



AMA/Specialty Society RVS Update Committee

An overview of the RUC process



AMA/Specialty Society RVS Update Committee

A process-driven collaboration that delivers the physician perspective

When Medicare transitioned to a physician payment system based on the resource-based relative value scale (RBRVS), the American Medical Association, anticipating the effects of this change, formulated a multi-specialty committee. This committee, known as the **AMA/Specialty Society RVS Update Committee (RUC)**, provides medicine with a powerful voice in describing the resources required to provide physician services.

Since 1991 the RUC has submitted numerous recommendations to the Centers for Medicare & Medicaid Services (CMS) that enhance the underlying data used to create relative values units (RVUs). The RUC, in conjunction with the Current Procedural Terminology (CPT) Editorial Panel, has created a process where specialty societies can develop relative value recommendations for new, revised and potentially misvalued codes as well as update RVUs to reflect changes in medical practice.

Through its unique structure, the RUC has created the best possible advocate for physician payment: physicians. It is the work of these dedicated physicians who contribute their time, energy and knowledge that make the RUC process a success that benefits all practicing physicians and care delivery.

Introduction to Medicare RBRVS

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

The **physician work component** accounts for an average of 50.9% of the total relative value for each service. The initial physician work relative values were based on the results of a Harvard University study. The factors used to determine physician work include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice.

The **practice expense component** of the RBRVS accounts for an average of 44.8% of the total relative value for each service. Practice expense relative values were initially based on a formula using average Medicare approved charges from 1991 (the year before the RBRVS was implemented) and the proportion of each specialty's revenues that is attributable to practice expenses. However, in January 1999, CMS began a transition to *resource-based* practice expense relative values for each CPT code that differs based on the site of service. In 2002, the resource-based practice expenses were fully transitioned.

On Jan. 1, 2000, CMS implemented the resource-based **professional liability insurance** (PLI) relative value units. The PLI component of the RBRVS accounts for an average of 4.3% of the total relative value for each service. With this implementation and final transition of the resource-based practice expense relative units on Jan. 1, 2002, all components of the RBRVS are resource-based.

The RUC, the CPT Editorial Panel and the RVS updating process

Annual updates to the physician work relative values are based on recommendations from a committee involving the American Medical Association and national medical specialty societies. This committee, **the RUC**, was formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised codes in the *Current Procedural Terminology* (CPT) book. Over 10,000 procedure codes are defined in CPT, and the relative values in the RBRVS were originally developed to correspond to the procedure definitions in CPT.

CPT is maintained by the CPT Editorial Panel. This 21-member panel is authorized to revise, update or modify CPT. Nineteen of the seats on the CPT Editorial Panel are held by physicians. These physician seats are nominated by wide range stakeholder organizations including, national medical specialty societies, the Blue Cross and Blue Shield Association, America’s Health Insurance Plans and the American Hospital Association among others. Two members of the CPT Editorial Panel represent HCPAC, an advisory committee representing non-MD/DO health professionals, and serve among the 19 physician-appointed seats. The coding system is updated annually (including addition of new codes, deletion of codes that are no longer used, and revisions in procedure descriptions) to ensure that it accurately reflects current medical practice. Changes in CPT necessitate annual updates to the RBRVS for the new and revised codes.

The RUC represents the entire medical profession, with 22 of its 32 members appointed by major national medical specialty societies including those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for high percentages of Medicare expenditures. Four seats rotate on a two-year basis, one seat reserved for a primary care representative, two reserved for an internal medicine subspecialty and the remaining seat is open to any other specialty society not a member of the RUC, except internal medicine subspecialties or primary care representatives. The RUC chair, the co-chair of the RUC’s HCPAC Review Board, the chair of the Practice Expense Subcommittee and representatives of the American Medical Association, the American Osteopathic Association and the CPT Editorial Panel hold the remaining six seats.

