting, however the American Academy of Otolaryngology Head and Neck Surgery (AAO-HNS) requested that the code be postponed until February 2005 so that the specialty may pursue a global period change from CMS. The committee agreed with this request, and suggested the code be refined with the rest of its CPT code family. Codes 69300, 69310, and 69320 are to be added to the February 2005 agenda.
7. Codes 88355, 88356, were postponed due to specialty society request.
8. The following codes were added to this meetings agenda after the American Society of Plastic Surgeons requested they be reconsidered: 12031, 12041
9. The American Association of Oral and Maxillofacial Surgeons (AAOMS) requested the committee review its proposed practice expense inputs for unclaimed code 21480. The committee agreed with the specialty society request and refined the code.
10. The American Academy of Family Physicians (AAFP) requested the committee review its proposed practice expense inputs for unclaimed code 21310. The committee agreed with the specialty society request however there was insufficient time for refinement. This code will be on the February 2005 agenda.
11. Codes 92510 and 92597 were recommended for the next 5 year review. Code 92597 was not refined by the workgroup because of this reason.
12. Codes 11100 and 11101 were refined by the group as they were being used as crosswalk codes for other dermatological procedures.
13. The following codes were moved to the February 2005 meeting due to time constraints or specialty society request: 15851, 15852, 21310, 19396, 19396, 38794, 60000, 60001, 69300, 86585, 89100, 89105, 89130, 89132, 89135, 89140, 89141, 89220, 92230, 92335, 93561, 93562, 95060

The following codes were reviewed at this meeting:

CPT Code	Descriptor	Specialty
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane	AADA
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane	AADA
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	ASPS
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0	ASPS
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0	ASPS
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0	ASPS
12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities	ASPS
12034	Layer closure of wounds of scalp, axillae, trunk and/or extremities	AADA, ASPS

12041	Layer closure of wounds of neck, hands, feet and/or external	ASPS
12042	Layer closure of wounds of neck, hands, feet and/or external	AADA, ASPS
12044	Layer closure of wounds of neck, hands, feet and/or external	AADA, ASPS
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	AADA, ASPS
12052	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	AADA, ASPS
12053	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	AADA, ASPS
12054	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	ASPS
12055	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	ASPS
12056	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	ASPS
12057	Layer closure of wounds of face, ears, eyelids, nose, lips and/or	ASPS
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	ASPS
20500	Injection of sinus tract; therapeutic (separate procedure)	APMA
21480	Closed treatment of temporomandibular dislocation; initial or	AAOMS
36522	Photopheresis, extracorporeal	AADA
40490	Biopsy of lip	AADA
41800	Drainage of abscess, cyst, hematoma from dentoalveolar	AAOMS
41805	Removal of embedded foreign body from dentoalveolar structures;	AAOMS
41806	Removal of embedded foreign body from dentoalveolar structures;	AAOMS
41822	Excision of fibrous tuberosities, dentoalveolar structures	AAOMS
41825	Excision of lesion or tumor (except listed above), dentoalveolar	AAOMS
41826	Excision of lesion or tumor (except listed above), dentoalveolar	AAOMS
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	AAOMS
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	AAOMS
42280	Maxillary impression for palatal prosthesis	AAOMS
68400	Incision, drainage of lacrimal gland	AAO, AOA
68420	Incision, drainage of lacrimal sac (dacryocystotomy or	AAO, AOA
68510	Biopsy of lacrimal gland	AAO, AOA
68530	Removal of foreign body or dacryolith, lacrimal passages	AAO, AOA
69100	Biopsy external ear	AADA
92015	Determination of refractive state	AAO, AOA
92230	Fluorescein angiography with interpretation and report	AAO, AOA
92260	Ophthalmodynamometry	AAO, AOA
92265	Needle oculoneurography, one or more extraocular muscles,	AAO, AOA
92284	Dark adaptation examination with interpretation and report	AAO, AOA
92287	Special anterior segment photography with interpretation and	AAO, AOA
92310	Prescription of optical and physical characteristics of and fitting of	AAO, AOA
92311	Prescription of optical and physical characteristics of and fitting of	AAO, AOA
92312	Prescription of optical and physical characteristics of and fitting of	AAO, AOA
92313	Prescription of optical and physical characteristics of and fitting of	AAO, AOA
92314	Prescription of optical and physical characteristics of contact lens,	AAO, AOA
92315	Prescription of optical and physical characteristics of contact lens,	AAO, AOA
92316	Prescription of optical and physical characteristics of contact lens,	AAO, AOA
92317	Prescription of optical and physical characteristics of contact lens,	AAO, AOA
92340	Fitting of spectacles, except for aphakia; monofocal	AAO, AOA
92341	Fitting of spectacles, except for aphakia; bifocal	AAO, AOA
92342	Fitting of spectacles, except for aphakia; multifocal, other than	AAO, AOA
92370	Repair and refitting spectacles; except for aphakia	AAO, AOA
92510	Aural rehabilitation following cochlear implant (includes evaluation	ASHA
96105	Assessment of aphasia (includes assessment of expressive and	ASHA, AAN
96900	Actinotherapy (ultraviolet light)	AADA

**AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
September 30, 2004**

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Jonathan Cooperman, PT
Robert Fifer, PhD
Anthony Hamm, DC
Emily H. Hill, PA-C
Marc Lenet, DPM

David Keepnews, RN, PhD
Bernard Pfeifer, MD
Antonio Puente, PhD
Christopher Quinn, OD
Doris Tomer, LCSW
Arthur Traugott, MD
Jane White, PhD, RD, FADA

I. Administrative Issues

Mary Foto, OTR, welcomed the National Association of Social Workers' (NASW) new member Doris Tomer, LCSW.

II. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that CMS will be reviewing the comments on the Proposed Rule which were received in late September 2004. The Final Rule is scheduled to be published in early November 2004.

III. HCPAC MPC

The HCPAC reviewed the CPT codes on the HCPAC MPC List. The HCPAC identified that further edits to the list need to occur. The HCPAC specialty societies will submit codes to be added or deleted to this list. The revised list will be reviewed at the February 2005 HCPAC Meeting.

IV. HCPAC Alternate Co-Chair

Robert C. Fifer, PhD, American Speech-Language-Hearing Association, was elected as the HCPAC Alternate Co-Chair. Nelda Spyres, LCSW regretfully had to step down as the HCPAC Alternate Co-Chair in the middle of her two-year term. Therefore, Dr. Fifer will fulfill her term by serving as the HCPAC Alternate Co-Chair until September 2005.

V. CNS Assessments/Tests – Education Session

Antonio Puente, PhD, American Psychological Association, presented an educational session on the services provided in the CNS Assessments/Tests (96100-96117). The psychological testing codes are scheduled to be presented to CPT in November 2004 and thereafter, if accepted, will be presented to the RUC HCPAC for relative value assignment.

VI. Other Issues

Susan Dombrowski, AMA Staff, announced the upcoming Annual HCPAC Meeting on November 5, 2004 and urged that any HCPAC society which would like to present a topic at the annual meeting submit any topics and materials to her by October 8, 2004.

**AMA/Specialty Society RVS Update Committee
Ad Hoc Pre-Service Time Workgroup
September, 2004**

The Workgroup met on September 30, 2004 and the following workgroup members were present: Doctors Topping (chair), Cohen, Gage, Lichtenfeld, Tuck, and Wiersema. The workgroup discussed whether the RUC should develop pre-service time standards and how the RUC approved pre-service time should be used in the RUC process. The workgroup recognized that the PEAC has used standards successfully and discussed whether a similar time standardization process should be developed for the RUC or whether the existing pre-service time data should be used as a guide for RUC members when reviewing new/revised codes. After examining a summary of RUC approved pre-service times, the workgroup concluded that there is currently a wide range of pre-service times within each global period. Although the times vary, the workgroup agreed that it would not be useful to develop standardized pre-service times. Instead the RUC should continue to use times established by the standard RUC survey process. Any proposed times should continue to be examined by the RUC on a code by code basis. The workgroup also agreed that the summary data should not be provided to the survey respondents as it would bias the responses. The workgroup passed the following recommendation:

Summary RUC approved pre-service time data should not be provided to RUC survey respondents.

The workgroup discussed if the summary data should be used by the RUC. The workgroup members agreed that there is not a need to develop standard pre-service times since this would be a substantial change from the current process that relies on survey data. Some workgroup members were concerned that RUC members would use the summary data to review new/revised codes rather than using specific reference services to evaluate the new/revised code. There was also a concern that a presenter would have to justify a proposed pre-service time in comparison to aggregate RUC approved median times rather than making a comparison to the reference code. Also, since the RUC has requested CMS to change the pre-service time definition, any comparison with existing data might be premature. Other members felt that the data would be useful to show the range of times for each of the global periods. Since the data is already included in the RUC database, providing data would not be a substantial change and may be useful for RUC members to consider as part of an individual code review. However, it was suggested that the RUC times be compared with CMS times to identify any possible differences. The workgroup agreed that the summary data should be provided to the RUC members periodically such as on an RUC agenda CD each year. The workgroup passed the following recommendation:

The RUC members will receive a summary of RUC approved pre-service times on a periodic basis.

**AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison
September 30, 2004**

The following Multi-Specialty Points of Comparison (MPC) members met on Thursday, September 30 to review specialty society requests to remove and add CPT codes from the MPC list: Doctors James Blankenship (Chair), John Derr, William Gee, Marc Lenet, Daniel Nagle, Susan Strate, and Maurits Wiersema.

Doctor Blankenship reviewed the recent history of the MPC and summarized the previously set criteria for classifying codes as A, B, or C. These criteria are:

A = The code meets all of the absolute criteria:

- 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.

B = The code does not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians.

C = The code does not have RUC time available and it is not performed by multiple specialties, however, the specialty society would like the code to be included as a reference point.

Specialty Society Requests to Add or Remove Codes from the MPC

The RUC provided specialty societies with the opportunity to review the MPC and suggest revisions to this list. The MPC list finalized at this meeting will be the list utilized in the Five-Year Review Process and the RUC meeting throughout 2005 and 2006 (The Five-Year Review will not be implemented until January 1, 2007).

The MPC Workgroup considered requests to add or remove services from the MPC and recommends the following:

<u>CPT Code</u>	<u>Action</u>	<u>Requesting Society</u>	<u>Dominant Specialty Agreement</u>
11040	Remove	APMA	
11043	Remove	ACS	
11200	Add	AAP	Yes, Dermatology
20551	Add	APMA	Yes, Family Medicine
28080	No action	APMA	<i>RUC time not validated, do not add</i>
28296	Remove	APMA	
33249	Add	ACC	

<u>CPT Code</u>	<u>Action</u>	<u>Requesting Society</u>	<u>Dominant Specialty Agreement</u>
35082	Remove	SVS	Yes, General Surgery
35301	Remove	SVS	Yes, General Surgery
35585	Remove	SVS	Yes, General Surgery
36200	Remove	ACC	Yes, Radiology
36405	Add	AAP	
37205	Remove	ACC	Yes, Radiology
51595	Remove	AUA	
52000	Remove	AUA	
54150	Remove	AAP	
55700	Remove	AUA	
55845	Remove	AUA	
62270	Remove	AAP	Yes, Neurology and Radiology
92982	Remove	ACC	
93018	Remove	ACC	
93501	Remove	ACC	
93751	Add	ACC	
99202	Remove	AAFP/AAN	Yes, Podiatry
99203	Remove	AAFP/AAN	Yes, Orthopaedic Surgery
99204	Remove	AAFP/AAN	Yes, Internal Medicine
99205	Remove	AAFP/AAN	Yes, Internal Medicine
99211	Remove	AAFP/AAN	Yes, Internal Medicine
99212	Remove	AAFP/AAN	
99213	Remove	AAFP/AAN	Yes, Internal Medicine
99214	Remove	AAFP/AAN	Yes, Internal Medicine
99215	Remove	AAFP/AAN	Yes, Internal Medicine
99222	Remove	AAFP/AAN	Yes, Internal Medicine
99223	Remove	AAFP/AAN	Yes, Internal Medicine
99232	Remove	AAFP/AAN	Yes, Internal Medicine
99233	Remove	AAFP/AAN	Yes, Internal Medicine
99238	Remove	AAFP/AAN	Yes, Internal Medicine
99242	Remove	AAN	Yes, General Surgery
99243	Remove	AAN	Yes, Orthopaedic Surgery
99244	Remove	AAN	Yes, Cardiology
99245	Remove	AAN	
99253	Remove	AAN	Yes, Cardiology
99254	Remove	AAN	Yes, Cardiology
99255	Remove	AAN	Yes, Cardiology

The MPC Workgroup noted that Evaluation and Management codes were proposed for removal from the MPC list because some societies believe they are mis-valued and plan to propose them for inclusion in the Five Year Review. The Workgroup

Page Three

agreed that these services serve as important reference points and should be added back to the MPC list upon completion of the Five-Year Review process.

The MPC Workgroup also recommends that the RUC formalize the current understanding that inclusion of a code on the MPC list does not preclude its identification for the Five-Year Review.

Other Issues

Vascular Surgery has requested that the IWP/UT be removed from the MPC for the following codes: 34203, 34802, 35141, 35531, 35656, 36830, 35631, 35646, 35654, 36819, and 36832. According to previous RUC action, this specialty society request will be implemented.

**AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
September 30, 2004**

The following members of the Professional Liability Insurance (PLI) Workgroup met on September 30, 2004 to discuss specialty society comments on the risk classification for individual CPT codes and the Bearing Point proposal for the Five-Year Review of PLI RVUs.: Doctors Gregory Przybylski (Chair), Michael Bishop, Neil Brooks, Norman Cohen, Anthony Hamm, David Hitzeman, Charles Mabry, Bernard Pfeifer, Sandra Reed, and J. Baldwin Smith. Mr. Rick Ensor from the Centers for Medicare and Medicaid Services (CMS) participated in the meeting via conference call.

PLI Premium Data – Status of CMS Criteria Development

Mr. Ensor has shared the survey utilized by Bearing Point to collect professional liability insurance premium data . The survey is included in the RUC's handout packet. Mr. Ensor indicates that this survey may serve as the "criteria" required to consider any other premium data that the RUC may obtain. Mr. Ensor also stated that claims data linked to zip code will be sufficient for CMS to distribute the data to Medicare geographical areas. Doctor Przybylski will discuss this survey and criteria with Doctor Stephen A. Kamenetzky, who was not able to attend this meeting., to determine if there are opportunities to utilize PIAA data.

Five-Year Review of PLI Relative Value Units

The Workgroup reviewed the RUC comment letter submitted on September 22nd and discussed several of the comments with Mr. Ensor, including:

- Mr. Ensor informed the Workgroup that the assistant-at-surgery claims were indeed utilized by the contractor in its methodology. CMS is in the process of removing these claims from the utilization data to be utilized in developing PLI relative values.
- CMS will address the comments on the dominant specialty approach in the Final Rule. It appears unlikely that CMS will accept the dominant specialty approach. However, CMS is considering other variations of this approach, including developing thresholds (eg, specialty must perform the service at least 10% of the time) and "cleaning the data" to remove erroneous claims (ie, typos in the CPT code numbers in claims processing that lead to psychiatry claims for hand reimplantation).
- CMS does not have the data available to include tail coverage in the development of PLI relative values. However, CMS would be interested in reviewing this data if they are able to obtain it from another source.

- The Workgroup again expressed concern regarding the methodology and outcome of the risk factor assignment outlined in the *Proposed Rule*. Mr. Ensor indicated that the comments submitted by the RUC were not specific enough to consider actual changes to the proposal. He indicated that Bearing Point utilized their own physicians to review the appropriateness of these risk factors. Mr. Ensor noted that CMS welcomes continued input from the RUC on the crosswalks and risk factor assignments. The Workgroup agreed that these risk factor assignments should be reviewed and recommends **that the PLI Workgroup review the assignment of non-surgical and surgical risk factors at the February RUC meeting.**

Direct Payment of PLI Premiums

Several members of the Workgroup argued that the current system of compensating physicians for Medicare's portion of their professional liability insurance premiums is broken. It was suggested that PLI should not be a component of the RBRVS payment system. A suggestion was made that a coalition of specialties submit a resolution to the AMA House of Delegates requesting that the AMA pursue legislation mandating a more direct way to pay physicians for their actual premium costs. **The PLI Workgroup requested that AMA staff forward all resolutions and reports on the PLI issue to the RUC.**

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
September 30, 2004**

The Practice Expense Subcommittee met during the September 2004 RUC meeting to discuss the practice expense inputs for Protein Electrophoresis, allocation of physician time components, and hear an update in the AMA's plans for practice expense data collection. The following Subcommittee members participated: Doctors Zwolak, (Chair), Allen, Brooks, Foto, Gee, Koopman, Moran, Przybylski, Siegel, and Strate.

Practice Expense Inputs for Protein Electrophoresis

At its April 2004 meeting, the RUC discussed the work and practice expense recommendations proposed by the College of American Pathologists (CAP) for codes involving Protein Electrophoresis. The RUC's discussions involved the appropriateness of cross-walking the work, and practice expense inputs from existing codes rather than performing a RUC survey for work recommendations, and surveying or convening a consensus panel for practice expense recommendations as required. The RUC agreed with the specialty society to cross-walk the work components and asked the practice expense subcommittee to further review the appropriateness of the practice expense recommendation for these pathology codes.

These new and revised codes are reported primarily under the Clinical Laboratory Fee Schedule (CLFS) by independent laboratories designated as a non-facility site of service. When the laboratory performs the service the technical component it is billed under the CLFS. When the laboratory requires physician interpretation, the code is billed by the physician under the Medicare Fee Schedule with a modifier 26. The physician may bill the codes from the facility or non-facility setting.

