

AMA/Specialty Society RVS Update Committee

The RUC is...	The RUC is <u>NOT</u> ...
an independent group exercising its First Amendment Right to petition the federal government.	an advisory committee to the Centers for Medicare and Medicaid Services (CMS). CMS is entirely responsible for the RBRVS. <u>All</u> modifications to the RBRVS are made through rulemaking and open to public comment.
<p>comprised of 29 members, 26 voting members (14 of these 26 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M* services).</p> <p>*Based on 2005 Medicare Claims Data and Medicare's BETOS E/M Classification. Includes distinct E/M reporting and visits bundled into 010 and 090 day global period services.</p>	dominated by proceduralists who do not understand the challenges faced by primary care physicians. Nearly all physician specialties report E/M services and understand the work involved. The RUC has recommended substantial increases to E/M each time the codes have been submitted for review. The RUC also requires expertise to review more than 7,000 non-E/M services reported in CPT. Example: a neurosurgeon on the RUC may be the one best able to criticize a proposal from cardiothoracic or orthopaedic surgery.
an expert panel. Individuals exercise their independent judgment and are <u>not</u> advocates for their specialty.	a political, representative committee. The RUC relies on socioeconomic expertise and objectivity. A common misperception is that members of the RUC vote en bloc. <u>This is not true.</u> The RUC requires a 2/3 vote (18 out of 26) to submit a recommendation to CMS. These votes are confidential and reviewed only by AMA staff. RUC members have voted against their own specialty's recommendations when they thought those recommendations were inappropriate. The AMA staff (who can see how individual RUC members vote) observe that voting does not usually align in blocs, and that voting often is contrary to the apparent self-interest of individual RUC members..
supported by an Advisory Committee of 100 specialty societies and health care professional organizations who collect data and formally present recommendations to the RUC. Advisory Committee members, not individual RUC members, are the advocates for their specialties.	a closed process. The RUC Chairman accepts requests for attendance at each meeting, including MedPAC staff, GAO staff, and international delegations. However, the RUC has a strict conflict of interest policy and does not want the influences of industry involved in the process. The RUC looks to each specialty society to provide accurate time and survey data. An attestation statement of accuracy and potential conflict of interest is now required of each advisor presenting to the RUC.
inclusive of all health care professionals. Non-MD/DOs (eg, nursing, podiatry, physical therapy) have an advisory committee, one voting seat on the RUC, and participate on RUC Subcommittees. The most recent Chair of the PE Subcommittee is the representative from the American Nurses Association.	interested or involved in scope of practice issues. The RUC understands its responsibility to be open and fair to all health care professionals who independently bill the Medicare program under the Fee Schedule. While some very real scope of practice issues exist between specialty societies and health care professional organizations involved in the RUC process, these discussions are not permitted at RUC meetings.

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credible. CMS has recognized the expertise of the RUC by adopting 95% of its work relative value recommendations.	unwilling to listen to feedback from CMS, MedPAC, or others to improve the committee's recommendations. The high acceptance rate is very important to the RUC. The RUC understands the boundaries within the RBRVS and abides by the definitions constructed by CMS. CMS has observers at each RUC meeting. If a concern is expressed, the RUC responds accordingly. MedPAC recently suggested that the RUC consider additional primary care representation. The RUC is currently doing this.
involved in reviewing direct practice expense inputs and submitting these recommendations to CMS. The RUC has reviewed 7,000 CPT codes and estimated the clinical staff (typically nursing) time, supplies, and equipment used in the provision of these services. CMS has only begun to transition the full impact of these recommendations into the RBRVS.	even able to recalculate the CMS practice expense relative value units, let alone establish them. The RUC submits recommendations on clinical staff (type and time); medical supplies (type and number of units); and medical equipment (type). All other elements of the data and the actual methodology have been developed by CMS. CMS prices the wages, supplies, and equipment. CMS has accepted supplemental overall practice expense data directly from specialties. The RUC's recommendations to improve both the practice expense and professional liability insurance (PLI) methodology have not yet been adopted (see attached <i>RUC Pending Recommendations to Improve the RBRVS</i>).
time-consuming and demanding. The RUC meets three times per year. The volunteer physicians spend 15 days per year in travel and meetings, and 6-8 days per year in preparation and review.	a way to spend a relaxing weekend. The RUC meetings typically begin at 7am and end at 7pm. Each physician service must be deliberated to determine the following: <ul style="list-style-type: none"> • Physician time (in many increments) • Clinical staff time (in many increments) • Medical supplies (type and # of units) • Medical equipment (type utilized) • Comparable key reference services • Work relative value unit (RVU) • Crosswalk to a temporary PLI RVU • Expected utilization data • Modifications to vignette and descriptions • Inherent conscious sedation • Modifier -51 application • Addition to new technology list (codes to be re-reviewed after 3 years of utilization data) It is a deliberative discussion, often requiring in depth facilitation. The E/M discussions took place over several meetings, with one session lasting until midnight. It is difficult to envision a government run process that could inspire so much voluntary service by so many professionals.

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<p>supported by the AMA and 100 specialty societies and health care professional organizations. Each society provides not only an advisor, but also staff representatives. The societies typically have one staff employed to collect survey data and provide other analysis for both the CPT and RUC processes, among other responsibilities. The AMA provides the meeting forum and a professional staff of five, all master degree level individuals.</p>	<p>free to organized medicine, but it is free to the federal government. The RUC activity provides the Medicare program with the ability to issue timely updates to the Medicare Physician Payment Schedule, at almost no cost to the government. A very conservative estimate of the annual cost to the AMA, specialty societies, and health care professional organizations is \$7 million per year in staff salaries, survey expense, meeting and travel expense, and lost wages of RUC volunteer physicians. This is a worthwhile investment to ensure physician input into the relativity of the RBRVS. However, it should be recognized that even with input from an advisory board or consultants, CMS could not replicate the resources to duplicate this process.</p>
<p>constantly improving its methodology and processes. While relying on the core principle of magnitude estimation from the Harvard/Hsiao studies, the RUC continuously looks to improve its ability to assess relativity across the RBRVS. For example, the RUC has developed standards and packages of direct practice expense inputs that can be applied fairly to all services.</p>	<p>stagnant. The process continuously evolves. The RUC has recognized that neither the specialties nor CMS have been able to address the identification of potentially mis-valued services using objective data. The RUC has, therefore, created a Five-Year Review Identification Workgroup.</p> <p>The RUC has already asked specialties to review codes where Medicare data indicate a shift from the inpatient setting to the outpatient setting to assess the appropriateness of the visit data bundled into the surgical global payment. The RUC has also identified services that are inherently reported together by the same physician on the same date of service. The American College of Cardiology has responded to a request by the RUC to review the coding for echocardiography to ensure that resources are not duplicated in the reporting of distinct services.</p> <p>The RUC will step up to the plate on this issue and identify other services for review. However, expectations regarding how much potential misvaluation exists within the RBRVS should be realistic and not expected to produce dramatic savings for offsetting the cost of fixing the SGR or improving payment to primary care. E/M comprises nearly 50% of all MFS spending. Even if Medicare were to cease coverage for all advanced imaging services (all CTs, all MRIs, all PET, etc) and reallocated this money back to all other physician services, E/M payment would only increase 6.5%.</p>