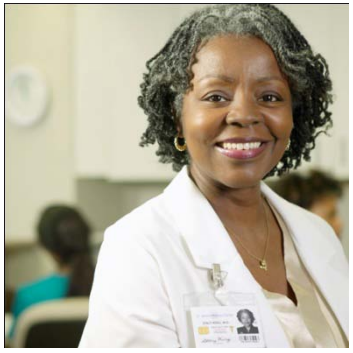

AMA/Specialty Society RVS Update Committee (RUC)

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AMA/Specialty Society RVS Update Committee, Chair

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TOGETHER WE ARE STRONGER

The RUC – An Overview

- The RUC is an independent group exercising its First Amendment Right to petition the federal government.
- The RUC is comprised of 29 members, 26 voting members (14 of these 26 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).
- The RUC is an expert panel. Individuals exercise their independent judgment and are **not** advocates for their specialty.

RUC Composition

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

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

**** indicates rotating seat***

The RUC – An Overview

- Meets three times a year to review new and revised codes developed from the CPT process.
- The RUC examines specialty society surveys and recommendations to develop relative value units (RVU) for physician work, physician time and practice expense recommendations to CMS.
- The Centers for Medicare and Medicaid Services (CMS) publishes final recommendations in the Final Rule each November for implementation January 1 each year.
- CMS has recognized the expertise of the RUC by adopting 95% of its work relative value recommendations since its inception.

The RUC – An Overview

- The RUC is supported by an Advisory Committee of 100 specialty societies and health care professional organizations who collect data and formally present recommendations to the RUC.
- The RUC is inclusive of all health care professionals. Non-MD/DOs (eg, nursing, podiatry, physical therapy) have an advisory committee, one voting seat on the RUC, and participate on RUC Subcommittees.

Health Care Professionals Advisory Committee (HCPAC) Composition

- Audiologists
- Chiropractors
- Dieticians
- Nurses
- Occupational Therapists
- Optometrists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychologists
- Social Workers
- Speech Pathologists

The RBRVS – An Overview

- 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

The RBRVS – An Overview

The resources utilized for each service are divided into three components (% of total relative values)

1. Physician Work (52%)
2. Practice Expense (44%)
3. Professional Liability Insurance (4%)

Payment rates are computed using geographical adjusted (via GPCIs) relative values and a monetary conversion factor.

Calculating Medicare Physician Payment

Total RVU =

[(work RVU x work GPCI)

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

+ (malpractice RVU x malpractice GPCI)]

Medicare Payment =

Total RVU x Conversion Factor*

**The Medicare Conversion Factor for CY 2010 = $36.0846*

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How Does the RUC Impact Medicare Payment to Physicians?

Medicare Conversion Factor

Congress controls, no RUC involvement

Geographic Practice Cost Indices (GPCI)

CMS determined, no RUC involvement

Coverage and Payment Policy Determination

CMS and Congress determine, no RUC involvement

How Does the RUC Impact Medicare Payment to Physicians? Physician Work

Physician Work is based on the time and intensity:

- 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

The RUC has submitted physician work recommendations to CMS since 1991 and CMS has historically implemented 95% of the RUC recommendations.

How Does the RUC Impact Medicare Payment to Physicians? Practice Expense

Practice Cost RVUs include direct costs (26%) and indirect costs (74%)

Direct - CMS accepts nearly all of the RUC's recommendations on direct costs, but then can recognize 50% of these costs in the budget neutral methodology.

- Clinical Staff Type and Time (CMS-wage rates)
- Medical Supplies (CMS determines pricing)
- Medical Equipment (CMS determines pricing)

Indirect – Computed by CMS based on claims data (to identify specialty), PPI Survey, direct costs, and physician work.

How Does the RUC Impact Medicare Payment to Physicians? Professional Liability Insurance

- CMS hires a contractor to determine professional liability insurance relative values every five years (2000, 2005, 2010).
- Methodology based on contractor collected premium data, claims data, and physician work.
- The RUC has had mixed results in influencing the CMS methodology and policy regarding payment related to professional liability premium costs.

How Does the RUC Determine Which Services Should be Reviewed Each Year?

- Annual updates for new or revised CPT® codes
- Three Five-Year Reviews of work values based on public comments and CMS assignment – 1997, 2002 & 2007
- Rolling review of RUC and CMS identified potentially misvalued services

RUC Process

CPT Editorial Panel/CMS

Level of Interest

Specialty Survey

Specialty RVS Committee

The RUC

CMS

Medicare Payment Schedule

How Does the RUC Review Services?