Previously, CMS assigned all staff, equipment, and supply costs for services with professional (PC) and technical (TC) components to the technical portion of the service. CMS did this because it was originally believed that generally all of these direct cost inputs were associated with obtaining the diagnostic information and there would be no direct costs associated with the physician interpretation. In August 2003, CMS has allowed limited exceptions where it is appropriate to assign direct inputs to the PC service. The RUC and several specialties expressed support for this change in methodology, and the RUC comment letter indicated that additional codes might be identified at future PEAC/RUC meetings.

Discussion:

Doctor Zwolak refreshed the group's memory on this practice expense issue, and Doctor Spires from CAP explained in detail the clinical staff activities necessary for these procedures. In addition, Doctor Spires explained that typically these codes are billed under the CLFS (approximately 75% of the time). For the non-typical abnormal cases (approximately 25% of the time), requiring physician work, the professional component of these codes is billed with the 26 modifier approximately 235,321 times a year (rather than what is currently listed in the RUC database, 657,984). In addition, Medicare has four specific criteria for billing these codes on the physician fee schedule. Subcommittee members agreed that these codes were distinct and required the CAP recommended 8 minutes of clinical staff time.

The Practice Expense Subcommittee recommends that the RUC accept the practice expense inputs recommended by CAP for new and revised codes; 84165, 84166, 86334, and 86335.

Physician Time & Visit Allocations

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes, which have only total physician time within CMS's database. The PEAC has assigned post operative practice expense through RUC and CMS physician time components. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide all the necessary time components for each of the identified codes. 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 and the RUC have expressed their concern that the physician time recommendations from this exercise be administrative for practice expense purposes only to allocate PE direct inputs and should have no bearing on physician work. With this in mind, the RUC has directed AMA staff to clearly identify these codes within the RUC database to indicate to RUC members that the physician time from this exercise is not to be considered when making work recommendations.

For this meeting, AMA staff obtained physician time allocations for 2 CPT codes. Subcommittee members carefully reviewed a physician time recommendation from the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Academy of Family Physicians (AAFP), and believed the recommended times were reasonable and should be accepted. Both society's recommendations were very substantially below the original CMS cross-walked time.

The point was made that Emergency Medicine is a high volume provider of both services. Dr. Bishop, representing ACEP, was consulted. After discussion with the ACEP delegation, the subcommittee was informed that ACEP supports the following reductions in physician time.

The Practice Expense Subcommittee recommends the following physician time components to be used for practice expense purposes only, these times will be flagged in the RUC database as not to be used for physician work purposes by the RUC or by CMS.

CPT Code	Pre-Service	Intra-Service	Immediate Post	Total Time Recommended	Total PR Time
21480	25	25	21	71	106
21310	20	15	10	45	100

Update on AMA's Plans for Practice Expense Data Collection

The AMA previously had performed the Socioeconomic Monitoring Survey (SMS), which included questions related to physician practice expense, which is currently being used by CMS in their practice expense methodology to develop practice expense relative values. CMS is currently utilizing older 1996 through 2000 SMS data in the practice expense methodology, as the AMA discontinued its survey in the year 2000.

Kathy Kuntzman, Vice President of the AMA's Health Policy department provided an update on SMS activities to the Practice Expense Subcommittee. She indicated that the AMA staff proposed to reinitiate an SMS-like survey in 2005, however staff were not able to secure funding for this activity in the budget planning process. Subcommittee members expressed their dismay regarding this news. The CMS representative mentioned that they are considering alternative means to collect the data. CMS hopes to provide an update on their plans at the next RUC meeting. Subcommittee members believed the data from the survey is critical for the development of practice expense relative values, MEI updates, and other research and made the following recommendation to the RUC.

The practice expense subcommittee recommends that the RUC request the AMA reconsider the funding of the SMS survey, in order to obtain updated practice expense data.

5 Year Review of Practice Expense Inputs

A CMS representative mentioned that they would like this subcommittee to discuss concepts surrounding a full review of the practice expense inputs similar to the 5 year review of physician work. Doctor Moran agreed that the sense of the PEAC was that such a review is indicated, and mentioned that the way the RUC reviews practice expense recommendation is different now than it did two to five years ago, and there hasn't been a mechanism to go back and make appropriate adjustments. CMS and subcommittee members believed this could be an issue for discussion its next meeting.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee
September, 2004**

Doctors Borgstede (chair), Blankenship, Cohen, Gage, Gerety, Levy, Lichtenfeld, Pfeifer, Plummer, Topping, and Tuck participated in the meeting.

