Resource-Based Relative Value Scale (RBRVS) and AMA/Specialty Society RVS Update Committee (RUC) Process
Medicare RBRVS

The resources required to provide a service is divided into three components:

- Physician work
- Practice expense
- Liability insurance
Components of physician work

Technical skill and physical effort
Mental effort and judgment
Time to perform service
Psychological stress

Data is collected by national medical specialty societies using a standardized survey process.
Components of practice expense

Clinical staff
(nurse, X-ray technician, etc)

Medical supplies
(gloves, syringes, etc)

Medical equipment
(exam table, CT scanner, etc)
Professional liability

• Costs are driven by the professional liability insurance premiums of the specialties that perform a service and the risk of the service.

• The risk of the service proxy to determine PLI RVUs is the physician work RVU.
Calculating payment: Step 1

\[
(WORK \times RVU) + (PE \times RVU) + (PLI \times RVU) = TOTAL \text{ RVU}
\]
Calculating payment: Step 2

Conversion factor (CF) is a monetary payment determined by Medicare each year. The CF for 2023 = $33.8872
RUC overview

• The RUC is an independent group of volunteer physicians exercising its First Amendment Right to petition the federal government.

• The RUC is comprised of 32 members, 29 voting members (18 of these 29 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).

• The RUC is an expert panel. Individuals exercise their independent judgment and are not advocates for their specialty.
RUC methodology

• RUC’s cycle for developing recommendations is closely coordinated with both the schedule for annual CPT code revisions and CMS’s schedule for annual updates in the Medicare payment schedule.

• CPT® Editorial Panel meets three times a year to consider coding changes for the next year’s edition. CMS publishes the annual update to the Medicare RVS in the Federal Register every year.

• The median number of survey respondents for a RUC survey is 70. Surveys for high volume services have more than 100 physician respondents. The RUC uses extant data (STS and NSQIP).
RUC composition

RUC Chair*
American Medical Association
CPT Editorial Panel*
Practice Expense Subcommittee*
Health Care Professionals Advisory Committee

Anesthesiology  Neurosurgery  Plastic Surgery
Cardiology  Obstetrics/Gynecology  Psychiatry
Cardiothoracic Surgery  Ophthalmology  Radiology
Dermatology  Orthopaedic Surgery  Urology
Emergency Medicine  Osteopathic Medicine
Family Medicine  Otolaryngology
General Surgery  Pathology
Geriatric Medicine  Pediatrics
Internal Medicine  Physical Medicine & Rehabilitation
Neurology

*Indicates a non-voting seat
RUC subcommittees and workgroups

Administrative Subcommittee
Primarily charged with the maintenance of the RUC’s procedural issues

Relativity Assessment Workgroup
Oversees the process of identification of potentially misvalued services

Multi-Specialty Points of Comparison (MPC) Workgroup
Charged with maintaining the list of codes used to compare relativity of codes under review to existing relative values
RUC subcommittees and workgroups

Practice Expense Subcommittee
Reviews direct practice expenses (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of practice expense relative values

Professional Liability Insurance (PLI) Workgroup
Reviews and suggests refinements to Medicare’s PLI relative value methodology

Research Subcommittee
Primarily charged with development and refinement of RUC methodology
RUC Advisory Committee

• One physician representative is appointed from over 120 specialty societies seated in the AMA House of Delegates.

• Advisory Committee members assist in the development of RVUs and present their specialties’ recommendations to the RUC.

• Each member comments on recommendations made by other specialties.

• Advisory Committee members are supported by an internal specialty RVS committee.
Health Care Professionals Advisory Committee (HCPAC) overview

• The HCPAC allows for the participation of limited license practitioners and allied health professionals in the RUC process.

• The professionals represented on the HCPAC use CPT to report the services they provide independently to Medicare patients, and they are paid for these services based on the RBRVS physician payment schedule.

• The HCPAC recommendations are sent directly to CMS.
HCPAC composition

- Audiologists
- Chiropractors
- Dieticians
- Nurses
- Occupational Therapists
- Optometrists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychologists
- Social Workers
- Speech Pathologists
Why RUC is important: A balanced system

Government retains oversight and final decision-making authority

Volunteer physicians provide invaluable expertise on complex medical procedures
RUC process

The RUC multi-stakeholder and transparent processes are difficult to replicate.