Composition of the AMA/Specialty Society RVS Update Committee

Chair*

American Medical Association

CPT Editorial Panel*

Health Care Professionals Advisory Committee

Practice Expense Subcommittee*:

Anesthesiology	Geriatric medicine	Orthopaedic surgery	Plastic surgery
Cardiology	Internal medicine	Osteopathic medicine	Primary care
Cardiothoracic surgery	(Two rotating seats)	Otolaryngology	(One rotating seat)
Dermatology	Neurology	Pathology	Psychiatry
Emergency medicine	Neurosurgery	Pediatrics	Radiology
Family medicine	Obstetrics/gynecology	Physical medicine and rehabilitation	Urology
General surgery	Ophthalmology		Other specialty
			(One rotating seat)

*Indicates non-voting seats

Advisory Committee

One physician representative is appointed from *each* of the approximately 125 specialty societies seated in the AMA House of Delegates to serve on the Advisory Committee to the RUC. Specialty societies that are not in the House of Delegates also may be invited to participate in developing relative values for coding changes of particular relevance to their members. Advisory Committee members designate an RVS Committee for *their* specialty, which is responsible for generating relative value recommendations using a survey method developed by the RUC. Specialty society advisors attend the RUC meeting and present their societies' recommendations, which the RUC evaluates. Specialties represented on both the RUC and the Advisory Committees are required to appoint *different* physicians to each committee to distinguish the role of advocate from that of evaluator.

Practice expense refinement

The AMA continues to participate and monitor all phases of the refinement of the practice expense relative values and continues to advocate that they be based on valid physician practice expense data. Since there is not a single universally accepted cost allocation methodology, it is especially important that CMS base its methodology on actual practice expense data. The decisions reached by CMS have enormous implications for physicians and all their patients, not just those on Medicare. Since many other payment systems use the Medicare RBRVS, the change to resource-based practice expense relative values has broad implications for the entire health care system.

Due to the significance of this issue, the RUC established a special subcommittee called the Practice Expense Advisory Committee (PEAC) to monitor this process. The PEAC was charged with the review of direct expense inputs (clinical labor activities, medical supplies and equipment) used to calculate practice expense relative values and made code-specific recommendations to the RUC. The RUC then made the final recommendation to CMS. The PEAC reviewed the practice expense inputs of essentially the entire Medicare Payment Schedule by submitting recommendations for more than 6,500 medical procedures. The composition of the PEAC mirrored the RUC with additional representation from nursing. The PEAC review process was similar to the RUC process, relying on specialty societies to make recommendations that were reviewed by a panel of medical experts and then forwarded to CMS. While the PEAC concluded its work in March 2004, the RUC continues to work closely with specialty societies and CMS to maintain the practice expense component of the RBRVS. The RUC, through its current Practice Expense Subcommittee, addresses any practice expense policy issues that arise. The Practice Expense Subcommittee also assists the RUC in its review of practice expense inputs for new and revised codes and codes identified through the relativity assessment process or by CMS.

