



February 8, 2007

Jeffrey A. Alexander, PhD
Editor-in-Chief
Medical Care Research and Review
109 S. Observatory
M3507 SPH II
Ann Arbor, Michigan 48109-2029

Dear Dr. Alexander:

The American Medical Association/Specialty Society Relative Value Update Committee (RUC) submits these comments in response to the article, "Validation of Physician Survey Estimates of Surgical Time Using Operating Room Logs," McCall, et al, *Medical Care Research and Review*, Vol. 63 No. 6. The McCall study, which compares extant data sources to RUC survey information and recommendations, has great relevance to the RUC and its participants as the RUC is currently reviewing the efficacy and appropriateness of such data sources. Given the significance of this issue and the implications of the study, the RUC agrees that it is necessary to submit its comments on the merits of the article. Specifically, we feel it exhibits numerous shortcomings in its collection of data, affecting the reliability of its conclusions.

Extant Data and the RUC Process

During the most recent Five-Year Review, the subject of using extant data as an alternative methodology to develop work relative value unit (RVU) recommendations was discussed and ultimately was approved in the cases of the National Surgical Quality Improvement Program (NSQIP) and the Society of Thoracic Surgeons (STS) database. The RUC felt that these alternative methodologies of developing work RVU recommendations were appropriate tools to be used in the Five Year Review Process. On June 21, 2006, the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule indicating various concerns it had with using this extant data for this purpose. CMS stated that while these databases are significant tools that can be used to improve the quality of patient care and could be used to validate the results from the RUC survey instrument, there were concerns about its representativeness; its correlation between time and work as time is only one component in a work RVU; the fact that these databases are not available for all specialties and; that the relativity of the fee schedule could be compromised by using a different method to determine work RVUs of a small number of codes because current work RVUs for other services are not based on this methodology.

The RUC agreed that due to this response, a policy should be developed for how extant data may be used in the RUC process. The development of such a policy is currently underway. These concerns include but are not limited to:

- Representative Data
- Equal Availability for Database Across Specialties

- Mixing of Methodologies in the RBRVS
- Using Extant Data for a Purpose in Which it was not Designed
- Identifying all Potential Databases
- How the Extant Data Will be Implemented in the RUC Process

The DJ Sullivan & Associates (DJSA) database exhibits a significant imperfection, reducing its relativity to the RBRVS. The services described in the database are not categorized by CPT code, but rather by non-uniform procedural descriptions from operative logs. This lack of comparable classification of services undermines the integrity of the DJSA data. While McCall addresses this by assigning the described procedures CPT codes, any discrepancy between the service description and the RBRVS impinges on the integrity of the database and the times reported. Admittedly, McCall brings attention to the 11% interrater disagreement, evidencing a significant lack of agreement between DJSA data, CPT, and, subsequently, the RBRVS. If CPT codes had been used to identify procedures, the correlation to the RBRVS procedures may achieve a higher rate of consistency.

RUC Time Data

The most significant shortcoming of this study is the nearly complete inaccuracy of the RUC time information provided and the lack of consideration for differences between RUC median time and Harvard time in the study's conclusions.

In the McCall study, the investigators provide two tables of data, quantifying their conclusions. Table 1 provides a comparison of the longest differences in intra-service time between the RUC median times and DJ Sullivan & Associates time. Nine services are listed, citing differences between 64 and 102 minutes. Three of the nine services have not been reviewed by the RUC and rely on Harvard time. Moreover, the values provided are not representative of the actual RUC intra-service times. Only two are accurately reported, while the remaining seven services incorrectly report RUC time.

In Table 2, the McCall study provides fifteen services with high utilization as well as inclusion on the RUC Multi-specialty Points of Comparison (MPC) list. Four of the 15 services do not presently appear on the MPC. Ten of the 15 services had not been reviewed by the RUC and accepted by CMS until after the date of the article's submission for publication, relying on Harvard time estimates for the study. Similar to the inaccuracies reported within Table 1, 11 of the 15 services listed do not correctly report the RUC intra-service time.

