

What the RUC is Going On?

BY GEORGE A. WILLIAMS, MD

Beginning in 2008 and continuing into 2011, retina specialists have witnessed significant cuts in reimbursement for surgical and office-based procedures and services by the Centers for Medicare and Medicaid Services (CMS). In 2008, the Current Procedure Terminology (CPT) coding and reimbursement for complex vitrectomy surgery was revamped resulting in an approximately 30% cut in payment for repair of complex retinal detachment and macular disease. In 2011, payment for intravitreal injection was also cut by about 30%, and optical coherence tomography was essentially cut in half. Although the economic impact of these cuts is readily apparent to retina specialists, the process which created these cuts is poorly understood by many. A brief overview of the Relative Value Scale (RVS) update process will allow retina specialists to better understand how their services are valued.

The Resource Based Relative Value Scale (RBRVS) was developed by Congress and implemented in 1992. The rationale for the RBRVS was to replace the previous charge-based payment system with a system that paid physicians based upon the resources necessary for provision of a service and to provide a standardized physician payment schedule based on the RBRVS. The resources of providing each service are divided into three components: physician work, practice expense (PE), and professional liability insurance (PLI). In 2010, the breakdown for physician work, PE, and PLI was approximately 52%, 44%, and 4%, respectively. Each of these components is measured in relative value units (RVU), which are multiplied by a conversion factor, updated yearly by CMS based on a formula known as the sustainable growth rate (SGR). The SGR has become a political hot potato and will be discussed in detail in a future installment of *Pennsylvania Avenue Updates*. The obvious question is, How are the RVU values determined?

DETERMINATION OF RVU VALUES

The initial physician work RVU values were determined by a Harvard University study. Subsequently, more than 4,000 codes, including many retina codes, have been revalued by the RVS Update Committee (RUC) of the American Medical Association (AMA). The factors used to determine the value of physician work are the time it takes to perform the service, the technical skill, and physical effort, the required mental effort and judgment, and stress due to the potential risk to the patient. The physician work values are

subject to continual review due to such factors as evolving technology, changes in patient population, and other changes in medical practice. Such reviews may be initiated by CMS, Medicare carriers, or professional medical organizations. Additionally, Congress requires CMS to review the entire fee schedule every 5 years. The processes for determining PE and PLI have evolved since the inception of the RBRVS; however, since 2002, PE and PLI have become entirely resource-based.

The relationship between the RUC and the CPT process is critical to the valuation process. More than 8,800 procedure codes are described in CPT, and the RBRVS values correspond to the procedure definitions in CPT. CPT is maintained by the CPT Editorial Panel, which is authorized by the AMA (which owns CPT) to revise, update, or modify CPT. Of the 17 seats on the panel, 11 are from the AMA and the remaining are from the Blue Cross Blue Shield Association, the Health Insurance Association of America, CMS, and the American Hospital Association. The coding system is updated annually by including new codes, deleting unused codes, and revising procedure descriptions. Changes in CPT require annual updates to the RBRVS for new or revised codes.

RUC ADVOCACY

The RUC represents the entire medical profession, with 23 of its 29 seats appointed by major national medical specialty societies including those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for a high percentage of Medicare expenditures. Retina specialists are represented by the American Academy of Ophthalmology. Three seats rotate on a 2-year basis, with two seats reserved for an internal medicine subspecialty and one for any other specialty. The RUC chair, the co-chair of the RUC HCPAC Review Board, and representatives of the AMA, CPT Editorial Panel, and American Osteopathic Association hold the remaining seats. Although RUC members are nominated by their respective specialty societies, they are not advocates for codes in their specialty and, in fact, cannot comment when codes within their specialty are presented for valuation. RUC members are charged with impartially determining the relative values of all codes presented.

