REPORT 14 OF THE BOARD OF TRUSTEES (A-08)
The RUC: Recent Activities to Improve the Valuation of Primary Care Services
(Resolution 124, A-07)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2007 Annual Meeting, the House of Delegates referred Resolution 124, introduced by the Oregon Delegation. The resolution calls on the American Medical Association (AMA) to (1) work with the AMA/Specialty Society RVS Update Committee (RUC) to address concerns of primary care reimbursement through such strategies including, but not limited to coordination of care codes, complexity modifiers, and fair compensation for Evaluation and Management (E/M) services; and (2) recommend the voting representation of the RUC be changed to provide primary care representation at least equal to the proportion of primary care physicians in the physician workforce.

The report provides the opportunity to fully articulate the improvements to E/M payment in 2007, made possible by the RUC's efforts to comprehensively review the physician work provided in office and hospital visits. Despite a stagnant 2007 conversion factor and a controversial Medicare budget neutrality adjustment, Medicare payment for a mid-level office visit increased by 13% due to the RUC's efforts. This followed other E/M increases in 1997, also the result of the RUC's recommendations. Since the inception of the RBRVS, E/M work relative values have increased by 45%, while other major categories of physician services have either decreased or increased slightly in work valuation. In addition, the RUC has also achieved success in improving valuation of immunization administration and establishing relative valuation for care coordination, telephone calls, on-line communications, and anticoagulant management. The real challenge is persuading the Centers for Medicare and Medicaid Services to cover and pay separately for these services. The Board of Trustees recommends that the AMA support the RUC's recommendations and continued advocacy for Medicare coverage and payment of these important services, performed widely by primary care physicians. The report also explains the RUC's role in responding to a request from Congress to develop care management codes and valuation related to the Medicare Medical Home Demonstration project.

The RUC was created in 1991, and its composition was designed by the AMA to ensure maximum participation in the new process. The balance of specialty representation was carefully considered. The original intent was to include all major specialties, primarily defined as the 24 Member Boards of the American Board of Medical Specialties. Additional direct participation on the RUC is provided through three available rotating seats. The RUC Advisory Committee was constructed to allow participation by every specialty seated in the AMA House of Delegates. The RUC Advisors serve as advocates for their specialty, while RUC members must exercise independent judgment and are not involved in their specialty's presentations. The report reviews the various appeals to gain permanent representation on the RUC and the RUC's careful consideration of these requests and its overall composition. The Board of Trustees continues to believe that the RUC has the experience that is required to review the valuation of physician services.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14 - A-08

Subject: The RUC: Recent Activities to Improve the Valuation of Primary Care Services (Resolution 124, A-07)

Presented by: Edward L. Langston, MD, Chair

Referred to: Reference Committee A (Linda B. Ford, MD, Chair)

INTRODUCTION

At the 2007 Annual Meeting, the House of Delegates referred Resolution 124, introduced by the Oregon Delegation. The resolution calls on the American Medical Association (AMA) to (1) work with the AMA/Specialty Society RVS Update Committee (RUC) to address concerns of primary care reimbursement through such strategies including but not limited to coordination of care codes, complexity modifiers, and fair compensation for Evaluation and Management (E/M) services; and (2) recommend the voting representation of the RUC be changed to provide primary care representation at least equal to the proportion of primary care physicians in the physician workforce. Testimony at the 2007 Annual Meeting was mixed as delegates sympathetic to primary care argued that more should be done to improve payment for their services. Opponents of Resolution 124 (A-07) recognized that the RUC was established to function as an expert panel and should not be subject to political discussions regarding composition. Delegates also testified that the RUC had done much over the past several years to achieve improvements in valuation in E/M services and other services commonly provided by primary care physicians.

RELEVANT AMA POLICY

The AMA has extensive policy supporting the RUC and its recommendations to the Centers for Medicare and Medicaid Services (CMS), including:

- Policy H-400.956, "RBRVS Development," (AMA Policy Database) calls on the AMA to: (1) strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) encourage payers using the relative work values of the Medicare Resource-Based Relative Value Scale (RBRVS) to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.

- Policy H-400.959, "Refining and Updating the Physician Work Component of the RBRVS," calls on the AMA to support the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS.

- Policy H-400.962, "The AMA/Specialty Society RVS Update Process", states that our AMA will strengthen its efforts to secure CMS adoption of the RUC's recommendations.

- Policy H-400.969, "RVS Updating," states that the RUC represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the Federal Government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the RUC for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; and (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues.

- Policy H-400.972, "Physician Payment Reform," requests that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the RUC for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.