- Evidence-based
- Deliberation-driven
- Well-defined criteria
- Clinical expertise
- 3 meeting per year
- Thousands of volunteers
- Hundreds of participants at each meeting
- Content represents input from the full House of Medicine

<table>
<thead>
<tr>
<th>CPT Editorial Panel</th>
<th>RUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 members appointed by AMA BOT</td>
<td>32 members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Specialists</th>
<th>Industry. Manufacturers, Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experts from hundreds of specialties</td>
<td>Companies bringing emerging technology to market</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Standing Advisory Groups</th>
<th>Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molecular Pathology, Vaccines</td>
<td>CMS, AHIP, Blue Cross</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Specialists</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experts from the House of Medicine</td>
<td>Input from the Centers for Medicare &amp; Medicaid Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standing Subcommittee</th>
<th>Health Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Expense, Research, Administrative</td>
<td>Clinical experts from the non-physician fields</td>
</tr>
</tbody>
</table>
RUC is a transparent process

RUC meetings are open to anyone who registers to attend.

- More than 300 individuals attend each RUC meeting including:
  - Physicians
  - Specialty society staff
  - Representatives from non-MD/DO health care professions
  - CMS representatives and other government representatives
  - Researchers
  - International delegations
  - Other interested parties

- Published on the web for greater visibility:
  - RUC meeting dates and locations
  - The vote total for each individual CPT® code
  - Minutes of each meeting

www.ama-assn.org/go/rbrvs
2025 cycle for CPT® code set and RUC recommendations

<table>
<thead>
<tr>
<th>CPT code set</th>
<th>CPT public agenda</th>
<th>CPT meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT code application submission deadline</td>
<td>Dec. 2, 2022</td>
<td>Feb. 2-4, 2023</td>
</tr>
<tr>
<td>Nov. 2, 2022</td>
<td>Feb. 6, 2023</td>
<td>May 4-6, 2023</td>
</tr>
<tr>
<td>Jun. 14, 2023</td>
<td>Jul. 14, 2023</td>
<td>Sep. 21-23, 2023</td>
</tr>
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<table>
<thead>
<tr>
<th>RUC</th>
<th>Surveys available to specialty societies</th>
<th>RUC agenda available</th>
<th>RUC meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 20, 2023</td>
<td>Apr. 5, 2023</td>
<td>Apr. 26–29, 2023</td>
<td></td>
</tr>
<tr>
<td>May 22, 2023</td>
<td>Aug. 30, 2023</td>
<td>Sep. 27–30, 2023</td>
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</table>

CPT codes and RUC recommendations for 2024 are made public in the CMS Medicare Payment Schedule Proposed Rule July 2023
CPT® and RUC collaboration to ensure appropriate coding

• RUC’s ongoing review of claims data helps to ensure that codes are described clearly:
  • **Utilization of services:** Examine unexpected increases in volume
  • **Specialties performing:** Review codes when unexpected specialties are reporting
  • **Site-of-service:** Review codes where unexpected site-of-service is in claims
  • **Billed Together Data:** How often CPT codes are reported with other services on the same date
  • **Medicare Provider utilization and payment data:** Physician and Other Supplier

• The RUC will work with the CPT® Editorial Panel to revise:
  • CPT guidelines
  • CPT code descriptors
  • CPT parentheticals, or
  • Develop CPT® Assistant articles for clarification on correct reporting
CPT 1993–2022 RUC recommendations

- CMS releases a Proposed Rule in July and conducts a 60-day comment period
- CMS publishes a Final Rule in November
- CMS’s acceptance rate is typically more than 90% annually
RUC meeting
# RUC practice expense spreadsheet

