

REPORT 5 OF THE BOARD OF TRUSTEES (I-05)
The AMA and The Relative Value Update Committee
(Informational)

EXECUTIVE SUMMARY

At the 2005 Annual Meeting, the House of Delegates approved Substitute Resolution 616, "The AMA and the Relative Value Update Committee." The resolution requested that the Board of Trustees prepare a report that explains the history and evolution of the RUC, that describes the current composition and operation of the AMA/Specialty Society RVS Update Committee (RUC), that explains the relationship of the RUC to our AMA, and explains the interaction between the RUC and the Centers for Medicare and Medicaid Services (CMS). In response to Medicare developing a new physician payment methodology in 1992, the AMA formed the AMA/Specialty Society RVS Update Committee (RUC) to act as an expert panel in developing relative value recommendations to CMS. There have been numerous changes and improvements to the payment system since 1992, many initiated by the RUC. This informational report discusses the RVS update process and the structure and composition of the RUC as well as the history of the RUC and the RUC's relationship with the AMA and CMS. The report summarizes how the RUC is organized and describes the rules and procedures that the RUC follows. The report also shows that the RUC's review of new medical procedures and services demonstrates organized medicine's unique impact on physician payment issues.

The RUC plays an important role in ensuring that physicians have significant input into the CMS payment process. Due to careful planning and dedication of RUC members, the RUC has played an important role in influencing the Medicare Physician Payment Schedule. The RUC has developed a detailed set of rules and procedures that govern the entire RUC process. These rules have contributed to the RUC's success by ensuring that all participants follow the same procedures in developing their recommendations. They also stipulate the RUC's structure and committee compositions as well as a wide range of methodological and administrative issues. The RUC is a unique multi-specialty committee dedicated to making relative value recommendations for new and revised codes as well as annually updating RVUs to reflect changes in medical practice. Because of this unique structure, the RUC has created the best possible advocate for physician reimbursement, the physician. It is the work of these dedicated physicians who contribute their time, energy, and knowledge that makes the RUC process a success that benefits all practicing physicians.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-05

Subject: The AMA and the Relative Value Update Committee

Presented by: Duane M. Cady, MD, Chair

1 At the 2005 Annual meeting, the House of Delegates adopted Substitute Resolution 616, “The
2 AMA and the Relative Value Update Committee.” The resolution requested that the Board of
3 Trustees prepare a report that explains the history and evolution of the RUC, that describes the
4 current composition and operation of the AMA/Specialty Society RVS Update Committee (RUC),
5 that explains the relationship of the RUC to our AMA, and explains the interaction between the
6 RUC and the Centers for Medicare and Medicaid Services (CMS).

7
8 This informational report discusses the RVS update process and the structure and composition of
9 the RUC as well as the history of the RUC and the RUC’s relationship with the AMA and CMS.
10 The report summarizes how the RUC is organized and describes the rules and procedures that the
11 RUC follows. The report will show that the RUC’s review of new medical procedures and services
12 demonstrates organized medicine’s unique impact on physician payment issues.

13
14 In 1992, Medicare significantly changed the way it pays for physicians’ services. Instead of basing
15 payments on charges, the federal government established a standardized physician payment
16 schedule based on a resource-based relative value scale (RBRVS). In the RBRVS system,
17 payments for services are determined by the resource costs needed to provide them. The cost of
18 providing each service is divided into three components: physician work, practice expense and
19 professional liability insurance. Payments are calculated by multiplying the combined costs of a
20 service by a conversion factor (a monetary amount that is determined by CMS). Payments are also
21 adjusted for geographical differences in resource costs.

22
23 The physician work component accounts, on average, for 52% of the total relative value for each
24 service. The initial physician work relative values were based on the results of a Harvard
25 University study. The factors used to determine physician work include the time it takes to
26 perform the service; the technical skill and physical effort; the required mental effort and judgment;
27 and stress due to the potential risk to the patient. The physician work relative values are updated
28 each year to account for changes in medical practice. Also, the legislation enacting the RBRVS
29 requires CMS to review the whole scale at least every five years.

30
31 The practice expense component of the RBRVS accounts for an average of 44% of the total
32 relative value for each service. Up until recently, practice expense relative values were based on a
33 formula using average Medicare approved charges from 1991 (the year before the RBRVS was
34 implemented) and the proportion of each specialty’s revenues that is attributable to practice
35 expenses. However, in January 1999, CMS began a transition to resource-based practice expense
36 relative values for each CPT code that differs based on the site of service. In 2002, the resource-
37 based practice expenses were fully transitioned.