- Once a code is identified, all specialty societies and organizations representing other health care professionals are provided with an opportunity to express their “level of interest” in developing recommendations (ie, survey or comment on other specialty’s survey).

- All interested specialty societies conduct a survey to collect data on the service/code in question. This is a standardized survey tool using CMS definition and methodology.

How Does the RUC Review Services?

- Specialty committees review the data, work with other interested specialties, and develop a recommendation to the RUC. The submissions for both physician work and direct practice expense inputs are all standardized.

- Specialty societies present recommendations to the RUC at one of the three face-to-face meetings each year.

How Does the RUC Review Services?

The RUC begins each review with the data presented by the specialty and then must ensure that relativity between services is appropriate.

How Does the RUC Review Services?

- The RUC discussion begins with the specialty society presentation, but the discussion focuses on comparisons between other services performed by the specialty and by other physicians.
  - Specialty Reference Service List
  - Multi-Specialty Points of Comparison (MPC)
  - RUC Database

RUC Database

Data for each code previously reviewed:

- Typical Patient Description
- Description of Physician Work
- RUC Rationale for Recommended Work Value
- Physician Time
- Medicare Claims Data
- Direct Practice Costs (clinical staff, medical supplies, and medical equipment)

Database is publicly available for purchase via the AMA: *RBRVS Data Manager*

Five-Year Review Process

- In addition to annual updates, the OBRA of 1990 requires CMS to comprehensively review all relative values at least every 5 years and make any needed adjustments.
- The RUC has made recommendations to CMS through 3 Five-Year Reviews
- Implementation of Five-Year Review RVUs
  - 1997
  - 2002
  - 2007

E/M Increases from last Five-Year Review

- Improved Payment for Evaluation and Management (E/M) Services – The RUC has recommended increases in E/M services each time that the primary care organizations and/or CMS have requested review.
- The most recent revision led to more than $4 billion in redistribution from surgery and other services to E/M, leading to a divisive debate within medicine, that while difficult, was ultimately productive to primary care.
- Since the inception of the RBRVS, a mid-level office visit (99213) has increased from $31 in 1992 to $66 in 2010. In comparison, payments for cataract surgery (66984) have decreased from $941 to $698 and payments for MRI of the lumbar spine (72148) have decreased from $485 to $425.




Creation of the Five-Year Review Identification Workgroup

- In its March 2006 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the RUC's ability to identify overvalued physician services.
- Led to creation of the Five-Year Review Identification workgroup in October 2006.
- The purpose of the Five-Year Review Identification Workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation.

The Mandate of the Workgroup

The identification and review of potentially misvalued services will be conducted on an ongoing basis, in addition to the Five-Year Review process. (Approved by the RUC February 2008)

Screening Mechanisms for Potentially Misvalued Services

- The Workgroup and CMS have identified more than 700 services through several screening mechanisms based on objective analyses.
- To date, the Workgroup has identified the following screens:
  - Site of Service Anomalies
  - High Volume Growth
  - CMS Fastest Growing Procedures
  - High IWPUT
  - Services Surveyed by One Specialty and Now Performed by a Different Specialty
  - Harvard Valued
  - Codes Inherently Performed Together
- The RUC also identifies “New Technology” services.

Screen 1: Site of Service Anomalies

- The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital evaluation and management services within their global period.
- With affirmative feedback from CMS representatives, the RUC moved forward and began reviewing these 21 services in September 2008.




Screen 1: Site of Service Anomalies

- The RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels, should not be performed in the outpatient setting.
- Some individuals referenced personal experiences that indicate hospitals keeping patients for one or more nights, yet reporting the procedure as outpatient.
- The RUC has developed a policy that states, “If a procedure or service is typically performed in the hospital and the patient is kept overnight and/or admitted, the RUC should evaluate it as an inpatient service or procedure using the hospital visits as a work proxy regardless of any status change made by the hospital.”

Screen 2: High Volume Growth – Generated by the RUC

The Workgroup assembled a list of approximately 100 services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006.

Screen 3: CMS Fastest Growing Procedures

In June 2008, CMS requested that the RUC review services with increasing utilization with a different measurement. CMS identified an additional 100 services that had grown at least 10% per year each year in 2005, 2006, and 2007.

Screen 4: High IWPUT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an excessive intensity of intra-service work. The query resulted in identification of 32 services.

Screen 5: Services Surveyed by One Specialty, Now Performed by A Different Specialty

The RUC has reviewed approximately 20 services that had originally been surveyed by one specialty, but according to utilization data are now performed predominantly by other specialties.