RUC RECOMMENDATIONS – PRIMARY CARE SERVICES

Evaluation and Management Services

On January 1, 1992, the Health Care Financing Administration (HCFA) implemented the RBRVS and assigned relative values for new E/M codes, first published in *CPT 1992*. The work relative values for E/M were based on a study by Harvard University. HCFA then worked with the Harvard researchers and the CPT Editorial Panel to develop a structure and intra-service time variation for the new E/M codes and crosswalked values to these new codes. After the publication of the *Final Rule* in November 1991, HCFA received numerous comments that the E/M codes were undervalued. Specialty societies offered a number of different approaches on reviewing the intensity relativity of E/M. These approaches varied from ascending intensity, descending intensity, or equivalent intensity within a family of E/M codes. HCFA concluded that they would not reach consensus within the medical community. HCFA chose to continue to use these Harvard data and value the E/M codes in a linear fashion, assigning a fixed intensity of intra-service work across all the codes in an E/M family.

The RUC has been presented with a request to review the family of E/M services on two occasions, in 1995 and again in 2005, during the first and third Five-Year Review of the RBRVS. There have been numerous revisions and additions to E/M since the inception of the RBRVS (e.g., nursing facility, home health, critical care services, newborn care) which resulted in improved coding and payment of specific E/M services. CMS provided the RUC only two opportunities, during the Five-Year Reviews, to review the relativity of E/M within the RBRVS.

1995 Five-Year Review Process

In 1995, the RUC recommended that the post-service work associated with E/M had increased due to the implementation of documentation guidelines. In addition, the RUC argued that the intra-service (face-to-face) work was undervalued compared to other services within the RBRVS. The RUC's recommendations were based on rigorous multidisciplinary review by surgeons and other specialists who shared the primary care groups' views regarding the increase in the work of E/M services in the previous five years and the failure of the current relative values to appropriately recognize the time and effort involved in both intra- and post-service work. The RUC vote to recommend increases to the E/M services was nearly unanimous.

In the May 1996 *Proposed Rule,* HCFA discussed its review of the RUC recommendations and concluded that the work relative values for E/M should remain based on three assumptions. These three assumptions originated during the Harvard study and were held constant in both the 1992 and 1995 refinements:

- All services within an E/M family (e.g., office visits) have the same intra-service work intensity.
- The intra-service physician work times in the CPT descriptors are correct.
- The pre-service and post-service work is a fixed percentage of intra-service work.

HCFA utilized 1989 and 1994 publications of the AMA's *Physician Marketplace Statistics* to identify that the median number of hours a physician works in patient care (51 hours) and the median number of patient visits per week (101) had not changed between 1989 and 1994. They further used this information to calculate the total number of hours that a physician would need to spend in patient care hours (78.5) to perform 101 visits, based on the 1995 RUC survey data. This was a key argument that HCFA utilized to reject the RUC survey time and recommendations.

Although HCFA did not agree with the RUC recommendations, the agency did agree that the E/M services should be increased. HCFA utilized a different approach to compute these increases. Using the above assumptions, HCFA increased the intra-service work intensity by 10% and fixed the percentage of pre- and post-service work in relation to intra-service work by 25%. This adjustment led to increases substantially lower than the RUC recommendations. For example, the RUC recommended a 45% overall increase in the work valuation for a 99213 to 0.80 (from 1996 value of 0.55) and HCFA only increased the value by 22% to 0.67.

RUC leadership met with HCFA throughout the summer of 1996 and argued that the new valuation of E/M remained flawed, stating that the proposed values were based on several questionable assumptions that warrant evaluation, including the assertion that all E/M services have the same work intensity. In the *Final Rule*, HCFA stated that "We will remain open to receiving further information that shows the relationships between some families of these services have changed."

2005 Five-Year Review Process

On December 16, 2004, 27 specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were increased during the first Five-Year Review in 1995. The RUC engaged in a 14 month review of E/M services, convening five face-to-face meetings and several conference calls. The RUC reviewed survey data that was identified as flawed in the same manner that was identified in the first Five-Year Review. The RUC agreed, however, with the specialty societies and with the previous RUC recommendation, that many of the E/M services were undervalued in comparison to other services in the RBRVS. The RUC was particularly compelled that CMS had not sufficiently addressed the RUC recommended increases to E/M in 1997. Utilizing an exhaustive comparison to other physician services, the RUC completed its review in February 2006 and recommended significant increases in E/M valuation. For example, the work value for 99213 was increased by 37%, from 0.67 to 0.92.