38
39 On January 1, 2000, CMS implemented the resource-based professional liability insurance (PLI)
40 relative value units. The PLI component of the RBRVS accounts for an average of 4% of the total

1 relative value for each service. The RUC began reviewing appropriate PLI relative value
2 crosswalks in 2004. With this implementation and final transition of the resource-based practice
3 expense relative units on January 1, 2002, all components of the RBRVS are resource-based.
4

5 **The RVS Updating Process**

6 Annual updates to the physician work relative values are based on recommendations from a
7 committee involving the AMA and national medical specialty societies. In response to the new
8 physician payment methodology, the AMA formed the RUC to act as an expert panel in developing
9 relative value recommendations to CMS. The AMA established a process in the course of its
10 activities to develop relative values for new or revised CPT codes. This process was established in
11 the course of the AMA's normal activities and as a basis for exercising its First Amendment right to
12 petition the Federal Government as part of its research and data collection activities, for monitoring
13 economic trends and in connection and related to the CPT development process. In addition, CMS
14 is mandated to make appropriate adjustments to the new RBRVS in response to the Omnibus
15 Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data
16 and procedures. The purpose of the RUC process is to provide recommendations to CMS for use
17 in annual updates to the new Medicare RVS.
18

19 There have been numerous changes and improvements to the payment system since 1992, many
20 initiated by the RUC, but the principal role and purpose of the RUC remains to provide final RVS
21 update recommendations to CMS. The RUC is a unique activity that involves the AMA and the
22 specialty societies and gives physicians a voice in shaping Medicare relative values. The AMA is
23 responsible for staffing the RUC and providing logistical support for the RUC meetings. Neither
24 the RUC nor any of its Committees or Subcommittees have the authority to direct the AMA to
25 conduct work projects, products or research.
26

27 The RUC represents the entire medical profession, with 23 of its 29 members appointed by major
28 national medical specialty societies including those recognized by the American Board of Medical
29 Specialties, those with a large percentage of physicians in patient care, and those that account for
30 high percentages of Medicare expenditures. Three seats rotate on a two-year basis, with two
31 reserved for an internal medicine subspecialty and one for any other specialty. The RUC Chair, the
32 Co-Chair of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board,
33 and representatives of the AMA, American Osteopathic Association, the Chair of the Practice
34 Expense Advisory Committee (PEAC) and CPT Editorial Panel hold the remaining six seats. The
35 AMA Board of Trustees selects the RUC chair and also the AMA representative to the RUC. The
36 individual RUC members are nominated by the specialty societies and are approved by the AMA.
37 Approval by the AMA is defined in the RUC's *Structure and Functions* as approval by the AMA
38 representative to the RUC (or the alternate representative in the absence of the representative) or
39 approval by the Executive Vice President of the AMA.

1 **Composition of the RVS Update Committee (RUC)**

- 2
3 Chair
4 American Medical Association
5 CPT Editorial Panel
6 American Osteopathic Association
7 Health Care Professionals Advisory Committee
8 Practice Expense Advisory Committee
9

| | |
|-----------------------|---------------------|
| Anesthesiology | Orthopaedic Surgery |
| Cardiology | Otolaryngology |
| Dermatology | Pathology |
| Emergency Medicine | Pediatrics |
| Family Medicine | Plastic Surgery |
| General Surgery | Psychiatry |
| Internal Medicine | Pulmonary Medicine* |
| Neurology | Radiology |
| Neurosurgery | Spine Surgery* |
| Obstetrics/Gynecology | Thoracic Surgery |
| Oncology* | Urology |
| Ophthalmology | |

10
11 (* *Indicates rotating seat*)
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13 **Advisory Committee**

14 One physician representative is appointed from each of the 109 specialty societies seated in the
15 AMA House of Delegates to serve on the *Advisory Committee* to the RUC. Specialty societies that
16 are not in the House of Delegates also may be invited to participate in developing relative values
17 for coding changes of particular relevance to their members. Advisory committee members
18 designate an RVS Committee for their specialty, which is responsible for generating relative value
19 recommendations using a survey method developed by the RUC. The advisors attend the RUC
20 meeting and present their societies' recommendations, which the RUC evaluates. Specialties
21 represented on both the RUC and the Advisory Committee are required to appoint different
22 physicians to each committee to distinguish the role of advocate from that of evaluator.
23

