

## **Understanding the AMA's Relative Value Update Committee (RUC) and its Survey Process**

The 31-person RUC advisory panel is responsible for assessing physician services and pricing them relative to other approved physician activities (visits, procedures, surgery, etc.). The RUC plays a critical role in the maintenance and development of physician reimbursement.

As a specialty society with a seat in the AMA House of Delegates, NANS is also a part of the AMA's multispecialty Relative Value Update Committee (RUC) and has an appointed RUC advisor-Damean Freas, MD and an alternate advisor-Peter Paphill, MD who are responsible for representing NANS members interests at the RUC. In this role, NANS has the opportunity to actively participate in the valuation of CPT procedure codes through the RUC survey and valuation process and views this process as critically important to NANS health policy activities. As part of NANS's participation, we will intermittently need your help filling out the RUC surveys when you receive them, this is a critically important step in the reimbursement valuation process.

Although the whole RUC review process can be tedious, and the Centers for Medicare and Medicaid Services (CMS) does not always accept the RUC's recommendations, the process provides a review that is consistent across all specialties and driven by physician input—an essential component to judging the resources required to perform these services. The RUC review process is time and labor-intensive and requires the regular surveying of members who perform specific services.

### **Why Participation is Critical**

The RUC process relies heavily on the engagement of practicing physicians through RUC surveys. Without robust responses to survey requests, the surveying societies cannot compile statistically-reliable data and, without that, cannot forward reliable and consistent recommendations to the RUC and CMS. When a member receives a request to participate in a RUC survey, it is essential that the member takes the 15-20 minutes to complete the online survey and offer their informed assessments of the relative resources required to provide their services.

Without robust participation from physicians who directly perform the procedures, the recommendations made to the RUC and CMS maybe based on less experienced specialists. Because of this, NANS strongly encourages all members asked to take part in RUC surveys to participate in the process when they have experience with the procedure under review. The NANS staff is available to assist members with questions regarding survey participation.

It is also critical that survey respondents complete the surveys correctly and accurately estimate the real time they spend on all resources involved in the provision of services. Surveys that are done inaccurately or which are not representative of the actual work, misalign the value. It is also important that survey respondents consider the typical time spent in each component, and not the easiest patient or the hardest patient. The underlying valuation is intended to be for the

typical or “median” service or patient and the most appropriate survey responses are based on median or typical components of a service.

## **History of the RUC**

The AMA established the RUC in response to a request from the Health Care Finance Administration (HCFA), the predecessor to CMS. HCFA wanted assistance in establishing a Resource-Based Relative Value Scale (RBRVS), which would be used to determine specific payment rates for specific physician procedures using a system where services are priced by comparing in a relative fashion to other services.

The RBRVS replaced the previous usual-and-customary system for pricing physician services and was designed to be based on the actual amount of resources needed to provide a particular physician service. At the time, the two resources studied for each service were physician work and physician practice expense. CMS later added medical malpractice as a third component.

The RUC, working with researchers from Harvard University, established the first RBRVS for the 1992 Medicare Physician Fee Schedule. Since then, the committee has had two purposes: to relatively value new procedures added to the Medicare Fee Schedule, and to regularly review relative value units (RVUs) for established procedures. It is the RUC’s second function (review of existing services) that has attracted the most attention and increasingly makes up a larger share of the RUC’s activities and for which you will see many of the surveys.

## **RUC Survey and Valuation Process**

For the last 24 years, the RUC has used essentially the same process for reviewing and valuing work and practice expense Relative Value Units. This longitudinal consistency is one of the key features of the relative value system and allows the continual comparison of physician services, not only across specialties, but over time as well, since the underlying process and data analysis are consistent.

When a service or procedure is being reviewed—either because it has been newly added to the current procedural terminology (CPT) Professional set of category I codes, or because it has been identified for an updated review—specialty societies are expected to conduct surveys of members who have direct knowledge and experience with the service(s). The RUC will request updated reviews of existing values for numerous reasons, including a change in primary specialty for a service, changes in primary site-of-service (e.g., transition from inpatient to outpatient, outpatient to office, etc.), change in the technique(s) used for the service, and other indications for which underlying valuations require a review. Note: the AMA CPT committee is responsible for defining/describing each code and is a separate process from the RUC.

Specialty societies, such as NANS, send links to a random sample of their membership and ask respondents to complete a series of approximately 12 questions related to the resources used by a physician in providing the service. Respondents are presented with the CPT code descriptor, a two to three-sentence description of the typical patient, and a set of 15-20 “key reference

services,” which are similar procedures from which respondents are asked to select the most similar service for the purposes of assessing the relative resources required to provide the service under review. This set of comparison procedures is put together by the RUC experts from the relevant specialty societies. Correctly selecting a comparative code is essential to the process as it determines a RVU base for comparison.