CMS accepted 100% of the RUC's recommendations and implemented the new E/M work relative values on January 1, 2007. The RUC's E/M valuation improvements in 2007 led to an annual $4 billion increase in E/M spending. CMS is required to maintain budget neutrality within the Medicare Physician Payment Schedule. Historically, these adjustments have been made to the conversion factor. Although this would have led to an approximate 5% reduction to the conversion factor in 2007, CMS instead created a new -10.1% "work adjuster" to be applied to the work relative value in the computation of payment. The work adjuster methodology is favorable to services that obtain a greater proportion of payment from practice expenses (imaging, diagnostic tests, etc.) and unfavorable to services where payment is largely derived from face-to-face time with patients. Seventy-five specialty societies signed on to an AMA-sponsored letter urging CMS to apply the budget neutrality adjustment to the conversion factor. The RUC convened a meeting with CMS leadership in October 2006 to implore the agency to apply the adjustment to the conversion factor. Unfortunately, CMS not only implemented the work adjuster in January 2007, but increased it to -11.94% on January 1, 2008.

AMA staff analyzed the work valuation within the RBRVS from 1992 to 2007 and determined that E/M (CPT codes 99201-99499) work valuation has increased by 45% since the establishment of this payment system. Other major classification of services have not increased at this rate (surgery = 9%, pathology = 6%, other tests/therapy = 14%). Imaging services work valuation has declined by 6%. E/M work valuation has improved substantially since the inception of the RBRVS as a result of the RUC's efforts.

<u>Immunization Administration</u>

The RUC led an extensive effort over the past decade to improve the valuation of immunization administration, a service most commonly provided by primary care physicians. The RUC first recommended to CMS in 1999 that physician work be recognized for immunization administration. CMS steadfastly refused to recognize any physician involvement in the counseling related to the provision of these services. The RUC repeatedly urged CMS to reconsider this action through public comment and direct advocacy to CMS staff. As a result of the RUC's advocacy, CMS published work relative values for immunization administration on January 1, 2005. In addition, the RUC has, and continues to, identify additional costs associated with immunization administration, including the Occupational Safety and Health Administration (OSHA) compliant safety needles and refrigeration costs. These efforts have led to significant increases in payment

1 for these services. In 2002, the national Medicare payment amount for 90471 *Immunization*
2 *administration* was $3.44 and today, that payment amount has increased to $20.57. The American
3 Academy of Pediatrics has acknowledged that these improvements have also positively impacted
4 payment for immunization services provided to patients with Medicaid or private health plan
5 coverage as the Medicare RBRVS is increasingly adopted by non-Medicare payers.
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7 Telephone Services
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9 In 2007, the CPT Editorial Panel and the RUC engaged in an effort to redesign telephone services
10 provided by a physician to clearly delineate the work outside the pre- and post- work of an E/M
11 service. Six new codes, three for physicians (99441-99443) and three for other health professionals
12 (98960-98962) were designed to be reported based on the duration of the call. The RUC worked
13 with the primary care specialty societies and presented work value recommendations to CMS in
14 May 2007. In November 2007, CMS announced that it had accepted the RUC's recommendations
15 for publication, which would represent modest 2008 Medicare national payment ranging from
16 $12.57 for a 5-10 minute call to $33.90 for a 21-30 minute call. However, CMS announced that
17 the agency will not provide coverage as the services describe non face-to-face time and would also
18 include telephone time with the parent or guardian of the patient. In a December 2007 public
19 comment letter, the RUC urged CMS to reconsider this non-coverage decision.
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21 Team Conferences
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23 Although physicians may report their time spent in a team conference when the patient and/or
24 family is present using E/M services, there was previously no way to report care coordination time
25 when a physician was required to participate in a medical team conference without the patient's
26 presence. In 2007, the CPT Editorial Panel and the RUC created codes and relative values for team
27 conferences. Although, CMS did publish the RUC's recommendations and a 2008 Medicare
28 national payment amount of $48.37 can be computed for 99367 *Team conference with*
29 *interdisciplinary team of health care professionals, patient and/or family not presented, 30 minutes*
30 *or more*, CMS will not pay separately for this designated bundled service. CMS considers this
31 service much like "other counseling services that are incorporated into existing E/M services." The
32 RUC would not consider team conferences to be "counseling services" and will continue to urge
33 CMS to reconsider the decision to bundle this service.
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35 Anticoagulant Management
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37 Long-standing Medicare payment policy has required physicians to perform anticoagulant
38 management via office visits where patients are provided their prothrombin time tests results and
39 receive any necessary adjustments to their medication. Although physicians may discuss results
40 with a patient and make an adjustment during a face-to-face encounter under some circumstances,
41 physicians often engage in these activities outside of a face-to-face encounter with the patient and
42 are not paid for these services. In 2006, the CPT Editorial Panel and the RUC agreed with the
43 primary care specialty societies that a carefully constructed coding solution to bundle services,
44 requiring a minimum number of International Normalized Ratio (INR) tests within a 90-day period,
45 would be the most effective way to ensure accurate coding and payment for this case management
46 service. Separate reporting of E/M services for management of INR testing would not be permitted
47 when these new codes were utilized. The RUC not only accepted the joint relative value
48 recommendations presented by internal medicine, cardiology, and neurology, but has also
49 repeatedly advocated for CMS separate payment of this service. Although CMS did publish the