<table>
<thead>
<tr>
<th>RUC Practice Expense Spreadsheet</th>
<th>Reference Code</th>
<th>Current Code</th>
<th>Recommended Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Activity Code</strong></td>
<td><strong>Clinical Staff Type Code</strong></td>
<td><strong>Clinical Staff Type</strong></td>
<td><strong>Clinical Staff Type Rate Per Minute</strong></td>
</tr>
<tr>
<td><strong>LOCATION</strong></td>
<td>Non Fac</td>
<td>Facility</td>
<td>Non Fac</td>
</tr>
<tr>
<td><strong>GLOBAL PERIOD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>TOTAL CLINICAL STAFF TIME</strong></td>
<td>LS7D</td>
<td>RLWLMITA</td>
<td>0.413</td>
</tr>
<tr>
<td><strong>TOTAL PRE-SERVICE CLINICAL STAFF TIME</strong></td>
<td>LS7D</td>
<td>RLWLMITA</td>
<td>0.413</td>
</tr>
<tr>
<td><strong>TOTAL SERVICE PERIOD CLINICAL STAFF TIME</strong></td>
<td>LS7D</td>
<td>RLWLMITA</td>
<td>0.413</td>
</tr>
<tr>
<td><strong>TOTAL POST-SERVICE CLINICAL STAFF TIME</strong></td>
<td>LS7D</td>
<td>RLWLMITA</td>
<td>0.413</td>
</tr>
<tr>
<td><strong>TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>PRE-SERVICE PERIOD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CA001</strong></td>
<td>Complete pre-service diagnostic and referral forms</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA002</strong></td>
<td>Coordinate pre-surgery services (including test results)</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA003</strong></td>
<td>Schedule space and equipment in facility</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA004</strong></td>
<td>Provide pre-service education/obtain consent</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA005</strong></td>
<td>Complete pre-procedure phone calls and prescription</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA006</strong></td>
<td>Confirm availability of prior images/studies</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA007</strong></td>
<td>Review patient record, extend information and questionnaire</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA008</strong></td>
<td>Perform regulatory mandated quality assurance activity (pre-service)</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA009</strong></td>
<td>Other activity, please include short clinical description here and type</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>End:</strong> When patient enters office/facility for surgery/procedure</td>
<td></td>
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<tr>
<td><strong>SERVICE PERIOD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Start:</strong> When patient enters office/facility for surgery/procedure:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service (of service period)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CA009</strong></td>
<td>Greet patient, provide gowning, ensure appropriate medical records are</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA010</strong></td>
<td>Obtain vital signs</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA011</strong></td>
<td>Provide education/obtain consent</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA012</strong></td>
<td>Review requisition, assess for special needs</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA013</strong></td>
<td>Prepare room, equipment and supplies</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
<tr>
<td><strong>CA014</strong></td>
<td>Confirm order, protocol exam</td>
<td>LS7D</td>
<td>RLWLMITA</td>
</tr>
</tbody>
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Summary of recommendations (SOR) form
Potentially misvalued services project

• To provide Medicare with reliable data on how physician work has changed over time, RUC is examining over 2,600 potentially misvalued medical services, accounting for $45 billion in Medicare spending.

• To date, RUC has recommended reductions and code deletions to over 1,500 services, redistributing over $5 billion annually.

• To date, 98% of the Medicare physician payment schedule has been reviewed by the RUC.
Potentially misvalued services project

- Codes under Review, 96, 4%
- Deleted, 497, 18%
- Decreased, 1,089, 41%
- Increased, 322, 12%
- Reaffirmed, 674, 25%
Update for evaluation & management (E/M)

• New coding and guidelines framework for evaluation and management office visits for 2021 and most other E/M families in 2023.

• Decrease administrative burden of documentation and coding.

• Decrease the need for audits, through the addition and expansion of key definitions and guidelines.

• Decrease unnecessary documentation in the medical record that is not needed for patient care.
RUC review of valuation of office visits

• 51 national medical specialty societies and other health care professional organizations surveyed the revised codes to measure physician time, work, and direct practice costs (nursing staff time, supplies, equipment). 1,700 physicians responded to the survey.

• The surveying specialties analyzed the data and presented recommendations to the RUC meeting of April 24–27, 2019. RUC recommendations were submitted to CMS in May 2019.

• In the CY2020 Medicare Physician Fee Schedule proposed rule, CMS announced their decision to implement the new CPT® framework and RUC-recommended valuation on January 1, 2021.

• Detailed information is also available at www.ama-assn.org/cpt-office-visits.
Medicare payment for office visits in 2021

• Medicare payment for office visits increased, on average, by 13% in 2021

• CPT® Code 99213 increased from $75 in 2019 to $92 in 2021

• Medicare requires budget neutrality resulting in redistribution. For example, CMS announced that the changes resulted in a 12% increase to family medicine and an 8% decrease to radiology.
More information

Department of Physician Payment Policy & Systems

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www.ama-assn.org/go/rbrvs
Physicians’ powerful ally in patient care