The AAOMS requested the research subcommittee to approve changes to the RUC survey instrument by adding a statement that instructs survey respondents that the reference list contains codes that do not include anesthesia or conscious sedation work. The Subcommittee approved this addition but didn't approve another proposed statement that would have reminded respondents to consider the work of conscious sedation. The subcommittee members felt that the survey instrument was sufficiently clear on this issue. Some workgroup members felt that the specialty should revise its reference service list to include additional codes that are on the RUC/CPT conscious sedation list. A suggestion was made that the reference list contain more codes that would be familiar to oral surgeons.

Ultrasound

The RUC chair assigned to the Research Subcommittee the issue of determining if there are rank order anomalies within the family of ultrasound procedures. The Subcommittee discussed in length whether a problem even exists. Based on an initial review of the list of ultrasound codes the subcommittee agreed that there potentially is a problem with variation of work values within the ultrasound family of codes. The subcommittee then discussed what next steps the subcommittee should follow. The subcommittee discussed various options such as possibly recommending to CMS that the codes be included in the upcoming five-year review. The subcommittee felt that the subcommittee needed to review the codes further before developing a definitive recommendation and that any potential review should not be limited to the upcoming five-year review. The subcommittee passed the following motion:

AMA staff will provide the Research Subcommittee with a list of ultrasound codes and the corresponding physician work data so that value of the ultrasound component of codes can be estimated along with an IPUT calculation.

Once the subcommittee reviews the data in more detail the subcommittee will determine if additional review is warranted.

Electronic Surveys

Doctor Gee informed the subcommittee of AUA's experiences in using electronic surveys for new/revised codes. AUA has found that using an electronic survey is cost effective with a shortened time frame that provides summary data allowing for easy analysis.

Alternative Methodologies for the Five-Year Review

The subcommittee agreed that if the RUC has previously approved an alternative methodology for a prior five-year review, then specialties should not have to come back to the subcommittee to request approval again. So that all specialties will know which methodologies have been approved, the research subcommittee will review all previously approved methodologies and determine if additional explanation and/or examples are needed before sending the list to specialties. This list will be provided to specialties prior to the next RUC meeting. Specialties that do not have an

approved alternative methodology will need to present their proposals to the Research Subcommittee.

Guidelines for Reference Service Lists

The Subcommittee reviewed a proposed list of guidelines for developing reference service lists. The RUC previously approved that specialty societies should determine the composition of their reference service lists used for each new/revised code survey but that a set of guidelines should be established that the specialties would follow in developing their lists. The RUC also approved at the April, 2004 RUC meeting adding the following question to the summary of recommendation form: "Is the reference service list consistent with the RUC guidelines? If not please explain."

The following is a set of guidelines that the subcommittee recommends for approval. The RUC previously agreed that once the subcommittee approved the initial list it would be sent to specialty societies for comment so it can be finalized at the next RUC meeting. The final guidelines will then be added to the RUC survey instructions document.

The Subcommittee approved the following set of guidelines. This includes reaffirmation of existing guidelines and new guidelines to be added to the existing guidelines.

Existing Guidelines:

- **Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.**
- **Services on the list should be those which are well understood and commonly provided by physicians in the specialty.**
- **Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)**

New Guidelines

- **If appropriate, codes from the MPC list may be included.**
- **Include RUC validated codes.**
- **Include codes with the same global period as the new/revised code.**
- **Include several high volume codes typically performed by the specialty.**

**AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
September 30, 2004**

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Michael Bishop, John Derr, David F. Hitzeman, Peter A. Hollmann, Charles Mick, J. Baldwin Smith, III, Peter Smith, Arthur Traugott, Richard Whitten and Robert Fifer, PhD

CPT/RUC Meeting Date Discussion

AMA Staff announced that at the April/May 2004 CPT Editorial Panel meeting, the Panel Members approved a motion of changing the number of CPT Meetings from four times a year to three times a year beginning with the 2007 CPT Cycle. The Administrative Subcommittee was informed by AMA staff that only one meeting within this CPT cycle has been scheduled. The Administrative Subcommittee agreed that the June 2-June 5 CPT Meeting would allow adequate time for the specialty societies to complete the RUC Survey process before the September 29-October 2, 2005 RUC Meeting. Once CPT has finalized its annual calendar, the Administrative Subcommittee will review the timeline between all CPT and RUC Meetings

Clarification of RUC Membership Criterion

The RUC had received a letter from the American College of Physicians (ACP) requesting clarification on the first criterion for a permanent seat on the RUC; “the specialty is an American Board of Medical Specialties (ABMS) specialty.” Doctor Leahy of the ACP gave a brief presentation regarding this request and clarified that not only was his society seeking clarification but also was requesting that this criterion be assessed to determine its suitability as a criterion for a permanent seat on the RUC. The Administrative Subcommittee discussed this request and approved the following motion:

A workgroup will be formed to assess the current criteria for a permanent seat on the RUC.