The results from the surveys are used most directly to determine the work RVU component of the Medicare Total RVU, but secondarily used for calculating the practice expense and malpractice RVUs as well. The malpractice RVU component is a much smaller percentage of the total RVU than the work component with practice expense RVUs being worth approximately 40% and malpractice RVUs worth approximately 3% of a service’s total RVU (the remaining being physician work). Note: these percentages vary by procedure with some procedures having practice expense RVUs that are more than 40% of their value.

From there, survey respondents are asked to estimate the typical time they spend providing three separate components of the service: the “pre” time, the “intra service” time, and the “post service” time. Pre-service time includes the time the physician typically spends face-to-face with a patient prior to the “intra-service” or “skin-to-skin” operating time including time spent reviewing records—as well as the time required to position a patient for service, spend in scrub, dress, and wait. The “intra-service” time is the time spent “skin-to-skin” or from the time of incision to closing or finishing a surgical procedure. Lastly, the “post-service” time consists of the time spent immediately after completion of a procedure, both in the operating room, dictating notes and records, and then all face-to-face visits with a patient in the hospital as well as in the office within the designated global period (either 90, 10, or 0); it is therefore important to know if there is a global period associated with the procedure under review as this will affect your post-service work.

Survey respondents are also asked to assess the relative complexity involved in providing the service by ranking its complexity and intensity to the key reference service identified by the survey respondent. The list of reference services provides survey respondents a set of procedures similar to the procedure(s) being surveyed and survey respondents choose the reference service that most closely approximates the level of work and intensity. The survey respondent is also asked to provide an estimate of the number of times he/she has provided the service in the last 12 months, as well as their best relative value unit estimate. While more experience with the service(s) under review is valuable, all survey responses are treated and accepted equally regardless of the volume of recently performed procedures.

Survey responses are collected by the specialty society, analyzed, then reviewed by society RUC advisors who will invest a significant amount of time and effort applying their experience and expertise in the RUC process interpreting and determining the most appropriate recommended times and values. These advisors are from specialty societies that have experience and expertise in the procedures being reviewed, (Note: any society can choose to be involved in any survey and the review of that procedure but typically this is based on their experience and interest in the service(s) being reviewed). Advisors then present recommended values to the full RUC at one of the three yearly meetings which occur in January, April and September/October. At that time, the RUC will vote to accept or amend the recommended values.

The committee also reviews the Practice Expense and Malpractice inputs for each procedure under review. A separate RUC subcommittee reviews practice expense values, which are designed to capture the direct and indirect non-physician time and inputs (e.g., labor costs for non-physician personnel, office overhead, costs of supplies and equipment) associated with the care provided by the physician. These inputs are based on expert review by society RUC advisors and presented at the RUC's Practice Expense subcommittee. Malpractice RVUs are based on the mix of providers of the service(s) reviewed (e.g., orthopedic surgeons or neurosurgeons) and their associated malpractice costs and are calculated through a formula that crosswalks the service(s) under review to service(s) with similar provider mixes. These formulas are maintained by the RUC's Malpractice subcommittee.

These RUC recommended relative values are then provided to CMS for inclusion in the annual Medicare Physician Fee Schedule. The actual payment for a procedure depends on the Physician Work, Practice Expense, and Malpractice relative value units assigned, times a conversion factor which is determined by CMS (or other private payers) each year.

### **Recent Example of Procedures Surveyed and Valued**

In November 2018, NANS, along with other specialty societies (ASA, AAPM&R, SIS, AAPM, ASIPP) participated in RUC surveys for a set of two new codes for treatment of Sacroiliac Joint Nerve treatment services; one for the diagnostic/therapeutic injection with steroid and one for radiofrequency ablation of the nerves.

The survey results were presented to the RUC at the January 2019 RUC, and then forwarded to CMS who based the 2020 Medicare Fee Schedule work RVU settings for the two new codes CPT code 64451, Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography) and 64625, Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography).

The survey showed median times for 64451 of 17 minutes pre-service evaluation, 1 minute of patient positioning, and 5 minutes of scrub, dress, and wait time, with 15 minutes intra-service time, and 7 minutes of immediate post-service time. The RUC recommended a work RVU of 1.52 which was accepted by CMS in the 2020 Medicare Physician Fee Schedule Final Rule.

The survey showed median times for 64625 of 13 minutes pre-service evaluation, 1 minute of patient positioning, and 5 minutes of scrub, dress, and wait time, with 30 minutes intra-service time, and 7 minutes of immediate post-service time, with a discharge visit and a post-operative patient visit. The RUC recommended a work RVU of 3.39 which was accepted by CMS in the 2020 Medicare Physician Fee Schedule Final Rule.

## **KEY TAKEAWAYS ABOUT THE RUC SURVEY PROCESS**

- **Survey participation is critical to future Medicare, and other payer, reimbursement**
- **Survey process relies on input from physicians performing the procedure**
- **Only 15-20 minutes to complete the online survey**
- **The survey refers to typical (median or mean) time– not the fastest or slowest time it took to perform a procedure**
- **This is important to your own future reimbursement so please do your part and respond to these surveys when you are selected to participate.**