24 **Practice Expense Advisory Committee (PEAC)**

25 The AMA continues to participate in and monitor all phases of the new practice expense relative
26 values refinement and continues to advocate that they be based on valid physician practice expense
27 data. Since there is not a single universally accepted cost allocation methodology, it is especially
28 important that CMS base its methodology on actual practice expense data. The decisions reached
29 by CMS have enormous implications for physicians and all their patients, not just those who treat
30 Medicare patients. Since many other payment systems use the Medicare RBRVS, the change to
31 resource-based practice expense relative values has broad implications for the entire health care
32 system. Due to the significance of this issue, the RUC established a special subcommittee called
33 the Practice Expense Advisory Committee (PEAC) to monitor this process. The PEAC was
34 charged with the review of direct expense inputs (clinical labor activities, medical supplies, and
35 equipment) used to calculate practice expense relative values and made code-specific
36 recommendations to the RUC. The RUC then made the final recommendation to CMS. The
37 PEAC specifically reviewed the practice expense inputs of essentially the entire Medicare Payment

1 Schedule by making recommendations on over 6,500 medical procedures. The composition of the
2 PEAC mirrored the RUC with additional representation from nursing. The PEAC review process
3 was similar to the RUC process, relying on specialty societies to make recommendations that were
4 reviewed by a panel of medical experts and then forwarded to CMS. The PEAC concluded its work
5 in March 2004. The RUC continues to work closely with specialty societies and CMS to maintain
6 the practice expense component of the RBRVS. The RUC has formed a practice expense review
7 committee that will continue to review any refinement issues that arise. This group will also assist
8 the RUC in its review of practice expense inputs for new and revised codes.

9
10 **The RUC Health Care Professionals Advisory Committee (HCPAC)**

11 The HCPAC was formed to allow for participation of limited-license practitioners and allied health
12 professionals in the RUC process. All of these professionals use CPT to report the services they
13 provide independently to Medicare patients, and they are paid for these services based on the
14 RBRVS physician payment schedule. The 11 organizations seated on the HCPAC represent
15 physician assistants, chiropractors, nurses, occupational therapists, optometrists, physical
16 therapists, podiatrists, psychologists, audiologists, speech pathologists, social workers and
17 registered dietitians. The HCPAC members together with three physician members of the RUC
18 comprise the *RUC HCPAC Review Board*, which is responsible for developing relative value
19 recommendations to CMS for new and revised codes that are reported principally by non-MD/DO
20 professionals. The Co-Chair of the Review Board also serves as a member of the RUC.

21
22 **RUC Subcommittees and Workgroups**

23 The RUC has three standing subcommittees and ad hoc workgroups are formed to study specific
24 issues. The subcommittees are chaired by RUC members but the subcommittees are comprised of
25 other RUC members, and members from the Advisory Committee, the HCPAC, and the PEAC.
26 This is another opportunity for Advisory Committee Members to become directly involved in the
27 RUC deliberations and influence the RUC process.

28
29 **RUC Membership Criteria**

30 When the AMA formed the RUC in 1991, a set of criteria was developed that the RUC has
31 subsequently adopted and used to evaluate requests from specialty societies for a permanent seat on
32 the RUC. The following is the original RUC criteria for a permanent seat on the RUC listed in
33 priority order:

- 34
35 1. The specialty is an American Board of Medical Specialties (ABMS) specialty.
36 2. The specialty comprises 1% of physicians in practice.
37 3. The specialty comprises 1% of physician Medicare expenditures.
38 4. Medicare revenue is at least 10% of mean practice revenue for the specialty.
39 5. The specialty is not meaningfully represented by an umbrella organization, as determined by
40 the RUC.

41
42 In 1997 the RUC voted to grant the American Academy of Neurology a permanent RUC seat
43 because it met all of the above criteria. Specialties that do not meet the above criteria but that have
44 a RUC advisor are eligible to be elected to one of the RUC's rotating seats. The RUC has two
45 internal medicine rotating seats and one other rotating seat. The second internal medicine rotating
46 seat was added in 1999 when the American College of Physicians and the American Society of
47 Internal Medicine merged. The following is a list of specialties that have held a RUC rotating seat:

1 Internal Medicine Rotating Seats (1991 – April 1999: 1 seat; September 1999 – present: 2 seats)

2 Gastroenterology: 1991-1994, 2003-2005
3 Geriatrics: 1995-1997, 2001-2004
4 Oncology: 1999-2001, 2005-2007
5 Pulmonary Medicine: 1999-2001, 2004-2006
6 Rheumatology 1997-1999, 2001-2003