Upon review of this motion, the RUC amended the Administrative Subcommittee’s motion to request the full Subcommittee to review the issue, rather than creating a special workgroup. **The RUC approved the following motion:**

The Administrative Subcommittee will assess the first criteria for RUC membership, related to ABMS specialties, at the February 2005 meeting.

Re-Review of RUC Recommendations

At the April 2004 RUC Meeting, a RUC member indicated that there is no formal process to review RUC recommendations made for CPT codes where the original RUC recommendations stated that it would be re-reviewed once widespread use of related new technology has been achieved. This issue was referred to the Administrative Subcommittee for discussion. The Administrative Subcommittee acknowledged that the RUC had reviewed this issue in the past and had determined that there could be many criteria that could establish widespread use including frequency, expenditures, site of

service, length of stay, number and type of providers and scientific information. Doctor Schmidt stated that he would work with RUC staff to create a proposal to develop and formalize this process. The proposal will be shared with the Administrative Subcommittee at the February 2005 RUC Meeting for further discussion

Update on the Medicare Contractor Medical Director's Request

At the April 2004 RUC Meeting, the Administrative Subcommittee reviewed the request made by the Medicare Contractor Medical Directors to obtain the RUC Database. The Administrative Subcommittee determined that pending receipt of a formal request from the Centers of Medicare and Medicaid Services requesting that their Contractors receive the database that a workgroup should be created to assess all issues surrounding this distribution. The RUC Database Distribution Workgroup members included Doctors J. Baldwin Smith III, John Derr and chaired by Peter Hollmann. Once the formal letter from CMS was received, the workgroup met to discuss the request and surrounding issues. Doctor Hollmann made a presentation to the Administrative Subcommittee highlighting the workgroups findings including database utilities, payer views, potential CMD uses and concerns. The Workgroup made the following recommendations: 1.) the database should be distributed to the CMDs with appropriate confidentiality agreements and amendments to the CMS license with CPT, 2.) the RUC will use the CMDs experience and advice for future product development and continuance of release, 3.) the licenses for use would be limited to one year and would limit the CMDs to use the RUC database for Medicare related issues only, 4.) at the end of one year, all CMDs would have to complete a survey detailing their use and the overall impact of its release and 5.) the release of the database would be concurrent with the distribution of the RUC databases to the RUC members with all of the CPT 2005 related information.

The Administrative Subcommittee discussed the recommendations made by the workgroup and agreed with all of the recommendations made by the workgroup with the exception of the fourth recommendation. A member of the Subcommittee proposed that the survey should be completed by the CMDs four times a year so that the RUC would be able to determine trends of its use. The Administrative Subcommittee agreed with this request and approved the following motion:

1. The RUC database will be distributed to CMDs with appropriate confidentiality agreements, and amendments to the CMS license with CPT.
2. The RUC will use the CMDs experience and advice for future product development and continuance of release.
3. The licenses for use would be limited to one year and would limit the CMDs to use the RUC database for the RBRVS/CPT process and Medicare related issues only.
4. During the span of their one year use, the CMDs will be required to quarterly complete a survey questioning their use and overall impact of the RUC Database release.
5. The release of the database would be concurrent with the distribution of the RUC databases to the RUC members with all of the CPT 2005 related information.

The RUC extracted this item. After more deliberation, a vote was taken.

The motion failed. The RUC will not release the database at this time.

In addition, to discussing the RUC database distribution to the Contractor Medical Directors, the workgroup recommended that the RUC Database be released to the Specialty Societies for use outside of the CPT/RUC process regarding Medicare related issues only (e.g. to allow them to assist their members with any questions regarding denied Medicare claims) The workgroup discussed this recommendation and agreed that the RUC database should be distributed to the specialty societies with all of the same restrictions as recommended for the distribution to the CMDs. After discussing this recommendation, the Administrative Subcommittee approved the following motion:

1. The RUC database will be distributed to the current distribution list of specialty societies with appropriate confidentiality agreements and amendments to their license with CPT.
2. The RUC will use these specialty societies experience and advice for future product development and continuance of release.
3. The licenses for use would be limited to one year and would limit these specialty societies to use the RUC database for the RBRVS/CPT Process and Medicare related issues only.
4. During the span of their one year use, these specialty societies will be required to quarterly complete a survey four times questioning their use and overall impact of the RUC Database release.
5. The release of the database would be concurrent with the distribution of the RUC databases to the RUC members with all of the CPT 2005 related information.

