CPT, The RUC and RVUs
Our Current Reimbursement Process

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Disclaimers

No Financial Disclosures

No Conflicts of Interest

Opinions - my own

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IN RECENT years, the medical community, government officials, and the general public have focused increasing concern on physician reimbursement. The immediate cause for the heightened concern is that the growth rate in expenditures for physicians' services has far outpaced the growth rate of the general economy. As a result, we spend a larger share of income each year for physicians' services...

A related concern is that these expenditures are not necessarily spent effectively. Greenspan et al, for example, concluded that 20% of implantation of permanent pacemakers was not indicated and that 36% was only possibly indicated. Similarly, Chassin et al judged unnecessary 17% of coronary angiograms and upper gastrointestinal endoscopies and 32% of carotid endarterectomies…

Societies differ in how they pay for physicians' services. Under a market exchange system, government has an interest in containing cost inflation and ensuring access to high-quality and cost-effective health care. Price, along with other policy instruments, may be an effective means of achieving these objectives. Method and rates of payment constitute economic incentives under which physicians make clinical decisions, choose specialties, and determine practice locations, although the exact degree of influence remains largely unknown owing to lack of adequate empirical evidence.

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Hsaio WC et al. Resource-based relative values: An overview. JAMA 260: 2347-2353, 1988

Resource-Based Relative Value Scale (RBRVS)

- Prior to 1992 Medicare payments based upon charges – "Reasonable and customary"
- In 1992 Medicare established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS).
  - Payments for services are determined by the resource costs needed to provide them.
  - Three components: physician work, practice expense and professional liability insurance.

Resource-Based Relative Value Scale (RBRVS)

- December 1985 - The Harvard National RBRVS Study is initiated.
- September 1988 - Harvard submits Phase I of the RBRVS Final Report to the Health Care Financing Administration (HCFA).
- December 1989 - Omnibus Budget Reconciliation Act of 1989, enacting a physician payment schedule based on an RBRVS.
- November 1991 - Initial Meeting of the AMA/Specialty Society RVS Update Committee (RUC)
- January 1992 - The Medicare RBRVS is implemented.
- May 1992 - The RUC considers the first relative value recommendation from a specialty society. HCFA accepts this recommendation.

Resource-Based Relative Value Scale (RBRVS)

- AMA provides expert assistance to CMS
- Built around two basic ideas:
  - CPT
  - RVU
- AMA manages the process by which both CPT and RVU recommendations are made to CMS.

Current Procedural Terminology (CPT)

- "listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians"
- "provide a uniform language that will accurately describe medical, surgical and diagnostic services, and will thereby provide an effective means for reliable communication"

Current Procedural Terminology – cpt 2005 Professional Edition. 4th Edition. Chicago, Illinois. AMA Press, 2004

Physicians' Current Procedural Terminology (CPT)

- **Established 1966 by the AMA**
- **Spans every conceivable procedure, operation, test, patient encounter**
  - **Supplemented by 5 digit alphanumerical HCPCS (Healthcare Common Procedure Coding System) codes**
- **Updated annually by AMA CPT Editorial Panel**
- **5-digit codes necessary, but may not be sufficient for payment**

AMA CPT Editorial Panel

- **CPT is maintained by the AMA CPT Editorial Panel.**
  - **17 member panel is authorized to revise, update, or modify CPT.**
  - **13 of the seats are nominated by the AMA**
    - **Includes a member with expertise in performance measurement and two members of the CPT HCPAC.**
  - **Remaining seats are nominated by the Blue Cross and Blue Shield Association, America's Health Insurance Plans, the Centers for Medicare and Medicaid Services and the American Hospital Association.**
  - ***Advisory Committee* to the CPT Editorial Panel – 1 representative from each of the 122 specialty societies seated in the AMA House of Delegates.**

AMA CPT Editorial Panel

- **Codes updated annually to reflect current medical practice.**
  - **Addition/deletion of codes and revisions in procedure description**