relative values and Medicare national payment amounts for anticoagulant management ($107.41 in 2008 for the first 90 days of monitoring), the agency has implemented a payment policy that considers this service bundled into office visits and notes that the agency "generally does not pay separately for disease-specific management services." Despite significant efforts by the CPT Editorial Panel and the RUC, the long-standing Medicare payment policy requiring face-to-face visits for anticoagulant management remains.

Care Plan Oversight

The CPT Editorial Panel and the RUC have a long history of recognizing and recommending valuation for care plan oversight for patients under the care of a home health agency, hospice, or nursing facility. Most recently, new codes were created to describe care plan oversight for a more comprehensive array of patients who are residing at home or in a domiciliary or rest home (e.g., assisted living facility). The RUC accepted the primary care specialty society recommendations and submitted them to CMS throughout the past decade. CMS has published the RUC recommendations for all of these care plan oversight services (CPT codes 99339, 99340, 99374-99380); however, CMS has adopted a bundled payment policy for most of these services, not recognizing separate payment for these physician time-based codes. After a four-year campaign by the AMA and primary care specialty societies, CMS began providing separate payment for home health care and hospice care supervision in 2001, but only after specific G codes (G0179-G0180) were created to comply with Medicare specific criteria for payment.

Education and Training for Patient Self-Management

In 2005, the CPT Editorial Panel created new CPT codes (98960-98962) to describe 30 minutes of education and training for patient self-management by a qualified health care professional. The RUC then submitted estimates of direct practice expenses for these services to CMS. CMS utilized the RUC's recommendations to publish relative values, which allows computation of 2008 Medicare national payment amounts ranging from $8 for each patient in a group of 5-8 patients to $22.47 for an individual patient in a private session. However, CMS announced that the agency would consider patient education and training bundled into E/M services and would not provide for separate payment for the provision of these services. In the December 1, 2006 *Final Rule*, CMS noted that "Other than diabetic education services (G0108 and G0109) specified by Congress, we do not cover separate education services outside of demonstrations or the Medicare Health Support program." The RUC has urged CMS to reconsider this policy.

Welcome to Medicare Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provided coverage for a Medicare beneficiary's Initial Preventive Physical Examination (IPPE) effective January 1, 2005. This "welcome to Medicare benefit" must occur within the first six months that the individual elects to participate in Medicare Part B. CMS implemented a G code (G0344) and determined the valuation of the service, without the input of the RUC. Despite assumptions that the physician time and direct expenses are similar to a high level office visit, the published valuation and 2008 Medicare national payment is one-third less than a 99215. The valuation and payment is also substantially lower than the published valuation for 99387 *Initial preventive exam for a patient over age 65,* a more logical crosswalk for G0344 and the code the AMA urged CMS to utilize for this new benefit. At the request of the American Academy of Family Physicians, the RUC has repeatedly commented that the committee be provided the opportunity to review and

provide input into the valuation of G0344, the most recent request in February 2008. Despite CMS' general willingness to forward almost any specialty society request to the RUC for review, CMS will not allow RUC review of this important and presumably undervalued service.

Medicare Medical Home Demonstration

The Tax Relief and Health Care Act of 2006 called on the Secretary of the Health and Human Services to create a new Medicare Medical Home Demonstration. The law further requires that payment shall be made for care management to physicians participating in the demonstration. The Secretary must use the RUC to "develop a care management fee code for such payments and a value for such code." Immediately following the enactment of this legislation, AMA staff contacted the CMS Office of Research and Development to discuss the CPT Editorial Panel and RUC process and to offer immediate assistance. However, it was not until mid-January 2008 that CMS requested the RUC's involvement, articulating for the first time that they would also need the RUC's assistance in the code descriptor formulation, as well as the valuation. CMS further requested that the input be provided no later than May 1, 2008. The RUC, acknowledging the need to be helpful to CMS and primary care, quickly organized a Medical Home Workgroup and began meeting weekly by conference call to provide as much input as feasible in such a short timeframe. By early March 2008, the Workgroup had succeeded in developing the descriptions of the medical home monthly care management codes. On April 29, 2008, the RUC submitted recommendations regarding the resources required for the monthly management of a patient eligible for the Medicare Medical Home Demonstration. CMS is currently reviewing the recommendation and is expected to implement the demonstration on January 1, 2009.