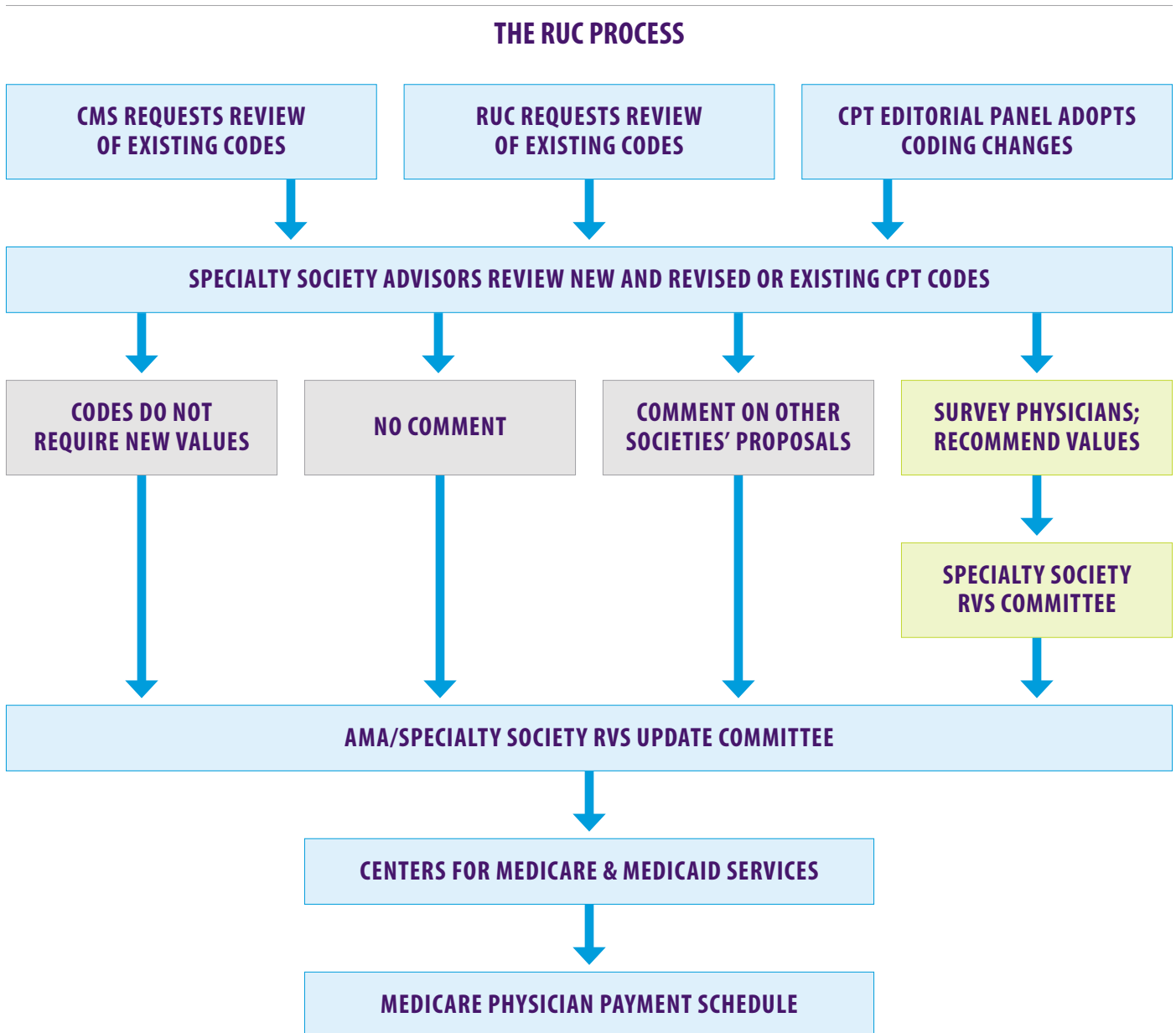
RUC Health Care Professionals Advisory Committee (HCPAC)

The HCPAC was formed to allow for participation of limited license practitioners and allied health professionals in the RUC process. The 12 organizations seated on the HCPAC represent physician assistants, chiropractors, nurses, occupational therapists, optometrists, physical therapists, podiatrists, psychologists, audiologists, speech pathologists, social workers and registered dietitians. All of these professionals 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 members together with three physician members of the RUC comprise the RUC HCPAC Review Board, which is responsible for developing relative value recommendations which are submitted to CMS for new, revised and potentially misvalued codes that are reported principally by non-MD/DO professionals. The co-chair of the HCPAC Review Board also serves as a member of the RUC.

RUC review process: Methodology and time cycle

The RUC's annual cycle for developing recommendations is closely coordinated with both the CPT Editorial Panel's schedule for annual code revisions and CMS's schedule for annual updates in the Medicare Payment Schedule. The CPT Editorial Panel meets three times a year to consider coding changes for the next year's edition. The RUC meets *after* the CPT Editorial Panel meetings to consider relative value codes that are changed or added by the Editorial Panel.

CMS publishes the annual update to the Medicare RVS in the *Federal Register* every year, at about the same time the AMA publishes the new *CPT* book for the coming year. The updated CPT codes and relative values go into effect annually on Jan. 1. Due to the close coordination between RUC and CPT and the timely submission of recommendations to CMS, physicians have the benefit of organized medicine's input into relative values for new codes in the same year that the coding changes appear in CPT.