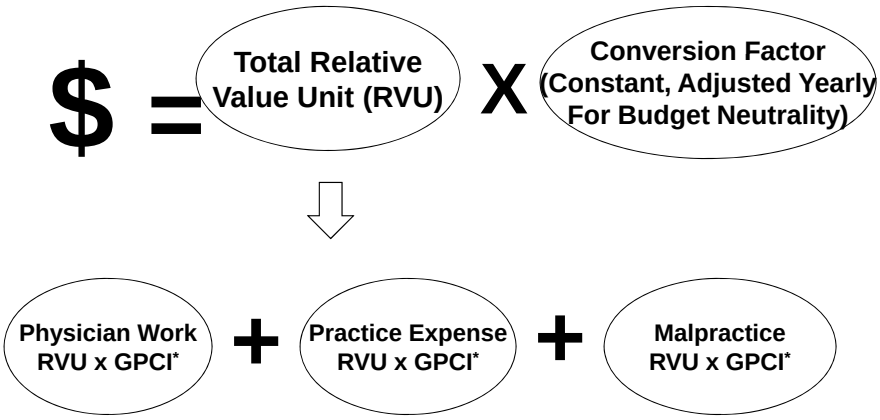
The CPT/RUC Health Care Professionals Advisory Committee (HCPAC)

- **HCPAC allows participation of limited license practitioners and allied health professionals in the CPT/RUC process.**
  - **11 organizations seated on HCPAC**
  - **Represent physician assistants, chiropractors, nurses, occupational therapists, optometrists, physical therapists, podiatrists, psychologists, audiologists, speech pathologists, social workers and registered dieticians.**
- **Responsible for developing codes and relative value recommendations for codes reported by non-MD/DO professionals.**

Relative Value Unit (RVU)

- A unit of measure to compare physician work
- Based on elements of time, intensity, technical skill/physical effort, mental effort/judgment and stress
- Comparison relative to other patient care activities
- Theoretically equalizes physician work independent of payment

Medicare Fee-For-Service Reimbursement
Financial Components of CPT Code Payments



*Geographic Practice Cost Index

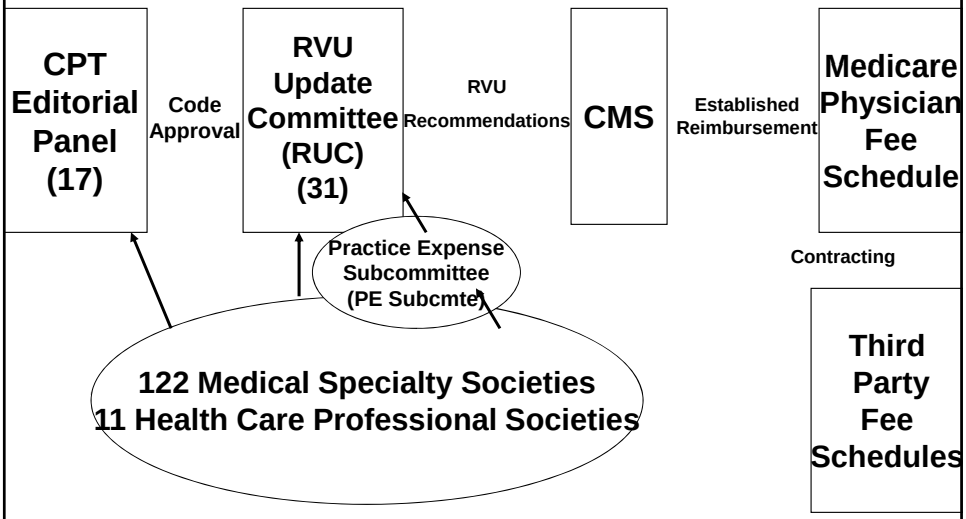
AMA RVS Update Committee (RUC)

- **A 31 member committee recommends RVU values for CPT Codes to CMS.**
  - **21 members appointed by medical specialty societies**
    - Includes 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.
  - **4 seats rotate on a 2-year basis**
    - 1 seat reserved for a primary care representative, 2 reserved for an internal medicine subspecialty and the remaining seat is open to any other specialty society not already a member
  - **6 seats - RUC Chair, Co-Chair of the RUC HCPAC Review Board, representatives of AMA and AOA, Chair of the Practice Expense Subcommittee and CPT Editorial Panel.**

AMA RVS Update Committee (RUC)

- **Advisory Committee to the RUC**
  - **Consists of 1 representative from each of the 122 specialty societies seated in the AMA House of Delegates**

Changing/Adding/Valuing A CPT Code: The Process



Changing/Adding/Valuing A CPT Code: The Timing for 2014 Medicare Payment Schedule