Screen 6: Harvard Valued Services – *Utilization Over 1 million*

- CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization.
- The RUC identified 9 Harvard valued services with high utilization (performed over 1 million times per year).
- The RUC also incorporated an additional 9 Harvard valued codes within the family of the 9 services identified.
- RUC reviewed 10 services in Oct 2009 and will review the remaining 8 services in Feb/April 2010.




Screen 6: Harvard Valued Services – *Utilization over 100,000*

- The RUC to continue review of Harvard-only valued codes with significant utilization.
- The RUC has expanded the review of Harvard codes to those with utilization over 100,000 which totals 38 services (plus related families). This review will occur in 2010.

Screen 7: Codes Reported Together: Bundled Services

- The Five-Year Review Identification Workgroup queried a Medicare Sample Claims Database to identify services performed by the same physician on the same date of service 95% of the time in an attempt to identify pairings of services that are inherently reported together.
- The RUC recommended the creation of a joint RUC and CPT workgroup to address these issues. To date, 32 codes have been referred for changes in CPT descriptors and/or creation of new services.




Screen 7: Codes Reported Together: Bundled Services

- Efficiencies were identified when the following services were bundled:
  - Echocardiography (2009)
  - Arteriovenous Shunt Imaging (2010)
  - Audiology Services (2010)
  - Myocardial Perfusion Imaging (2010)
  - Urodynamic Studies (2010)
- Additional coding change proposals are to be considered 2011 CPT cycle as well.

U.S. Government Accountability Office (GAO) Report – July 2009

Medicare Physician Payments: Fees could better reflect efficiencies achieved when services are provider together

The GAO recommends that CMS ensure that physician fees reflect efficiencies occurring when services are commonly furnished together.

The GAO's review suggests expanding the multiple procedure payment reduction (MPPR) policy to non-surgical and non-imaging services when provided together.

U.S. Government Accountability Office (GAO) Report – July 2009

- The GAO suggests that Congress consider exempting any resulting savings from federal budget neutrality so savings accrue to Medicare.

- Additionally, in the Proposed Rule for 2010, CMS states that the agency is actively engaged in continuing to analyze codes furnished together more than 75 percent of the time, excluding E/M codes.




Screen 7: Codes Reported Together: Bundled Services

- The RUC has conducted a systematic broader review than GAO and determined that the remaining code pairs that are performed together are limited.
- The RUC analyzed code pairs provided on the same day by the same provider more than 75% of the time, excluding E/M, ZZZ and modifier -51 exempt codes.
- 20 groups of high volume services are under active review in 2010 to determine if further bundling by CPT is warranted.




New Technology

- During the RUC review of new and revised services, the RUC considers the technology involved in order to identify new technology services that should be re-reviewed.
- The list of these services is maintained by the Five-Year Review Identification Workgroup and forwarded to CMS in May along with the RUC recommendations for consideration in the November Final Rule on physician payment.
- Currently, codes are identified as new technology based on recommendations from the specialty society and consensus among RUC members at the time of RUC review for the services.

New Technology

- RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code.
- The Workgroup maintains and develops all standards and procedures associated with the list. The new technology list currently contains more than 143 services.




New Technology – Timeline for Re-Review

- Code is identified as a new technology service at the RUC meeting in which it is initially reviewed.
- Code is flagged in the next version of the RUC database with date to be reviewed.
- Code will be reviewed in 5 years – after at least three years of utilization data are available.
- The re-review cycle commences in September 2010 for codes identified in 2005.




Summary of RUC Recommendations

- To date, the Workgroup has identified 775 codes for review.
- Codes Completed – 501
  - Work and PE Maintained – 143
  - Work Increased – 29
  - Work Decreased – 146
  - Direct Practice Expense Reviewed – 108
  - Deleted from CPT - 75




Summary of RUC Recommendations

Codes Under Review – 274

• Referred to CPT	44
• RUC to Review April 2010	130
• Request for Action Plan	33
• Review at a future RUC Meeting	67

4th Five-Year Review of RBRVS

- On February 26, CMS forwarded a list of 214 services to the RUC to review as part of the 4th Five-Year Review of the RBRVS, most submitted by public and contractor medical director comments.
- CMS did request that the RUC continue its work to validate services not reviewed since the Harvard Studies, lowering the threshold to those performed 30,000 times per year in the Medicare population. CMS also requests a continued discussion related to services that have shifted from the inpatient setting.
- The RUC will review these services in October 2010; CMS to review in 2011 and publish a proposed rule; implementation in 2012.


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