RUC Recommendations - Methodological Improvement to RBRVS

In addition to the numerous recommendations for specific services principally performed by primary care physicians, the RUC has offered several improvements to the underlying methodology within the RBRVS that would have a positive impact on primary care. The following are RUC recommendations that are under review by CMS:

- CMS should assume a higher equipment utilization rate for all equipment, providing an opportunity to specialties to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations. When CMS initially proposed the practice expense methodology, the agency utilized data from a study by Abt Associates to assign an equipment utilization rate (assumed percentage of time the equipment would be in use in an office) of 70%. After concerns were raised with this assumption, CMS used a lower utilization rate (50%), despite the lack of any actual data to support it. The RUC has repeatedly urged the agency to reinstate a higher rate, leaving open the ability to appeal if specialties provide actual data to justify a lower rate for specific equipment. The Medicare Payment Advisory Commission (MedPAC) has also suggested that the 50% utilization rate is unrealistic, particularly for high cost equipment such as magnetic resonance imaging. An increase in the utilization rate would redistribute practice expense relative values to other services that do not rely on expensive equipment.

- CMS should adjust the 11% cost of capital rate to a market competitive rate. CMS currently utilizes an interest rate of 11% in pricing medical equipment. This rate has not been reviewed or modified since 1998. Like the equipment utilization discussion above, a decrease in the cost

of capital rate would redistribute practice expense relative values to other services that do not rely on expensive equipment.

- CMS should review the pricing of high cost medical supplies on an annual basis. The RUC has expressed concern that the pricing for high cost disposable medical supplies (priced at or above $200) is not frequently updated. The RUC has recommended that these supplies be separately reported with J codes or individually identified within the payment bundle and then be re-priced on an annual basis.

- CMS should work with the AMA and other health professional organizations to conduct a multi-specialty survey effort to ensure that all practice expense payment is based on consistently obtained timely data. CMS is currently utilizing practice cost data from 1995-1999 surveys conducted by the AMA's Center for Health Policy Research, adjusted to 2005 dollars for the majority of specialties (including internal medicine, pediatrics, and family medicine). CMS has accepted more recent data from 13 Medicare specialties (e.g., diagnostic testing facilities, radiology, cardiology, and dermatology) and implemented this data into the 2008 practice expense relative values. The AMA is leading an effort to collect consistent, reliable data for all Medicare specialties. CMS has been supportive of this effort. It is anticipated that these data will be available for CMS consideration in March 2009 for the 2010 Medicare Physician Payment Schedule.

- CMS should improve the professional liability insurance (PLI) relative value methodology. The PLI component of the RBRVS comprises only 4% of the Medicare payment, averaged across all services, on a national level. However, for many specialties in markets with high premium rates, the PLI component is a substantial percentage of their overall payment. CMS has not yet responded to several RUC recommendations to improve the PLI determinations, including reductions to the technical component of imaging and diagnostic tests. Currently, CMS PLI payment for the technical component of mammography is at a higher rate than the rate for the physician's interpretation of the mammogram. The PLI payment for a chest x-ray is higher than a high level office visit. While the work and practice expense relative values for E/M have increased dramatically since 1992, the PLI relative valuation has remained constant.

The RUC has also created a Five-Year Identification Workgroup to identify potentially misvalued services. Although the RUC has recommended reductions to the work values of more than 400 services since the inception of the RBRVS, MedPAC and some members of Congress have argued that more needs to be done to identify overvaluation within the payment system. The RUC has already made progress in ramping up their ability to identify and review misvalued services. In March 2008 and May 2008, the RUC submitted recommendations to reduce work values for several physician services where hospital visits were no longer typical. The committee has also initiated a review of services with high volume growth and outlier physician work intensity. Services that have been identified as new technology have been flagged to be re-reviewed after three years of claim data are available. In addition, a joint CPT/RUC workgroup has also requested that specialty societies develop coding proposals to bundle services that are inherently reported together on the same date by the same physician. The RUC is the group with the expertise required to ensure the work relativity is appropriate within the RBRVS. The recent activities of the RUC are prudent and necessary. However, expectations regarding the available resources to redistribute to primary care and others from this presumed "overvaluation" are unrealistic. E/M comprises 52% of the total work relative values in the RBRVS. Therefore, major reductions in other physician services may only provide modest improvements in the relativity of E/M.