The CPT Process		The RUC Process		
Deadline for Submission of CPT Proposals	**CPT Meeting**	**LOI Sent to Specialty Societies Due to AMA**	**Society Survey Recommendations Due to AMA RUC**	**RUC Meeting**
March 7, 2012	May 17-19, 2012	June 22, 2012	September 11, 2012	October 4-7, 2012
July 18, 2012	October 11-13, 2012	November 2, 2012	January 8, 2013	Jan 31-Feb 3, 2013*
November 7, 2012	February 7-9, 2013*	February 22, 2013	April 2, 2013	April 25-28, 2013

Proposing a CPT code? Questions and Paperwork

- Performed by large numbers of physicians? Who
- New service? Clinical efficacy well established?
  - 5 articles articles in US, peer-reviewed journals
- How currently reported? Why inadequate?
- Bundled with anything? An E/M same day?
- Representative vignette
  - Describes the typical patient who would receive the procedure(s)/service(s).
- What diagnoses? Volume estimates (total and Medicare)
- What Category?

CPT Categories

- **Category I CPT Codes**
  - Describe procedures and services with 5-digit code and descriptors, intended for common practice by many physicians nationally
- **Category II CPT Codes – Performance Measurement**
  - Optional performance measurement tracking codes intended to reduce the need for chart abstraction
- **Category III CPT Codes – Emerging Technology**
  - Temporary set of tracking codes for new and for emerging technology, intended to facilitate data collection

The RUC Process Steps 1 - 3

- **Step 1: The CPT Editorial Panel's decisions transmitted to the RUC**
- **Step 2: Specialty society indicates level of interest in developing a relative value recommendation.**
- **Step 3: AMA distributes survey instruments for specialty societies.**
  - **Required to survey at least 30 practicing physicians.**
  - **10 to 20 services act as reference points.**
  - **Surveyed physicians asked to evaluate the work involved in the new/revised code relative to these reference points.**

Survey Request

Thank you for agreeing to participate in the survey. The American College of Chest Physicians (ACCP) represented by Burt Lesnick, MD, FCCP and the American Thoracic Society (ATS) represented by Kathrin Nicolacakis, MD, FCCP are advisors representing pulmonary medicine at the American Medical Association (AMA) Specialty Society Relative Value Update Committee (RUC).

ACCP and ATS are asking you to complete a separate RUC survey on 94060 Bronchodilator Responsiveness and a separate survey that includes four new PFT codes for lung volumes, airway resistance and diffusing capacity, 940X1-940X4. Note that we have deleted 10 PFT codes and replaced with four new codes for PFTs performed by plethysmography, gas dilution and oscillometry and an add-on code for diffusing capacity. These bundled PFT codes resulted from the analysis of pulmonologists reporting to Medicare four or five codes to measure lung volumes, airway resistance and diffusing capacity that included duplication of pre- and post-service time (ie, 25-30 minutes each for pre-service time, eg, greeting the patient and an additional 25-30 minutes each after completing the test), and multiple supplies, eg, mouthpieces. With advances in technology, there are economies that will be evident upon completion of the surveys. Completing these surveys for the five codes should take under one hour.

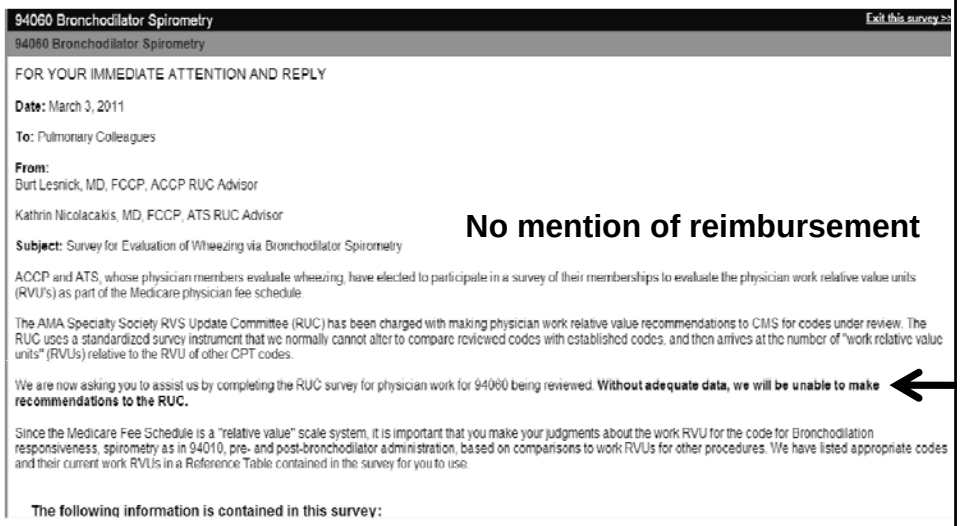
The surveys need to be completed by March 15, 2011. Your individual response to the 6 questions is needed. Click on the links below to go to the two surveys. I suggest that you start with 94060 since all the questions are basically the same. It will make the survey with the four new codes, 940X1-940X4 easier for you to complete.

