



# The RBRVS and the AMA/ Specialty Society RVS Update Committee (RUC) Process

2009





# Medicare RBRVS



- Medicare implemented the Resource-Based Relative Value Scale (RBRVS) on January 1, 1992



- Standardized physician payment schedule where payments for services are determined by the resource costs needed to provide them



- Most public and private payors utilize the Medicare RBRVS





# Medicare RBRVS



- The cost of providing each service is divided into three components



1. Physician Work
2. Practice Expense
3. Professional Liability Insurance





# Physician Work



- Determined by:
  - The time it takes to perform the service
  - The technical skill and physical effort
  - The required mental effort and judgment
  - Stress due to the potential risk to the patient





# Practice Expense



- Initially formed using average Medicare approved charges from 1991 and a proportion of each specialty's revenues that is attributable to practice expenses
- In 1999, CMS transitioned to a resource-based practice expense relative value for each CPT code that differs based on the site of service
- By 2002, the resource-based practice expenses were fully transitioned



# Professional Liability Insurance



- In 2000, CMS implemented the resource-based professional liability insurance (PLI) relative value units





# Components of the RBRVS

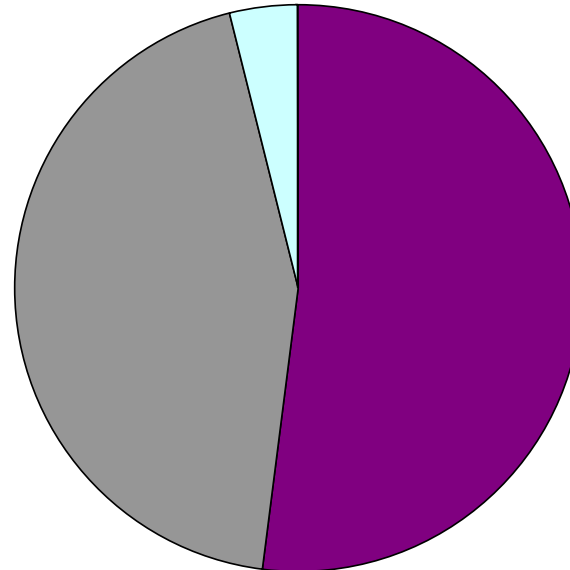
*Percent of Total Relative Value*



**Professional  
Liability  
Insurance, 4%**

**Practice  
Expense, 44%**

**Physician  
Work, 52%**





## Medicare RBRVS

- Payments are calculated by multiplying the combined costs of a services by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services )
- Payments are also adjusted for geographical differences in resource costs (geographic practice cost index (GPCI))



# Calculating Payment

- The formula for calculating payment schedule amounts entails adjusting RVUs, which correspond to services, by the budget neutrality work adjustor and by the GPCIs, which correspond to payment localities.
- The general formula for calculating Medicare payment amounts for Jan 1 – December 31, 2009 is expressed as:

**Total RVU =**

**[(work RVU x work GPCI)**

**+ (practice expense RVU x practice expense GPCI)**

**+ (malpractice RVU x malpractice GPCI)]**

**Total RVU x Conversion Factor\* = Medicare Payment**

*\*The Conversion Factor for CY 2009 = \$36.0666*





# Medicare's Payment System for Physician Services



Since the introduction of RBRVS, changes have included:



- Annual updates for new or revised CPT<sup>®</sup> codes
- Three Five-Year Reviews of work values – 1997, 2002 & 2007
- Resource-Based Practice Expense RVUs – 1999
- Resource-Based PLI RVUs – 2000





# RUC Cycle and Methodology



- RUC's cycle for developing recommendations is closely coordinated with both CPT's schedule for annual code revisions and CMS's schedule for annual updates in the Medicare Payment Schedule
- CPT meets three times a year to consider coding changes for the next year's edition
- CMS publishes the annual update to the Medicare RVS in the *Federal Register* every year
- These codes and relative values go into effect annually on January 1





# RUC Composition

American Medical Association  
CPT Editorial Panel  
American Osteopathic Association  
Practice Expense Review Committee  
Health Care Professionals Advisory Committee