RUC COMPOSITION

The AMA and several major national medical societies identified the need for physician input into the new RBRVS payment system and created the RUC in 1991. As a guide, the leadership from these organizations looked to the American Board of Medical Specialties (ABMS) to identify the major specialties and all documentation from this time clearly indicate that the 24 Member Boards of ABMS were considered to be one of the most important criteria for membership. The RUC has also defined the first criteria to refer to the 24 Member Boards of ABMS, noting that all specialties currently represented on the RUC with permanent seats are grandfathered on the RUC regardless of inclusion or exclusion on the list of 24 Member Boards of ABMS. The original RUC criteria used in 1991 have since been adopted by the RUC and listed below in priority order:

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

AMA/Specialty Society RVS Update Committee

The RUC is a private volunteer committee comprised of physicians and other health care professionals. The RUC's mission is to make recommendations to CMS regarding the Medicare RBRVS. Individual RUC members serve as experts, utilizing their independent judgment, and are not advocates for their specialty societies. The RUC is comprised of 29 individuals, with 26 voting members. Twenty of the 26 voting members are appointed by major national medical specialty societies to three-year terms, with total tenure determined by the specialty. Three voting seats rotate on a 2-year basis, with two reserved for an internal medicine subspecialty, and one for any other specialty. Representatives of these three rotating seats are nominated by specialty societies and elected by the RUC. The AMA, American Osteopathic Association, and the Health Care Professionals Advisory Committee Review Board each have a voting seat on the RUC. The RUC Chair, the Chair of the Practice Expense Subcommittee, and the CPT Editorial Panel each hold a non-voting seat on the RUC. A complete list of the RUC composition and specialties that have held rotating seat positions is included as an appendix to this report.

RUC Advisory Committee

The RUC Process is supported by an Advisory Committee of physicians and specialty society staff from each of the 109 national medical specialty societies seated in the AMA House of Delegates. Specialty societies that are not in the House of Delegates also may be invited to participate if the RUC identifies a particular expertise required for physician services under consideration. A special advisory committee of non-MD/DO health care professionals, the HCPAC, is comprised of those professions that independently report their services to Medicare and are paid under the RBRVS methodology. Most of the specialty society and other health care professional representatives are supported by coding and socioeconomic policy committees within their respective organizations. While the role of RUC members is to exercise their judgment independent of their specialties, Advisory Committee members are permitted to advocate of behalf of their specialties. A number of physician advisors attend each RUC meeting regardless of whether their specialty has an issue under review by the RUC. This interest in the RUC process is appreciated by leadership and the

Chair often appoints these individuals to RUC subcommittees, workgroups, and facilitation committees to capitalize on their expertise and interest.

Requests to Revise RUC Composition

The RUC has received a number of requests by individual specialties and coalitions of specialties throughout the past decade to add additional permanent seats to the RUC. The RUC has carefully reviewed each request.

Neurology

In 1997, the American Academy of Neurology petitioned the RUC for a permanent seat, as neurology met each of the criteria. The RUC reviewed original documentation from the creation of the RUC and noted that an assumption had been made that neurology was represented by the American Society of Internal Medicine due to a presumed shared staff contract. Neurology argued that the specialty was not represented by ASIM and should not fall under the umbrella of internal medicine. The RUC agreed with the specialty that neurology was not meaningfully represented by an umbrella organization. The RUC granted the request for a permanent seat to neurology.

Gastroenterology

Gastroenterology first requested a permanent seat on the RUC in 1991 upon formation of the RUC. AMA leadership indicated that since gastroenterology was not one of the 24 Member Boards of ABMS, the AMA could not grant this request. At that time, the gastroenterology community first raised the concern that cardiology was granted a permanent seat, while not being represented on the 24 Member Boards of ABMS. Cardiology, however, far exceeded other RUC membership criteria (e.g., cardiology represents nearly 10% of Medicare physician spending). Gastroenterology was provided the first rotating seat on the RUC from 1991-1994, represented by three different physicians during this period. Beginning in 2002, and continuing through recent years, representatives of gastroenterology have repeatedly requested permanent representation on the RUC. At each request, the RUC has noted that gastroenterology is not one of the 24 Member Boards of ABMS and is also represented by Internal Medicine. The RUC has elected gastroenterology to two additional rotating seat terms (2003-2005, 2007-2009). In addition, representatives of gastroenterology have been valued members on numerous RUC subcommittees and workgroups, including the Five-Year Review Workgroup to review E/M and most recently the Medical Home Workgroup.

Geriatric Medicine

In 1996, the American Geriatrics Society (AGS) requested that geriatric medicine be granted a permanent seat on the RUC. Geriatric Medicine fails to meet many of the criteria for RUC membership, including: not a Member Board of ABMS; less than 1% of practicing physicians; and less than 1% of Medicare physician expenditures. Therefore, the RUC did not grant a permanent seat to geriatric medicine. However, geriatric medicine has been elected by the RUC to serve three terms in a rotating seat position (1995-1997, 2001-2004, and 2006-2008). In addition, representatives of geriatric medicine have been appointed key roles within RUC subcommittees and workgroups. In 2005, while not serving on the RUC, a geriatrician was the Chair of the third Five-Year Review of the RBRVS.