The RUC extracted this item for discussion and determined that the release of the RUC database should be tabled until this issue is reviewed by the AMA legal counsel and other AMA staff.

American Medical Association

Physicians dedicated to the health of America



William L. Rich III, MD, FACS 515 North State Street 312 464-5604
Chairman Chicago, Illinois 60610 312 464-5849 Fax
AMA/Specialty Society RVS
Update Committee

November 3, 2004

Michael D. Maves, MD, MBA
Executive Vice President/Chief Executive Officer
American Medical Association
515 North State Street
Chicago, Illinois 60610

Dear Mike:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the AMA's continued support in ensuring that the medical community has maximum input into the Resource-Based Relative Value Scale (RBRVS). I am writing to you to ask that the AMA resume collection of data that impacts the RBRVS and the annual updates in Medicare physician payment.

As you know, the RUC has been actively involved in refining the resource-based practice expense relative values since their introduction in 1999. The RUC has principally been involved in refining direct practice expense inputs (clinical staff, medical supplies, and medical equipment) for nearly 7,000 CPT codes. This has been time-consuming, detailed work that would not have been possible without the dedication of more than one hundred volunteer physicians over the course of the past five-years. The result is a more accurate database of direct practice expense data.

Moreover, our work has not been isolated to the direct practice expense data, as this is only one element of the overall practice expense methodology. The RUC has refined physician time for many codes to provide consistency in allocations among pre, intra, and post-service periods, because this too is an important component in both the work and practice expense relative values. The RUC has also offered various suggestions regarding the overall methodology used to compute the practice expense relative values.

As you know, the Centers for Medicare and Medicaid Services (CMS) currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring Survey (SMS) to calculate a "practice expense per hour" estimation for each medical specialty. This information is used to determine practice expense pools, while the data refined by the RUC and its Practice Expense Advisory Committee (PEAC) allows allocation of practice expense RVUs to individual CPT codes. Not long after CMS adopted this approach, the AMA discontinued the SMS survey. We understand that this was due to problems with obtaining adequate responses and organizational budget concerns.

Michael D. Maves, MD, MBA
November 3, 2004
Page Two

The RUC has been very interested in a new effort to collect updated practice expenses and physician hours, which is utilized in CMS's top-down methodology. The RUC is particularly concerned that as 2005 approaches, the 1995-1999 data no longer reflect the actual costs of maintaining a physician practice. While several specialty societies have conducted their own practice expense surveys to collect more recent data, the RUC believes that it would be more productive and fair for all of medicine to be surveyed at once, using a consistent approach and timeline.

The RUC understands that collecting practice expense data from physicians is difficult and expensive. However, we also know that individual specialties have been able to collect this information and we believe that an AMA effort would be successful. We would offer and encourage the AMA to work through the RUC to involve the specialties in both constructing the survey and funding the effort. We believe that the specialties understand the importance of collecting this information, not only for determining practice expense relative values, but also for updating, and potentially improving, the Medical Economic Index (MEI).

We understand that senior management from the AMA and some members of the AMA Board of Trustees may attend our February 3-6, 2005 RUC meeting. We would welcome the opportunity to discuss this issue at this meeting. We appreciate your consideration of our request and offer to continue to work with you to ensure that the RBRVS system is fair and updated to reflect today's medical practice.

Sincerely,

William L. Rich, III, MD, FACS
William L. Rich, III, MD, FACS

cc: RUC participants

CPT	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Pre Service Time	Median Intra Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total RUC Time
11004	30	15	20		90	30							1						226
11005	30	15	15		120	30							1						251
11006	30	15	20		120	30							1						215
11008					60														60
58356	30	10	10		45	30							0.5						166
76820	5		0		10	5													20
76821	5				10	5													20
88367					42														42
88368					45														45
88187				5	30	3													38
88188				5	35	3													43
88189				5	40	5													50
88360					35														35
88361					40														40
88365					40														40
88367					42														40
88368					45														42
0196X1				15	30	10													45
0196X2				15	35	10													55
90760				2	3	2													60
90761					3														7
90765				2	5	2													3
90766					3														9
90767				1	5														3
90768				1	3														6
90772				2	3	2													4
90774				2	5	2													7
90775				1	3														9
96413				4	7	2													4
96415					5														13
96417				2	6														5
96401				4	3	2													8
96402				4	3	2													9
96409				4	5	2													9
96411				3	4														11
96416				4	4	2													7
96521				4	4	2													10
96523				2															10
96522				4	4	2													2
																			10