- |                     |                       |                    |
|---------------------|-----------------------|--------------------|
| Anesthesiology      | Internal Medicine     | Pediatric Surgery* |
| Cardiology          | Neurology             | Pediatrics         |
| Dermatology         | Neurosurgery          | Plastic Surgery    |
| Emergency Medicine  | Obstetrics/Gynecology | Psychiatry         |
| Family Medicine     | Ophthalmology         | Radiology          |
| Gastroenterology*   | Orthopaedic Surgery   | Thoracic Surgery   |
| General Surgery     | Otolaryngology        | Urology            |
| Infectious Disease* | Pathology             |                    |

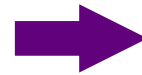
\* indicates rotating seat





# RUC Cycle

CPT Editorial Panel



Level of Interest



Medicare Payment Schedule

Survey



CMS

Specialty RVS Committee



The RUC





## RUC Cycle



- **Step 1:** CPT's new or revised codes are submitted to the RUC staff



- **Step 2:** Members of the RUC Advisory Committee review and indicate their societies' level of interest on developing a relative value recommendation



- **Step 3:** AMA staff distribute survey instruments for the specialty societies to evaluate the work involved in the new or revised code





## RUC Cycle

- **Step 4:** The specialty RVS committees conduct the surveys, review the results and prepare their recommendations to the RUC
- **Step 5:** The specialty advisors present the recommendations at the RUC meeting
- **Step 6:** The RUC may decide to adopt a specialty society's recommendation, refer it back to the specialty society or modify it before submitting it to CMS
- **Step 7:** The RUC's recommendations are forwarded to CMS in May of each year



# Confidentiality



- All RUC materials are confidential and for RUC use only
- Cannot publish RVU recommendations until CMS publishes *Federal Register*





# CPT 1993 - 2008 RUC Recommendations



- Over 3,500 RUC recommendations for new and revised codes
- Over 300 RUC recommendations for carrier priced or non-covered services



- 1118 RUC recommendations during the First Five-Year Review



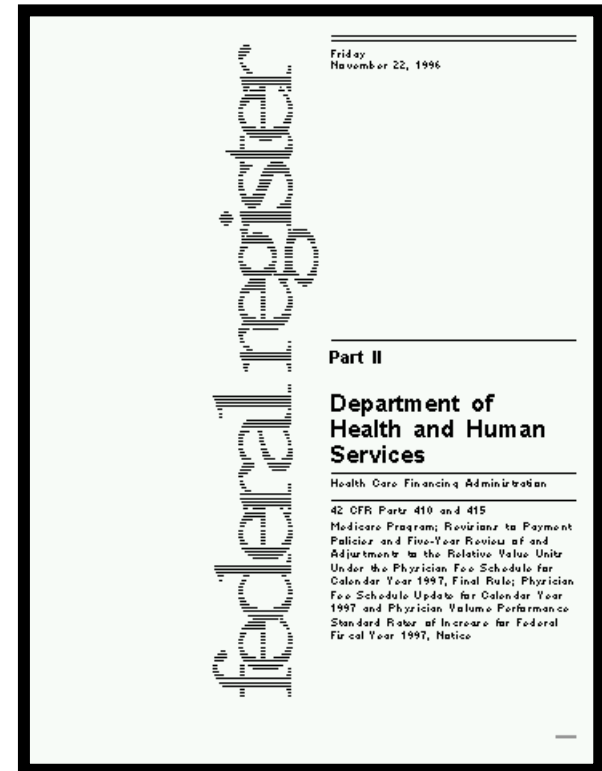
- 858 RUC recommendations during the Second Five-Year Review
- 751 RUC recommendations during Third Five-Year Review





# CPT 1993 - 2009 RUC Recommendations

- CMS/Carrier Medical Director review
- Implementation of “interim” values by Medicare carriers with 60-day Comment period
- CMS’s acceptance rate has increased to more than 90% annually





