RUC and the Code Valuation Process

Matthew Grierson, MD, FAAPMR; Barry Smith, MD, FAAPMR; and Carolyn Winter-Rosenberg, AAPM&R Manager of Reimbursement and Regulatory Affairs

AAPM&R recognizes that many members may not be familiar with how payers determine the amount they should reimburse for each service. As payment has declined in recent years, these seemingly arbitrary cuts cause frustration. Your Academy advocates for fair reimbursement by providing input to the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC), which is one of the key processes by which the Centers for Medicare & Medicaid Services (CMS) determines how to value services. This article seeks to educate members on the importance of our role in this process. This article is an update to, "What Every Physiatrist Should Know About CPT and RUC," originally published in the November 2014 issue of *The Physiatrist*. You can access this article at **www.aapmr.org/thephysiatrist.**

In 1992, the way physicians were paid was drastically changed. Prior to this time, the federal government paid for services based on a system of customary, prevailing, and reasonable charges. By the 1980s, this system had led to significant geographic variability in payment. To resolve this, CMS was required under the Omnibus Budget Reconciliation Act (OBRA) of 1989 to replace the existing fee-setting process with the resource-based relative value scale (RBRVS). The RBRVS system was developed by a multi-disciplinary team at Harvard University. Under RBRVS, each service is assigned a total relative value unit (RVU) based on 3 components:

- Physician work—the time, technical skills, physical effort, mental judgement, and potential risk of performing a service.
- Practice expense (PE)—direct clinical staff time, disposable medical supplies, and equipment needed to perform the service and indirect practice costs.
- Professional liability insurance (PLI)—the liability costs apportioned to each service.

The final (total) payment is calculated by multiplying the 3 components of a service by a conversion factor, which is a monetary amount determined annually by CMS and separately by individual insurance companies. Additionally, payments are adjusted for geographic differences.

In addition to requiring implementation of RBRVS, OBRA required implementation of a "budget-neutral" conversion factor. Under this budget neutral system, payment for individual services could fluctuate; however, the total Medicare expenditures would stay the same. This creates what people have referred to as a "zero-sum game." When a particular service sees an increase in payment, or when a new service is added, essentially all other services likely will experience a decrease in payment through downward adjustments to the conversion factor.

Once implemented, it quickly became clear that regular updates to the RBRVS system would be necessary. To provide direct physician input into these updates, the American Medical Association created the Relative Value Scale (RVS) Update Committee, or RUC. The RUC provides recommendations to CMS, which can be accepted, rejected or modified. These decisions have a ripple effect throughout the private insurance market, and can affect compensation. For example, for employed physicians whose productivity is judged based on RVUs. Thus, it is imperative that the RUC undertakes a thorough and objective analysis of each code to ensure that CMS accepts values that are obtained with appropriate physician input.

The RUC includes a panel of 31 physician representatives who meet 3 times per year to recommend RVUs for new services and changes to RVUs for existing services. The panel members do not advocate on behalf of their society, but rather serve as impartial voting members. An additional 300 medical advisors from specialty societies such as AAPM&R also attend the RUC meetings and present recommendations on behalf of their specialty to the RUC panel. In this way, specialty societies, including AAPM&R, have a say in the RVU changes recommended by the RUC to CMS.

Appropriately valuing physician work is a difficult task, which is compounded by the fact that valuing physician work is a moving target. With newer technologies and changing practice patterns, what was once considered a highly-technical procedure 10 years ago may 'lose relative value' as physicians identify more efficient ways of performing the procedure or 'gain relative value' as newer technologies, such as ultrasound, are incorporated. A code's relative value may also change if the patient population changes in a way that makes the procedure more difficult. The process of continually reevaluating physician work must account for all this variability, and CMS is in constant search of potentially misvalued codes that show up in regular screens of their data.

When CMS or the RUC identifies a code as 'potentially misvalued,' the Academy and Academy members' role in the RUC valuation process is significant. Large cuts to the value are softened by the coordinated work of our Academy staff and volunteers who work closely with other specialty societies with similar interests. Members are often called upon to participate in a formal survey regarding the details of physician work. Credibility of the submission to the RUC is dependent on the volume of survey responses received as well as the accuracy of the information provided in member surveys. This process only works if the surveyed physician answers the survey honestly. Critical to this is that the physician must give the average time it takes for him to do the typical case in the clinical vignette. This is not a time to be boastful about how quickly one might be able to do the service. That underestimation of time spent only lowers the RVU value. Conversely, submitting an outrageous over estimate of the time spent would be a clear outlier to the RUC and would call the survey's validity into question. Further, the surveys must be random and have a significant number of participants. Small survey numbers are rejected out of hand by the RUC Panel. Without this critical survey information, there is no feasible way to build an argument, and no possibility for change.

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When analyzing survey data, the RUC is careful to ensure that duplicate payments are not made for physician work. For instance, CMS would not want to pay for time spent checking vital signs for a procedure if an E/M code was typically billed with the procedure and those same vital signs had already been taken. If 2 codes are typically billed together at the same visit, then CMS would only want to pay once for the time spent putting the patient into the one position needed for the entire set of procedures. The RUC understands that in some cases, a physician will spend extra time with some patients, but they value the code based on what is 'typical' with the understanding that variabilities in time or effort will average out over time. The evaluation of all the equipment, time, and effort used during a procedure can become very granular, which is why it is vital that Academy members continue to be thoughtful and thorough when filling out any RUC surveys.

Looking to the future, there is some uncertainty regarding how physicians will be valued. With more emphasis on quality and care in larger systems and the growth of Alternative Payment Models or other incentives for high value care, it is difficult to say how this will affect the RUC's process. What is clear is that your Academy is hard at work keeping an eye to the horizon to ensure you are prepared for any changes that may affect your practice.