7
8 “Other” Specialty Rotating Seat (1 seat)

9
10 Child Psychiatry: 1997-1999
11 Nuclear Medicine: 1992-1994
12 Radiation Oncology: 2001-2003
13 Pediatric Surgery 1995-1996
14 Spine Surgery: 2005-2007
15 Vascular Surgery: 1999-2001, 2003-2005

16
17 The RUC periodically reviews its rules and procedures as well as those pertaining to membership
18 on the RUC. For example, in February, 2005 the RUC was asked to clarify the term ABMS
19 specialty, which applies to the first criterion. The RUC determined after reviewing documents
20 from June 1991 pertaining to the proposed composition of the RUC that this criterion refers to the
21 24 approved ABMS specialty boards. Therefore the RUC approved the following motion:

22
23 The first criterion for a permanent seat on the RUC, as currently stated in the “Criteria for
24 Participation” section of the RUC Structure and Functions document, the specialty is an ABMS
25 specialty, refers to the 24 approved ABMS specialty boards. All other specialties currently
26 represented on the RUC with permanent seats should be grandfathered on the RUC regardless of
27 inclusion or exclusion on this list of 24 ABMS specialties.

28
29 **Terms and Voting**

30 The 20 permanent specialty society representatives, AOA representatives, and alternate
31 representatives hold terms of three years. The Chair of the RUC holds an annual term of two years,
32 with a maximum tenure of six years. The AMA representative and alternate representative have
33 terms of three years, with a maximum tenure of six years. The CPT Editorial Panel representative
34 is appointed by the CPT Editorial Panel Chair and is a representative to the RUC for the same term
35 as his or her tenure on the CPT Editorial Panel. The RUC HCPAC Review Board representative is
36 a representative to the RUC for the same term as his or her tenure as Co-Chair of the RUC HCPAC
37 Review Board which will be determined by the RUC HCPAC Review Board. The PEAC
38 representative is a representative to the RUC for the same term as his or her tenure as the Chair of
39 the PEAC.

40
41 Representatives from the AMA, the AOA, each specialty society and the RUC HCPAC Review
42 Board Co-Chair each are entitled to one vote and the Chair only votes in the event of a tie vote.
43 The representatives from the CPT Editorial Panel and the Practice Expense Advisory Committee
44 are not entitled to vote.

45
46 **RUC Cycle and Methodology**

47 The RUC’s annual cycle for developing recommendations is closely coordinated with both the CPT
48 Editorial Panel’s schedule for annual code revisions and the CMS schedule for annual updates in
49 the Medicare Payment Schedule. The Editorial Panel meets three times a year to consider coding

1 changes for the next year's edition. The RUC meets after the Editorial Panel meetings to consider
2 relative value codes that are changed or added by the Editorial Panel.

3
4 The CPT Editorial Panel's yearly cycle must be completed in February of each year so that the
5 RUC can submit its recommendations to CMS in May. CMS publishes the annual update to the
6 Medicare RVS in the *Federal Register* every year, at about the same time that the AMA publishes
7 the new *CPT* book for the coming year. The updated CPT codes and relative values go into effect
8 annually on January 1. Due to the close coordination between RUC and CPT and the timely
9 submission of recommendations to CMS, physicians have the benefit of organized medicine's input
10 into relative values for new codes in the same year that the coding changes appear in CPT.

11
12 The RUC process for developing relative value recommendations is as follows:

- 13
14 • **Step 1** The CPT Editorial Panel's new or revised codes are transmitted to the RUC staff,
15 who prepare a "Level of Interest" form. This form summarizes the panel's coding actions.
16
- 17 • **Step 2** Members of the RUC Advisory Committee and specialty society staff review the
18 summary and indicate their societies' level of interest in developing a relative value
19 recommendation. The societies have several options: (1) they can survey their members to
20 obtain data on the amount of work involved in a service and develop recommendations
21 based on the survey results; (2) they can comment in writing on recommendations
22 developed by other societies; (3) in the case of revised codes, they may decide that the
23 coding change does not require action because it does not significantly alter the nature of
24 the service; or (4) they may take no action because the codes are not used by physicians in
25 their specialty.
26
- 27 • **Step 3** AMA staff develops survey instruments for the specialty societies. The societies
28 are required to survey at least 30 practicing physicians. The RUC survey instrument asks
29 physicians to use a list of 15 to 25 services as reference points that have been selected by
30 the specialty RVS committee. Physicians receiving the survey are asked to evaluate the
31 work involved in the new or revised code relative to the reference points. The survey data
32 may be augmented by analysis of Medicare claims data and information from other studies
33 of the procedure, such as the Harvard RBRVS study.
34
- 35 • **Step 4** The specialty RVS committees conduct the surveys, review the results, and prepare
36 their recommendations to the RUC. When two or more societies are involved in
37 developing recommendations, the RUC encourages them to coordinate their survey
38 procedures and develop a consensus recommendation. The written recommendations are
39 disseminated to the RUC before the meeting and consist of physician work, time, and
40 practice expense recommendations.
41
- 42 • **Step 5** The specialty Advisors present the recommendations at the RUC meeting. The
43 Advisory Committee members' presentations are followed by a thorough question-and-
44 answer period during which the Advisors must defend every aspect of their proposal(s).
45
- 46 • **Step 6** The RUC may decide to adopt a specialty society's recommendation, refer it back
47 to the specialty society, or modify it before submitting it to CMS. Final recommendations
48 to CMS must be adopted by a two-thirds majority of the RUC members.

1 Recommendations that require additional evaluation by the RUC are referred to a
 2 Facilitation Committee.

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- **Step 7** The RUC’s recommendations are forwarded to CMS in May of each year. CMS convenes a meeting of selected Carrier Medical Directors to review the RUC’s recommendations.
- **Step 8** The Medicare Physician Payment Schedule, which includes CMS’s review of the RUC recommendations, is published late Fall.

Annual RBRVS Updates, 1993-2006

11 The RUC has submitted more than 3,000 relative value recommendations for new and revised
 12 codes for the 1993-2006 RBRVS annual updates. In addition, the RUC submitted more than 300
 13 recommendations to CMS for carrier priced or non-covered services, including preventive
 14 medicine visits. A major reason for evaluating these codes using the RBRVS system is the
 15 widespread adoption of the Medicare payment system by state Medicaid programs and other
 16 insurance programs covering pediatric populations. Each year CMS has relied heavily upon these
 17 recommendations when establishing interim values for new or revised CPT codes. CMS’s
 18 acceptance rate for the RUC’s recommendations is more than 90% annually. It is important to
 19 remember that CMS makes the final RVU determinations and the RUC is not a CMS sponsored
 20 committee. CMS officials attend all RUC meetings as observers, and participate in the
 21 deliberations, but they cannot vote. The following chart shows recommendations submitted since
 22 the beginning of the RUC:
 23

History of RUC Recommendations

| Year | Recommendations Submitted (Number of CPT® Codes) | Work Relative Values Adopted at or Above RUC Recommendations (After Completion of Refinement Process) |
|-----------------------------|---|---|
| CPT 1993 | 253 | 79% |
| CPT 1994 | 561 | 89% |
| CPT 1995 | 339 | 90% |
| CPT 1996 | 196 | 90% |
| CPT 1997 | 90 | 96% |
| CPT 1998 | 208 | 96% |
| CPT 1999 | 70 | 93% |
| CPT 2000 | 130 | 88% |
| CPT 2001 | 224 | 95% |
| CPT 2002 | 314 | 95% |
| CPT 2003 | 350 | 96% |
| CPT 2004 | 162 | 96% |
| CPT 2005 | 149 | 99% |
| First 5-Year Review (1997) | 1118 | 96% |
| Second 5-Year Review (2002) | 858 | 98% |

1 **The RBRVS Five-Year Review Process**

2 In addition to annual updates reflecting changes in CPT, Section 1848(C)2 (B) of the Omnibus
3 Budget Reconciliation Act of 1990(42 USC 51395W-4(a)) requires CMS to comprehensively
4 review all relative values at least every five years and make any needed adjustments. The changes
5 resulting from the first Five-Year review of the RBRVS became effective January 1, 1997.
6 Relative value changes from the second Five-Year Review of the RBRVS were implemented on
7 January 1, 2002 and changes from the third review will be implemented January 1, 2007. The
8 success of the RUC's role in the annual updates led CMS to seek assistance from the RUC in the
9 Five-Year Review processes.