## RUC Advisory Committee



- One physician representative is appointed from each of the 109 specialty societies seated in the AMA House of Delegates



- Advisory Committee members assist in the development of RVUs and present their specialties' recommendations to the RUC



- Each member comments on recommendations made by other specialties
- Advisory Committee members are supported by an internal specialty RVS committee





# Health Care Professionals Advisory Committee (HCPAC) Composition



Audiologists

Physical Therapists

Chiropractors

Physician Assistants

Dieticians

Podiatrists

Nurses

Psychologists

Occupational Therapists

Social Workers

Optometrists

Speech Pathologists





# HCPAC



- Purpose: To allow for the participation of limited license practitioners and allied health professionals in the RUC process



- The professionals represented on the HCPAC use CPT to report the services they provide independently to Medicare patients, and they are paid for these services based on the RBRVS physician payment schedule



- The HCPAC recommendations are sent directly to CMS





# RUC Practice Expense Activities

- The RUC submits recommendations to CMS on practice expense inputs for new and revised codes
- The Practice Expense Advisory Committee (PEAC), (1999-2004) was responsible for reviewing existing practice expense data
- The PEAC reviewed and made recommendations on almost 6,500 codes from a variety of specialties
- The RUC Practice Expense Subcommittee continues to review and make recommendations on practice expense inputs (clinical labor, medical supplies and equipment)





# RUC Subcommittees and Workgroups

- *Administrative Subcommittee* – primarily charged with the maintenance of the RUC's procedural issues
- *Extant Data Workgroup* – reviewing potential sources of physician time data
- *Five-Year Review Identification Workgroup* – oversees the process of the Five-Year Review of the RBRVS and identification of potentially misvalued services
- *Multi-Specialty Points of Comparison (MPC) Workgroup* – charged with maintaining the list of codes, which is used to compare relativity of codes under review to existing relative values



# RUC Subcommittees and Workgroups

- *Practice Expense Subcommittee* – reviews direct practice expenses (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of practice expense relative values
- *Professional Liability Insurance (PLI) Workgroup* – reviews and suggests refinements to Medicare’s PLI relative value methodology
- *Research Subcommittee* – primarily charged with development and refinement of RUC methodology





# The RBRVS Five-Year Review

- Omnibus Budget Reconciliation Act of 1990 requires CMS to review all relative values at least every five-years and make any needed adjustments
- Five-Year Review results implemented on January 1, 1997 and every five years thereafter





# First Five-Year Review of the RBRVS

- Corrected anomalies in work values for codes

Example: Gynecologic procedures to equate urology procedures

- Improvements to Evaluation and Management work relative values
- Updated RBRVS to reflect increased work for certain procedures since the inception of RBRVS





## Second Five-Year Review of the RBRVS



- Unprecedented opportunity to improve the accuracy of the physician work component
- The RUC submitted recommendations on 870 individual CPT codes to CMS
- On November 1, 2001, CMS published a Final Rule in the Federal Register with refined work relative value units. CMS accepted 98% of the RUC's recommendations. The relative value changes were implemented on January 1, 2002





## Third Five-Year Review of the RBRVS *Evaluation and Management Services*

- 27 specialties presented a consensus comment letter to CMS stating that the work of E/M services had changed significantly since the first Five-Year Review in 1995
- The societies also concluded that they believed E/M services were not appropriately valued because:
  - the intensity, complexity, and duration of intra-service medical care had increased in the past ten years;
  - the intensity, complexity, and duration of the pre- and post-service time had expanded; and
  - the work per unit of time for E/M services is less than the work per unit of time for almost any other service





## Third Five-Year Review of the RBRVS *Evaluation and Management Services*

- This Five-Year Review included 35 E/M services
- The RUC submitted formal recommendations to CMS for:
  - increases in work RVUs for 28 E/M services
  - maintaining the work RVUs for 7 E/M services
- In the June 2006 Proposed Rule, CMS has indicated that it will accept 100% of the RUC's recommendations for E/M services





# Third Five-Year Review of the RBRVS

- The RUC submitted formal recommendations for 751 identified codes to CMS in October 2005, February 2006, March 2007 and May 2007
- CMS published a Proposed Rule in June 2006 regarding their consideration of the public comments and the RUC recommendations
- After a comment period, CMS published the final work relative values in the November 2006 Final Rule
- New work relative value recommendations resulting from this third Five-Year Review of the RBRVS were effective January 1, 2007





## Creation of the Five-Year Review Identification Workgroup



- In its March 2006 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) commented that the RUC's Five-Year Review process leads to substantially more increases in work RVUs than decreases.
- MedPAC expressed concerns about the RUC's ability to identify overvalued physician services.