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

- **Step 1.** The CPT Editorial Panel's new or revised codes and CMS and RUC identified potentially misvalued services are transmitted to the RUC staff, who then prepare a "Level of Interest" form. This form summarizes the panel's coding actions and specific CMS requests.
- **Step 2.** Members of the RUC Advisory Committee and specialty society staff review the summary and indicate their societies' level of interest in developing a relative value recommendation. The societies have several options: (1) they can survey their members to obtain data on the amount of work involved in a service and develop recommendations based on the survey results; (2) they can comment in writing on recommendations developed by other societies; (3) in the case of revised codes, they may decide that the coding change does not require action because it does not significantly alter the nature of the service; or (4) they may take no action because the codes are not used by physicians in their specialty.
- **Step 3.** AMA staff distributes survey instruments for the specialty societies. The societies are required to survey at least 30 practicing physicians. The RUC survey instrument asks physicians to use a list of 10 to 20 services as reference points that have been selected by the specialty RVS committee. Physicians receiving the survey are asked to evaluate the work involved in the new, revised or potentially misvalued code relative to the reference points. The survey data may be augmented by analysis of Medicare claims data and information from other studies of the procedure, such as the Harvard RBRVS study.
- **Step 4.** The specialty RVS committees conduct the surveys, review the results and prepare their recommendations to the RUC. When two or more societies are involved in developing recommendations, the RUC encourages them to coordinate their survey procedures and develop a consensus recommendation. The written recommendations are disseminated to the RUC before the meeting and consist of physician work, time and practice expense recommendations.
- **Step 5.** The specialty advisors present the recommendations at the RUC meeting. The RUC Advisory Committee members' presentations are followed by a thorough question-and-answer period during which the specialty advisors must defend every aspect of their proposal(s).
- **Step 6.** The RUC may decide to adopt a specialty society's recommendation, refer it back to the specialty society or modify it before submitting it to CMS. Final recommendations to CMS must be adopted by a two-thirds majority of the RUC members. Recommendations that require additional evaluation by the RUC are referred to a Facilitation Committee.
- **Step 7.** The RUC's recommendations are forwarded to CMS. CMS medical officers and contractor medical directors review the RUC's recommendations.
- **Step 8.** The Medicare Physician Payment Schedule, which includes CMS's review of the RUC recommendations, proposals are published in July and finalized in November each year.

Annual RBRVS updates and new, revised and potentially misvalued CPT codes (1993–2024)

The RUC has submitted over 7,700 relative value recommendations for new, revised and potentially misvalued codes for the 1993–2024 RBRVS annual updates. In addition, the RUC submitted approximately 402 recommendations to CMS for carrier priced or non-covered services, including preventive medicine visits.

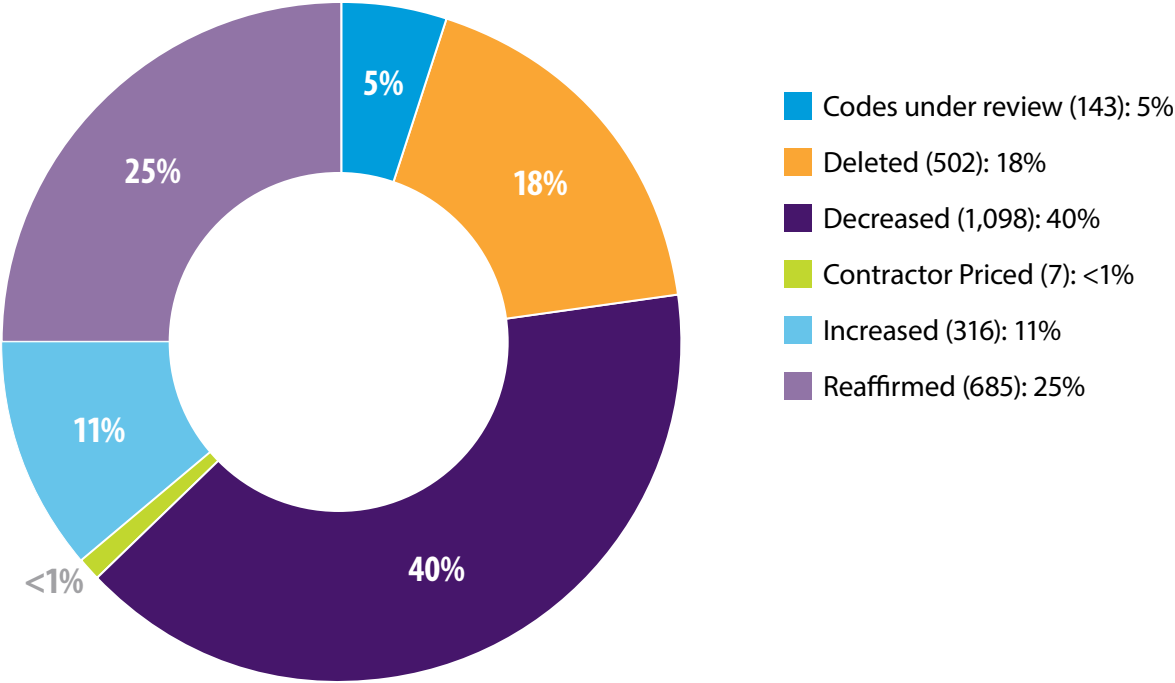
A major reason for evaluating these codes using the RBRVS system is the widespread adoption of the Medicare payment system by state Medicaid programs and other insurance programs covering pediatric populations. Each year CMS considers these recommendations when establishing values for new or revised CPT codes. CMS's acceptance rate for the RUC's recommendations is typically more than 90% annually.