10
11 Each Five-Year review presents an unprecedented opportunity to improve the accuracy of the
12 physician work component of the RBRVS, as well as a significant challenge to the medical
13 community. All of the codes on the Medicare Physician Payment Schedule were open for public
14 comment as part of each Five-Year review.

15
16 During the public comment period for the initial Five-Year Review, CMS received nearly 500
17 letters identifying about 1,100 CPT codes for review. The Carrier Medical Directors, the American
18 Academy of Pediatrics (AAP) and special studies conducted for three specialty societies identified
19 additional codes for review. Following an initial review in late February 1995, CMS referred to the
20 RUC comments on about 3,500 codes. The second Five-Year Review was initiated in March 2000
21 when CMS shared comments submitted by 30 specialties on more than 870 codes. For the current
22 Five-Year review, the RUC will review 710 codes.

23
24 **Results of the Five-Year Reviews**

25
26 *Year 1995 Five-Year Review*

27 In September 1995, the RUC submitted to CMS relative value recommendations for more than
28 1,000 individual codes for the first Five-Year Review. Of the 1,000 codes evaluated individually,
29 the majority of the recommendations made by the RUC were to maintain the current relative work
30 values. However, the RUC recommended increasing the value for about 300 services, which
31 addressed long-standing concerns about several major groups of services. The data gathered on the
32 work involved in the evaluation and management, gynecology, and vascular surgery services, for
33 example, supported the contention that these services were originally valued too low, and the RUC
34 recommended significant increases. These data tended to show that the work involved in the
35 services had increased since the Harvard study was conducted and that the services had been
36 undervalued relative to key reference services since the RBRVS was originally implemented.

37
38 The recommendations may be summarized as follows:

- 39
40
- 41 • For 296 codes, the RUC recommended that the relative value be increased.
 - 42 • For 650 codes, the RUC recommended that the current relative value be maintained.
 - 43 • For 107 codes, the RUC recommended that the relative value be decreased.
 - 44 • The RUC referred 65 codes to the CPT Editorial Panel to consider coding changes prior to further consideration of the relative value.

1 Overall, CMS accepted nearly 96% of the RUC's recommendations, including 100% acceptance
2 for several specialties.

3 *Year 2000 Five-Year Review*

4 In October 2000, the RUC submitted recommendations on 870 individual CPT codes to CMS. The
5 RUC recommended increases to many surgical services, primarily to address vascular and general
6 surgery procedures that have been historically undervalued. The recommendations may be
7 summarized as follows:

- 8
- 9 • For 469 codes, the RUC recommended that the relative values be increased.
 - 10 • For 311 codes, the RUC recommended that the current relative value be maintained.
 - 11 • For 27 codes, the RUC recommended that the relative values be decreased.
 - 12 • The RUC referred 63 codes to the CPT Editorial Panel to consider coding changes prior to
13 consideration of the work relative value.
- 14

15 CMS accepted 98% of the RUC's recommendations. The relative value changes were
16 implemented on January 1, 2002.

17

18 *Year 2005 Five-Year Review*

19 In February 2005, CMS submitted 710 codes to the RUC to review for the third, Five-Year Review
20 of the RBRVS. This Five-Year review is particularly contentious as the evaluation and
21 management services, along with many high-volume codes identified by CMS, are to be reviewed.
22 The potential for specialty re-distribution of payments resulting from this review presents
23 challenges for the RUC.

24

25 The RUC convened meetings in August and September to review the codes under review. The
26 RUC plans to submit recommendations to CMS in October 2005. CMS will publish a Proposed
27 and Final Rule in 2006 announcing their decisions regarding these codes. New relative values will
28 be implemented on January 1, 2007.

29

30 **Conclusion**

31

32 Because of the careful planning and dedication of RUC members, the RUC has played an
33 important role in influencing the Medicare Physician Payment Schedule. The RUC has developed
34 a detailed set of rules and procedures that govern the entire RUC process. These rules have
35 contributed to the RUC's success by ensuring that all participants follow the same procedures in
36 developing their recommendations. They also stipulate the RUC's structure and committee
37 compositions as well as a wide range of methodological and administrative issues. The RUC is a
38 unique multi-specialty committee dedicated to making relative value recommendations for new and
39 revised codes as well as annually updating RVUs to reflect changes in medical practice. Because
40 of this unique structure, the RUC has created the best possible advocate for physician
41 reimbursement, the physician. It is the work of these dedicated physicians who contribute their
42 time, energy and knowledge that makes the RUC process a success that benefits all practicing
43 physicians.