## Creation of the Five-Year Review Identification Workgroup



- MedPAC recommended the establishment of a separate standing panel of medical economic experts to identify overvalued services.



- MedPAC suggested that the new panel could identify overvalued services through various statistical analyses.





## Creation of the Five-Year Review Identification Workgroup

- Though no action was taken by the Congress, MedPAC reiterated these comments and recommendations in subsequent reports to Congress in 2007 and 2008.
- MedPAC also expressed an opinion that the growth in volume of services might be evidence of misvaluation.



## Creation of the Five-Year Review Identification Workgroup



- The RUC maintained that it has the requisite expertise in identifying appropriate valuation and has a history of doing so.



- Prior to the MedPAC recommendations, the RUC recommended reducing the RVUs for nearly 400 services (1992 – 1997).



- The RUC established its Five-Year Review Identification Workgroup in October 2006.





# The Mandate of the Workgroup

- The purpose of the Five Year Review Identification Workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The Workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of “new technology” services. (Approved by the RUC October 2006)
- The identification and review of potentially misvalued services will be conducted on an ongoing basis, rather than at the upcoming Five-Year Review. (Approved by the RUC February 2008)





# Screening Mechanisms for Potentially Misvalued Services



- The Workgroup has identified several screening mechanisms based on objective analyses
- To date, the Workgroup has identified the following screens:
  - Site of Service Anomalies
  - High Intra-service Work Per Unit of Time (IWPUT)
  - CMS Fastest Growing Procedures
  - Codes Inherently Performed Together
- The Workgroup also identifies “new technology” services





# The Process of Review

- The Workgroup develops an objective criterion (also called a “screen”) for identification of potential misvaluation.
- The Workgroup recommends the criterion to the RUC for approval.
- The Workgroup applies the screen to the universe of physician services and generates a list of codes meeting the screen.





# The Process of Review

- The codes identified by a screen are forwarded to all specialty societies before a RUC meeting in a “level of interest” process.
- Specialties are asked to develop work-plans to either explain why the service is appropriately valued despite meeting the screen criteria or, if there is no clinical explanation, a plan to address the aberration.





# The Process of Review

- Codes that have no clinical explanation for appearing on the screen may be addressed through:
  - Referral to CPT where the descriptor is ambiguous and results in incorrect reporting.
  - If a change in the descriptor is not necessary, referral to CPT Assistant to develop education to promote appropriate reporting.
  - Survey and re-valuation of physician work or practice expense, where the service is potentially misvalued.



# The Process of Review

- The Workgroup reviews the comments of the specialty society and makes a recommendation to the RUC.
- The RUC, then refers the service to CPT or recommends that the service be surveyed after solicitation from CMS.
- CMS then approves/requests review of valuation for existing CPT codes.



# Summary of Recommendations to Date



- To date, the Workgroup has identified 485 codes for review. The following is a summary of the RUC recommendations based on these reviews.





# Summary of Recommendations to Date

- Revised work and/or practice expense: . . . 138
- Review in Feb 2009: . . . . . 45
- Referral to CPT: . . . . .105
- Review in two to three years: . . . . .29
- Removal from the screen: . . . . . 46
- Recommend CPT Asst. Article: . . . . . 21\*
- Request additional data from CMS: . . . . . 7
- New Technology . . . . .115

\*Recommendation of a CPT Assistant article for these 21 codes was a secondary action, made in addition to another recommended action.





## More Information



*For additional information, please contact:*

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