The role of advocate for a specialty comes through the RUC Advisory Committee. One physician representative is appointed from each of the 122 specialty societies seated in the AMA House of Delegates. Advisory Committee members

designate an RVS Committee for their specialty, which is responsible for generating relative value recommendations using a survey method developed by the RUC. The survey is critical to the justification of the recommendations. The advisors attend the RUC meeting and present their societies' recommendations for RUC evaluation. The RUC then forwards recommended values to CMS for consideration. Although CMS has historically accepted more than 95% of the RUC values, it is important to recognize that it is CMS, not the RUC, that is responsible for the final determination of all values. The RUC has no legislative or regulatory power and is merely an advisory body to CMS. The RUC and CPT meetings are linked and occur in February, April, and October of each year. The CPT Editorial Panel coding changes for new or revised codes are submitted to the RUC for valuation.

The RUC's annual cycle for developing recommendations is closely coordinated with both the CPT Editorial Panel schedule for annual code revisions and the CMS schedule for annual updates in the Medicare Payment Schedule. The CPT Editorial Panel's cycle ends in February so that the RUC can submit its recommendations to CMS in May. CMS publishes the annual update to the Medicare RVS in the Federal Register in the late fall at about the same time that the AMA publishes the new CPT book for the coming year. The updated CPT codes and relative values become effective annually on January 1.

The RUC process for developing relative values involves eight stages:

- **Stage 1.** New or revised codes from CPT are transmitted to RUC staff, who then prepare a summary of the changes in a level-of-interest request.
- **Stage 2.** The level-of-interest request is reviewed by the respective RUC advisory committees to establish whether they are interested in developing relative value recommendations. If so, they will survey their members to obtain data on the amount of work involved in a service and develop recommendations based on the survey results. The quality of the survey data is central to the strength and validity of the recommendation.
- **Stage 3.** The AMA staff distributes survey instruments for the specialty societies. The societies are required to survey at least 30 practicing physicians. The RUC survey instrument asks physicians to use a list of 15 to 25 services that have been valued by the RUC and selected by the specialty society as reference points. Physicians are asked to evaluate the new work relative to the reference points. The survey data may be augmented by analysis of Medicare claims data and information from other sources.
- **Stage 4.** The specialty RVS committees conduct the surveys, review the results, and submit their recommendations to the RUC for physician work, time and practice expense. These recommendations are reviewed by RUC

members prior to the meeting.

- **Stage 5.** The specialty advisors present the recommendations to the RUC. The RUC then discusses the recommendations and queries the presenters on the rationale behind the proposal.
- **Stage 6.** The RUC may decide to accept a recommendation, refer it back to the specialty society, or modify it before submitting it to CMS. Final recommendations to CMS must be adopted by a two-thirds majority of the RUC. Recommendations that are not accepted by the RUC may be discussed in a facilitation process and then re-submitted to the RUC during the course of the meeting.
- **Stage 7.** The RUC's recommendations are forwarded to CMS in May. CMS Medical Officers and Contractor Medical Directors consider the RUC's recommendations.
- **Step 8.** The Medicare Payment Schedule, which includes CMS's comments on the RUC recommendations, is published in the late fall for implementation January 1. These values are considered interim for 1 year, and specialties can submit additional comments to CMS for consideration if they disagree with the published values.

The RUC process has been criticized for being too generous to physicians in general and to physicians who perform procedures in particular. In response to comments from the Medicare Payment Advisory Commission, the RUC formed the Relativity Assessment Workgroup in 2006 to identify potentially misvalued services. The Workgroup screening process includes services commonly billed together, services with high volume growth, services with shift in site-of-service, services with only original Harvard data, change in specialty performance and services with high intensity. Many ophthalmology services fall under these screens are therefore subject to continuing review.

The RUC process is clearly not perfect, and recently ophthalmology has disagreed on new values involving vitrectomy, intravitreal injections, and OCT. Despite these disagreements, I have not seen a proposal for a better process that will continue to allow substantive physician input. For those who wish for a different system, be careful what you ask for. ■

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