Relativity Assessment Workgroup, and its work reviewing potentially misvalued services

In 2006 the RUC formed the Relativity Assessment Workgroup to identify potentially misvalued services using objective mechanisms for reevaluation. In addition, the workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of “new technology” services. The workgroup was established by the RUC following comments from the Medicare Payment Advisory Commission urging CMS to demonstrate greater diligence in the identification of both potentially over- and under-valued services within the payment schedule for review during the five-year reviews.

The RUC has identified over 2,750 potentially misvalued services through objective screening criteria. The RUC has recommended that over half of the services identified be decreased or deleted (Chart 1). Overall, the RUC has reviewed approximately 95% of the Medicare Physician Payment Schedule allowed charges. Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges.

CHART 1. RUC POTENTIALLY MISVALUED SERVICES PROJECT
(total number of codes in project = 2,751)



The RUC has worked vigorously over the past several years to identify and address misvaluations in the RBRVS through provision of revised physician time data and resources cost recommendations to CMS. The RUC fully acknowledges that there are services that are now performed more efficiently and these codes have been or will be addressed. For example, the time and valuation for cataract surgery was significantly reduced in 2013 and again in 2020. The RUC’s efforts for 2009–2024 have resulted in more than \$5 billion in annual redistribution within the Medicare Physician Payment Schedule.

The Relativity Assessment Workgroup continues to identify and review services

The workgroup's identification screening process to date includes:

- Bundled CPT services—services often billed together
- Site-of-service anomalies—services with site of service shifts (i.e., services that were typically in the inpatient setting and are now typically performed in the outpatient setting or physician office)
- Harvard-valued—services performed over 30,000 times a year that still have the original Harvard established value
- CMS/other source—services performed over 20,000 times a year that were not reviewed by either Harvard or the RUC, but are assigned by CMS
- Services surveyed by one specialty but are now predominantly performed by a different specialty
- High-volume growth—services with a utilization increase of 100% or more in a five-year period
- High Intra-service Work Per Unit of Time (IWPUT)—services with high intensity relative to other services
- Negative Intra-service Work Per Unit of Time (IWPUT)—services with negative intensity for the intra-service period per minute, indicating possible misvaluation
- High Level E/M in Global Period—services with all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period
- Services with low work RVUs that are billed in multiple units per patient
- Services with low work RVUs that have high utilization
- Services identified on the RUC Multi-Specialty Points of Comparison (MPC) List—a list of common services performed by specialties and used for comparison during the RUC survey process
- High expenditure procedural codes—codes under the Medicare Physician Payment Schedule that have not been reviewed in the last five years with the highest payments per specialty
- Services with stand-alone PE time—codes with PE time assumptions not based on physician time
- Pre-service time analysis—codes with pre-service time greater than the standard pre-service time package 4 *Facility-Difficult Patient/Difficult Procedure* (63 minutes)
- Post-operative visits—010 and 090-day global period services with more than six post-operative office visits
- 000-Day Global Services Reported with an E/M with Modifier 25—services with a 000-day global period billed with an E/M 50% of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000
- Contractor-priced high volume—contractor-priced Category I CPT codes performed over 10,000 times a year
- CPT Modifier -51 Exempt—services on the services on the CPT Modifier -51 *Multiple Procedures* exempt list performed over 10,000 times a year
- High Volume Category III codes—Category III CPT codes with Medicare utilization over 1,000
- PE Units Screen—services with more than 1 median unit of service reported and direct practice expense supply item unit cost greater than \$100