Coalition of Internal Medicine Subspecialties

In 2005, gastroenterology led a coalition of internal medicine subspecialties, including pulmonary medicine and hematology/oncology to petition for permanent seats on the RUC. At that time, the coalition began using the terminology “ABMS-recognized specialty” and presenting a number of arguments from the American Board of Internal Medicine (ABIM), and later ABMS, arguing that each of these specialties were indeed recognized as “specialties.” The RUC explained that the membership criteria, as applied at the beginning of the RUC and adopted by the committee later, referenced the 24 Member Boards of ABMS. If the committee redefined the first criteria to be any specialty “recognized” by ABMS, the RUC size would become unworkable. The RUC did not approved the request to add each of these specialties. Pulmonary Medicine (1999-2001 and 2004-2006) and Hematology/Oncology (1999-2001 and 2005-2007) have each been elected by the RUC for two rotating seat terms.

This coalition of internal medicine specialties was not satisfied with the outcome of the RUC consideration and submitted Resolution 616 to the House of Delegates in June 2005. The resolution requested that the AMA specify that the ABMS specialty criteria be expanded beyond the 24 Member Boards of the ABMS to include both specialties and subspecialties recognized by the ABMS. All testimony, other than from those specialties who authored the resolution, opposed AMA action on this Resolution. At the end of the testimony, one delegate suggested that an AMA informational report on the RUC would be helpful. Board of Trustees Report 5, “The AMA and the Relative Value Update Committee,” was presented and filed at the 2005 Interim Meeting.

Primary Care

The RUC was engaged in an intensive review of the E/M services in late 2005 and early 2006. During that timeframe, MedPAC first raised the issue regarding primary care representation on the RUC. In its March 2006 report to Congress, released after the E/M valuation had been resolved in early February 2006, MedPAC removed recommendations related to the RUC composition from its March 1 Report to Congress. The Chairman of the RUC had informed the Commission that he had asked the RUC to convene an extensive overall review of its composition. MedPAC included a statement in the March report that the Commission would continue to monitor the RUC’s discussions. This discussion led to a comprehensive RUC review of its composition in 2006-2007.

2006-2007 RUC Composition Review

The RUC was designed to be an expert panel, rather than a representative committee. In reviewing the committee’s composition, the RUC first addressed whether the group had the expertise necessary to provide recommendations to CMS on relative values for physician services. A survey of all the specialties in the House of Delegates was conducted in November 2006 and the majority of the respondents indicated that the RUC did have the appropriate expertise. For those indicating that the RUC could benefit from additional expertise, the most common suggestion was to consider one new primary care rotating seat.

The RUC also asked AMA staff to compare the outcome of specialty society recommendations when the specialty was seated on the RUC via a rotating seat versus when the specialty was not seated on the RUC. The analysis provided no consistent pattern regarding success in presenting recommendations to the RUC. In fact, many of the specialty societies were more successful in achieving RUC approval of their recommendations when they were not seated on the RUC.

The RUC reviewed the size of other AMA and AMA/specialty society committees. The RUC has, by far, the largest number of voting members. The RUC has 26 voting members, while AMA Councils have 9-12 members; the CPT Editorial Panel has 17 members; the AMA Board of Trustees has 21 members, and the Physician Consortium for Performance Improvement Executive Committee is comprised of 22 voting members. The RUC is concerned that an increase in the size of the committee would make it unwieldy.

To address the specific concern expressed by MedPAC and several primary care organizations that the RUC increase its primary care representation, the RUC requested AMA staff to analyze Medicare claims data related to E/M services. The RUC reviews individual CPT codes, not payment or income levels of specific specialties or categories of specialties. The most prevalent services provided by primary care physician are E/M services. Therefore, the analysis reviewed each specialty society represented on the RUC to determine what percentage of the specialty's overall Medicare charges related to E/M services. These data were analyzed as observers presumed that RUC members are more likely to provide a favorable review of E/M if the services comprises a large portion of their specialty's payment. Twelve of the 23 specialty society representatives on the RUC receive the majority of their Medicare payments from the provision of E/M services, including: psychiatry, geriatric medicine, emergency medicine, family medicine, internal medicine, pediatric medicine, osteopathic medicine, ophthalmology, neurology, obstetrics/gynecology, otolaryngology, and general surgery. All but three specialties (radiology, anesthesiology, and pathology) receive at least 35% of their Medicare payment from the provision of E/M services. The RUC concluded that the current expertise to review E/M services is sufficient.