In the published Tables 1 and 2, nearly all of the RUC median times reported are incorrect. Of the 22 distinct services described in both tables, only four correctly indicate the RUC time, accounting for an error rate of 82%. The average misrepresentation of time was almost 19 minutes per service, with an average over-estimation of 16 minutes per service. This difference positively skews all findings in the report. Some of the times are as much as 102 minutes higher than accurate RUC time. Based on the McCall data for these 22 services, the mean increase in RUC time versus DJSA time is more than 45 minutes. However, using accurate RUC median

time, that difference is reduced to less than 30 minutes. If this error is extrapolated for the 60 services referenced by the study, the merits of the study's conclusions are clearly compromised.

Table 1. Comparison of codes identified in the McCall study with correct RUC median times included

CPT Code	DJSA Intra-Service Time	McCall "RUC" Intra-Service Time	Actual RUC or Harvard Median Intra-Service Time	McCall Stated Error	Difference of DJSA Intra-Service Time to actual RUC or Harvard Intra-Service Time	Time Source
†19240	82	92	104	-8	22	Harvard
19318	160	225	150	75	-10	RUC
27134	153	240	240	0	87	RUC
27447	96	163	124	39	28	*Harvard
29881	34	77	66	11	32	Harvard
30520	46	71	60	9	14	*Harvard
31622	22	47	30	17	8	RUC
32480	116	180	155	25	39	RUC
33512	199	268	213	55	14	RUC
35081	162	203	210	-7	48	RUC
43235	18	30	20	10	2	*Harvard
43239	8	35	34	1	26	RUC
44140	92	150	150	0	58	RUC
45330	16	18	17	1	1	*Harvard
50230	141	215	222	-7	81	Harvard
52000	13	17	15	2	2	*Harvard
55845	176	240	247	-7	71	Harvard
58150	99	120	120	0	21	RUC
58210	138	240	240	0	102	RUC
58260	79	95	60	35	-19	RUC
61510	201	302	200	102	-1	RUC
64721	16	30	25	5	9	*Harvard

* These services were reviewed by the RUC after the McCall study data were gathered and originally reported on December 12, 2001. At the time of the McCall study, Harvard time was used

†Deleted from CPT 2007

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Improvements to the RUC Process and RBRVS

There have been many improvements made to the RBRVS since the McCall study was originally conducted. Namely, the RBRVS has undergone a third Five-Year Review. The article infers that the RUC process and the Five-Year Review process have an inherent bias toward increasing RVUs. The article also conjectures surgical times are inflated, increasing surgical RVUs at the expense of all other specialties, particularly primary care, due to budget neutrality provisions. This is not an accurate portrayal of the RUC process or budget neutrality. At the most recent Five-Year Review, conducted in 2005 and implemented in 2007, the RUC recommended improvements to the work RVUs for numerous services including most Evaluation and Management (E/M) Services. The RUC found compelling evidence that incorrect assumptions were made regarding the time and intensity of E/M services in the past and recommended work RVU increases for 28 E/M services. CMS accepted 100% of these recommendations. The E/M improvements were projected to increase Medicare physician spending by \$4.5 billion, requiring a budget neutrality adjustment of -10.1% to all work RVUs in 2007.

The McCall article represents findings regarding surgical procedures from one chapter of a larger study originally published in 2001. The original report included a comparison of RUC median intra-service time for E/M services with the National Ambulatory Medical Care Survey extant database. The E/M comparison also resulted in similar time discrepancies to the surgical procedures, expressing relativity between surgical time and E/M time when compared to extant data. The most important aspect of the RBRVS is its relativity across all physician services. While payment policies and conversion factors may change, the accurate relativity and valuation of work is what makes the RBRVS a successful physician payment system.

In addition to these improvements, the RUC recently began to require each RUC specialty society-appointed advisor to provide a signed statement of attestation for each survey and RUC recommendation submitted. The addition of this attestation statement provides a greater level of integrity and accountability, helping to ensure appropriately conducted and accurately summarized surveys of physician time, work and intensity. The RUC has made other changes to the physician work survey throughout the years to provide more accurate and clear descriptions of pre-service, intra-service, and post-service time.

The RUC appreciates and is receptive to outside studies and analyses of the precision and effectiveness of the RBRVS and the RUC process. However, we are concerned that the misrepresentation of RUC data skews the study findings. The RUC would have welcomed the opportunity to provide correct time data with the authors. We hope that in the future, studies on the RUC process and the RBRVS, with the potential to affect physician practices, are accurately and meticulously conducted and reviewed. Thank you for the opportunity to comment.

Sincerely,



William L. Rich, III, MD, FACS

cc: RUC Participants