RBRVS five-year review and update process

In addition to annual updates reflecting changes in CPT, Section 1848(C)(2)(B) of the Omnibus Budget Reconciliation Act of 1990 requires CMS to comprehensively review all relative values at least once every five years and make any needed adjustments. The success of the RUC's role in the annual updates led CMS to seek assistance from the RUC in each of the four five-year review processes. The changes resulting from the four RBRVS five-year reviews became effective in January of 1997, 2002, 2007 and 2012.

Each five-year review presented an unprecedented opportunity to improve the accuracy of the physician work component of the RBRVS, as well as a significant challenge to the medical community. All codes on the Medicare Physician Payment Schedule were open for public comment as part of each mandatory five-year review. The initial five-year review included the development of relative values for pediatric services. The Social Security Amendments Act of 1994 required that RVUs be developed for the full range of pediatric services, as well as determining whether significant variations existed in the work required to furnish similar pediatric patient services.

During the public comment period for the initial five-year review, CMS received nearly 500 letters identifying about 1,100 CPT codes for review. The Carrier Medical Directors, the American Academy of Pediatrics (AAP) and special studies conducted for three specialty societies identified additional codes for review. Following an initial review in late February 1995, CMS referred to the RUC comments on about 3,500 codes.

The second five-year review was initiated in March 2000 when CMS shared comments submitted by 30 specialties on more than 870 codes. The third five-year review began in February 2005 when CMS provided public comments from 44 specialty societies related to 556 codes. In addition, CMS requested that the RUC review an additional 168 codes, selected principally because they were high-volume codes that had not been reviewed since the initial implementation of the RBRVS in 1992.

The fourth five-year review began with the request for public comment from CMS in the November 2009 *Federal Register*. As a result of this solicitation, 290 codes were identified by specialties and CMS to be reviewed in the 2010 five-year review process. In October 2010 and February 2011, all RUC recommendations were submitted to CMS for consideration, with resulting changes effective Jan. 1, 2012.

The RUC is committed to improving and maintaining the validity of the RBRVS over time. Through the RUC, the AMA and the specialty societies have worked aggressively to identify and correct flaws and gaps in the RBRVS. The RUC will continue to review all services considered to be inappropriately valued. **CMS now calls for public comments on an annual basis, rather than in a five-year review**, as part of the comment process on the Medicare Physician Payment Schedule each year. Public nominations must be submitted no later than February 10th of each year.

The value, history and work of the AMA/Specialty Society RVS Update Committee (RUC)

The RUC is a unique multi-specialty committee dedicated to making relative value recommendations for new, revised, and potentially misvalued codes as well as updating RVUs to reflect changes in medical practice. The RUC carefully reviews survey data presented by specialty societies and develops recommendations for consideration by CMS. Since its formation in 1991, the RUC has achieved many noteworthy accomplishments, including:

- **May 1992:** The RUC considered the first relative value recommendation from a specialty society. The American College of Obstetricians and Gynecologists, the Society of Interventional Radiology, and the American College of Radiology presented a work RVU recommendation for CPT code 58345 *Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography*. CMS accepted this first recommendation. This action was the beginning of a meaningful working relationship with CMS that has resulted in a typical annual acceptance rate of over 90% for RUC recommendations.
- **January 1997:** The RUC participated in the first five-year review of the RBRVS, a process dedicated to reviewing the practice expense and work RVUs associated with the entire Medicare Relative Value Scale (RVS). The RUC submitted more than 1,000 CPT codes, including increases to the evaluation and management (E/M) services. CMS did not fully accept the E/M increase in 1997 and the RUC would pursue this recommendation again for implementation in 2007. CMS accepted 95% of the RUC's recommendations for all services, which included RVU changes to 400 codes.
- **March 2004:** The RUC assumed the responsibility of correcting flawed Medicare data by creating a subcommittee called the Practice Expense Advisory Committee (PEAC) in November 1998. It was the PEAC's charge to review the practice expense inputs (clinical staff, medical supplies and equipment) of existing codes. In March 2004, the PEAC successfully completed its review and refinement of direct practice expense inputs for 6,500 CPT codes.
- **January 2007:** Improvements to work relative values for E/M services were implemented as a result of the RUC's efforts in the third five-year review of the RBRVS.
- **April 2008:** The RUC submitted work relative value and direct practice expense input recommendations to CMS on the Medicare Medical Home Demonstration project.
- **January 2009:** CMS implements the first RUC recommendation resulting from the RUC's Relativity Assessment Workgroup to identify misvalued physician services. To date, over 2,700 physician services have been examined, leading to more than \$5 billion in annual redistribution within the Medicare Physician Payment Schedule.
- **January 2013:** CMS implements RUC recommendations and begins payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home. In 2022, these codes were provided 1.2 million times, representing \$282 million in Medicare spending.
- **January 2015:** The RUC and CPT Editorial Panel continue their initiative to address payment for non face-to-face services and Medicare announced it will pay for monthly care management services. CPT code 99490 is designed to capture non-face-to-face services for all patients receiving 20 minutes or more of clinical staff management time to address multiple, significant (two or more) chronic conditions. This code was reported over 4.7 million times in 2022 with \$292 million in Medicare spending.

- September 2020:** Due to the COVID-19 pandemic public health emergency (PHE), practices incurred significant costs to maintain safe offices, particularly in implementing specific infection control measures related to screening patients, purchasing personal protective equipment (PPE), and implementing office redesign measures to ensure social distancing. To address these costs, the RUC requested that CMS provide new funding and payment to assist physicians and QHPs for ongoing costs during the PHE. The RUC received survey responses from 50 national medical societies and other health care professional organizations, analyzing more than 800 invoices on the additional direct practice expenses incurred during the PHE. The CPT Editorial Panel created and the RUC recommended CMS implement relative values and payment for CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease*. During the COVID pandemic, the RUC submitted recommendations for over 50 immunization administration codes.
- January 2021:** For 2021, CMS finalized a decision to implement historic changes to coding and payment of E/M office visits. These changes adopt the CPT Editorial Panel changes to the E/M office visit CPT codes (99201-99215) code descriptors, and documentation guidelines that directly address administrative burden by simplifying the reporting and documentation process. Changes include allowing physicians to choose whether their documentation is based on medical decision-making or total time on the date of the encounter. In addition, CMS also adopted the RUC recommendations to increase the valuation of the office visits on Jan. 1, 2021. For more details visit www.ama-assn.org/cpt-office-visits. In 2023, the RUC recommended and CMS implemented similar revisions and valuation improvements to other E/M visit code sets, including inpatient and observation visits, ED visits, nursing facility visits, and home visits.

HISTORY OF RUC RECOMMENDATIONS

Year	Recommendations submitted (number of CPT® Codes)	Work relative values 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%
CPT 2006	283	97%
CPT 2007	254	98%
CPT 2008	266	100%
CPT 2009	233	97%
CPT 2010	216	98%
CPT 2011	292	82%*
CPT 2012	328	87%
CPT 2013	363	90%
CPT 2014	265	76%
CPT 2015	350	86%
CPT 2016	278	78%
CPT 2017	200	85%
CPT 2018	275	100%
CPT 2019	182	80%
CPT 2020	301	79%
CPT 2021	154	77%
CPT 2022	185	77%
CPT 2023	206	80%
CPT 2024	87	97%
First five-year review (1997)	1118	96%
Second five-year review (2002)	870	98%
Third five-year review (2007)	751	97%
Fourth five-year review (2012)	290	75%

* CMS applied a budget neutrality adjustment for additional services in a way contrary to the RUC recommendations.

More information

Visit our website: <http://www.ama-assn.org/go/rbrvs>

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