Agenda

- The RUC Process
- Process to Improve Valuation within RBRVS
- Chronic Care Coordination Workgroup (C3W)
- Request from AAFP Regarding RUC Composition
The RUC Process

• Created by the AMA and major national medical specialty societies in 1991 to ensure physicians a voice in the new Medicare RBRVS Payment System

• AMA leadership worked with leadership within former ASIM and ACS to initially design the RUC and its processes
The RUC Process

RUC Composition (January 2012)

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

Anesthesiology  Neurology  Plastic Surgery
Cardiology  Neurosurgery  Pulmonary Medicine*
Dermatology  Obstetrics/Gynecology  Psychiatry
Emergency Medicine  Ophthalmology  Radiology
Family Medicine  Orthopaedic Surgery  Rheumatology*
General Surgery  Otolaryngology  Thoracic Surgery
Internal Medicine  Pathology  Urology
* indicates rotating seat  Pediatrics  Vascular Surgery*
The RUC Process

• RUC Advisory Committee – One physician representative and one staff appointment from each of the 122 specialty societies in the AMA House of Delegates

• Health Care Professionals Advisory Committee – Allows for participation by non-MD/DO health professionals who are required to use CPT and RBRVS
The RUC Process

The RUC reviews the resource costs consumed in the provision of a physician service as described by CPT and considering the three RBRVS components:

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

www.ama-assn.org/go/rbrvs
The RUC Process – Annual Cycle

CPT Editorial Panel → Level of Interest

Medicare Payment Schedule

CMS

Survey → Specialty RVS Committee

The RUC
Process to Improve Valuation Within RBRVS

• In response to inadequate identification from CMS in the previous Five-Year Review of the RBRVS processes (1995, 2000 and 2005), the RUC decided to objectively identify potentially misvalued codes within the RBRVS

• Similar timing to initial MedPAC discussions regarding relativity within the RBRVS
Process to Improve Valuation Within RBRVS

Total Number of Codes Identified 1199

**Codes Completed** 896

- Work and PE Maintained 294
- Work Increased 59
- Work Decreased 294
- PE Inputs Reduced 119
- Deleted from CPT 130

**Codes Under Review** 303

- Referred to CPT 185
- 2012/2013 Review 118
Process to Improve Valuation Within RBRVS

• A joint CPT/RUC workgroup has been identifying code bundles since 2008. To date, more than 75 potential bundles have been identified. Many are services reported by cardiology and radiology under the former component coding system. Work will be complete by CPT 2014.

Example – Bundling of CT of the Pelvis and Abdomen

The efforts are more comprehensive than recommendations made by the GAO
Process to Improve Valuation Within RBRVS

- Approximately $400 million was redistributed to the 2011 Medicare conversion factor (0.5% increase) to account for the efforts on the work relative values. When the redistribution for practice expense and PLI is factored in, the total overall redistribution for 2011 was $1 billion.

The RUC’s efforts for 2009-2012 resulted in $1.5 billion in redistribution within the MFS, with small additional CF increases 2009, 2010, and 2012.
Chronic Care Coordination Workgroup

• July 19 Proposed Rule for 2012 Medicare Physician Payment Schedule – CMS requested that RUC review all of E/M to ensure that care coordination was appropriately valued

• July 29 Meeting with Donald Berwick, MD – Doctors Robert Wah (Chair of AMA BoT), Peter Hollmann (Chair of CPT) and I met with CMS to discuss this request
Chronic Care Coordination Workgroup

• Specialty society comments to CMS and our message was consistent: a re-review of E/M would not be productive and would not address CMS stated goals:
  – Incentivize care coordination and improve health care delivery to patients with chronic disease
  – Improve payments to primary care to “shore up primary care and nursing”
Chronic Care Coordination Workgroup

• Informed Doctor Berwick that the CPT Editorial Panel and the RUC would engage in an effort to ensure that the coding and valuation of care coordination are appropriate.

• Created the Chronic Care Coordination Workgroup (C3W) in August 2011.
Chronic Care Coordination Workgroup

• The C3W will provide strategic direction to CPT and RUC to address the adequacy of coding and valuation of care coordination services and prevention/management of chronic disease.

• A request to CMS to immediately implement payment for anticoagulant management, telephone calls, team conferences and patient education was submitted to CMS on October 3, 2011.
Chronic Care Coordination Workgroup

- October press statement received some positive media attention, including from AAFP leadership, who stated that CMS acceptance of the RUC’s recommendations would be “a game changer”

- The C3W recommendations/minutes are at [www.ama-assn.org/go/carecoordination](http://www.ama-assn.org/go/carecoordination)
Chronic Care Coordination Workgroup

- CMS Final Rule: Medicare will not recognize payment for non face-to-face services in 2012. However, CMS expressed interest in a continued dialogue regarding care coordination.
- Next Steps: Develop long-term strategy for care coordination codes and other CPT needs: CPT Workgroups; Medical home
RUC Review of AAFP Request

The RUC has added a primary care rotating seat, a geriatrics seat, and will publish total vote counts for each CPT code.
Concluding Remarks

• RUC is an evolving committee and process – looks nothing like it did 20 years ago
• Strong leadership within the Committee and in the numerous volunteers that are engaged in the process
• Critical that physicians and other health professionals provide expertise on the resource costs for the RBRVS, which is likely to continue to have a presence for many years in physician payment