Members of the RUC's Administrative Subcommittee continued to advocate consideration of a new primary care rotating seat. The Subcommittee engaged in a two-meeting (April and September 2007) discussion regarding the definition and eligibility requirements for a primary care rotating seat. After the primary care organizations compromised to accept the AMA definition of primary care, the Administrative Subcommittee recommended that the RUC approve the new seat. The proposal would alter the RUC's bylaws, or Structures and Functions, requiring a 2/3 vote of approval. The proposal was not approved. The RUC concluded that its current expertise is sufficient.

DISCUSSION

The extensive summary of the RUC activities to improve valuation of primary care services clearly illustrates that it is not the RUC, nor its composition, that is at issue. Outside observers look to the RUC's published acceptance rates of 95% for new/revised CPT codes and assume that the RUC has absolute influence on the overall relativity within the RBRVS. What these observers fail to understand is that a number of services (e.g., anticoagulant management, telephone services, and care plan oversight) performed by primary care physicians have been articulated and valued by CPT and the RUC, but ignored by CMS. Where the RUC has been successful in defending primary care services (e.g., E/M valuation, immunization administration), it has required years of advocacy to convince CMS to reconsider its policy. Physician work only comprises one-half of the RBRVS; the other one-half is based on practice expense and PLI premium costs and includes a number of flawed CMS assumptions in the underlying methodologies.

The Board of Trustees believes that organized medicine should work together to support the RUC's efforts. Every specialty in the House of Delegates is invited to participate in the RUC process and

1 serve as advocates for their specific specialty. The RUC has been carefully designed to represent
2 the profession, not advocate for specific specialties or coalitions. The ongoing discussion
3 regarding composition only serves as a distraction to ensuring an improved Medicare physician
4 payment system for all physicians.
5
6 As detailed in this report the RUC efforts have had positive impact on E/M services. The increased
7 E/M valuation (45% increase in work valuation since 1992) has had a direct impact on many
8 physician practices. In fact, the American College of Physicians estimates that the most recent
9 RUC recommendations to increase the work valuation of E/M services will result in $5,000 -
10 $10,000 in increased annual Medicare payments to each internist. These increases should also be
11 realized in payment from other health plans that utilize the RBRVS to determine physician
12 payment. However, there are anecdotal reports that some private payers, and even physician
13 groups, have not yet incorporated these changes into their payment and compensation systems.
14 There is work yet to be done to ensure that payers update their systems to be based on the most
15 recent RBRVS.
16
17 Of course, the biggest physician payment challenge remains the flawed Medicare sustainable
18 growth rate (SGR) formula. Although the E/M relative valuation has increased significantly since
19 the inception of the RBRVS, a stagnant conversion factor has mitigated this increase. Relative
20 values may be redistributed throughout the system, but unless the monetary conversion factor
21 keeps pace with the increased cost of running a physician practice, all physicians will suffer.
22
23 RECOMMENDATIONS
24
25 The Board of Trustees recommends that the following recommendations be adopted in lieu of
26 Resolution 124 (A-07), and that the remainder of this report be filed:
27
28 1. That our American Medical Association continue to advocate for the adoption of
29 AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate
30 payment for physician services that do not necessarily require face-to-face interaction with a
31 patient.
32
33 2. That our AMA reaffirm Policies H-400.956, "RBRVS Development," H-400-959, "Refining
34 and Updating the Physician Work Component of the RBRVS," H-400.962, "The
35 AMA/Specialty Society RVS Update Process," H-400.969, "RVS Updating," and H-400.972,
36 "Physician Payment Reform."

Fiscal Note: Continue to advocate for adoption of RUC recommendations and separate additional payment for physician services at an estimated cost of $2,188.

Appendix

COMPOSTITION OF AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE (RUC)

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

Anesthesiology	Geriatric Medicine*	Pathology
Cardiology	Internal Medicine	Pediatrics
Cardiothoracic Surgery	Neurology	Pediatric Surgery*
Dermatology	Neurosurgery	Plastic Surgery
Emergency Medicine	Obstetrics/Gynecology	Psychiatry
Family Medicine	Ophthalmology	Radiology
Gastroenterology*	Orthopaedic Surgery	Urology
General Surgery	Otolaryngology	**Current Rotating Seat*

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

Gastroenterology:	1991-1994, 2003-2005, 2007-2009
Geriatric Medicine:	1995-1997, 2001-2004, 2006-2008
Hematology/Oncology	1999-2001, 2005-2007
Pulmonary Medicine	1999-2001, 2004-2006
Rheumatology:	1997-1999, 2001-2003

"Other" Specialty Rotating Seat (1 seat)

Child Psychiatry:	1997-1999
Nuclear Medicine:	1992-1994
Radiation Oncology:	2001-2003
Pediatric Surgery:	1995-1996, 2007-2009
Spine Medicine	2005-2007
Vascular Surgery	1999-2001, 2003-2005