94060 https://www.surveymonkey.com/s/NG3TMT6

940X1-940X4 https://www.surveymonkey.com/s/WQGGHDX

If clicking on the links doesn't work, please copy the links above to access the SurveyMonkey survey through your browser. If you have any questions while completing the survey, do not hesitate to call Diane Krier-Morrow, MBA, MPH, CCS-P, ACCP and ATS consultant staff at 847-677-9464 or email me at dkriermorr@aol.com and she can talk you through the survey questions in 5-10 minutes.

Survey



94060 Bronchodilator Spirometry

Exit this survey >>

94060 Bronchodilator Spirometry

FOR YOUR IMMEDIATE ATTENTION AND REPLY

Date: March 3, 2011

To: Pulmonary Colleagues

From:
Burt Lesnick, MD, FCCP, ACCP RUC Advisor

Kathrin Nicolacakis, MD, FCCP, ATS RUC Advisor

Subject: Survey for Evaluation of Wheezing via Bronchodilator Spirometry

ACCP and ATS, whose physician members evaluate wheezing, have elected to participate in a survey of their memberships to evaluate the physician work relative value units (RVU's) as part of the Medicare physician fee schedule.

The AMA Specialty Society RVS Update Committee (RUC) has been charged with making physician work relative value recommendations to CMS for codes under review. The RUC uses a standardized survey instrument that we normally cannot alter to compare reviewed codes with established codes, and then arrives at the number of "work relative value units" (RVUs) relative to the RVU of other CPT codes.

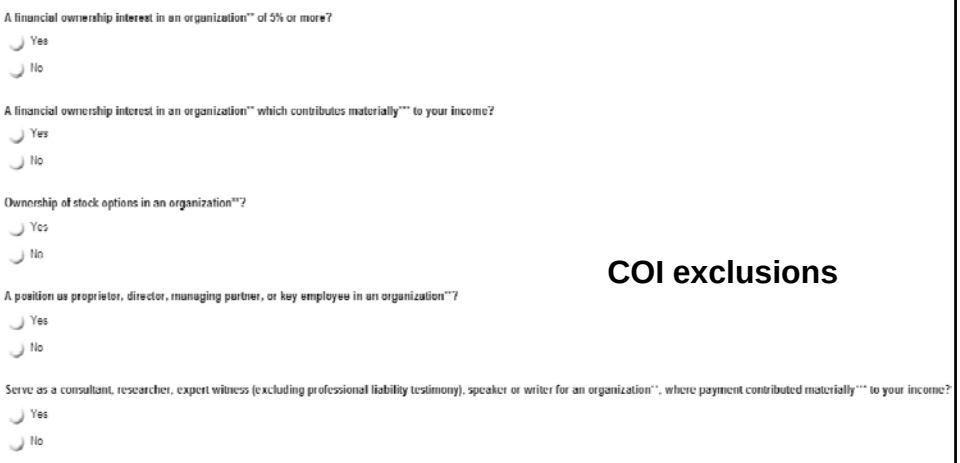
We are now asking you to assist us by completing the RUC survey for physician work for 94060 being reviewed. **Without adequate data, we will be unable to make recommendations to the RUC.**

Since the Medicare Fee Schedule is a "relative value" scale system, it is important that you make your judgments about the work RVU for the code for Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration, based on comparisons to work RVUs for other procedures. We have listed appropriate codes and their current work RVUs in a Reference Table contained in the survey for you to use.

The following information is contained in this survey:

No mention of reimbursement

Survey



A financial ownership interest in an organization"* of 5% or more?

- Yes
- No

A financial ownership interest in an organization"* which contributes materially"* to your income?

- Yes
- No

Ownership of stock options in an organization"*?

- Yes
- No

A position as proprietor, director, managing partner, or key employee in an organization"*?

- Yes
- No

Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization"*, where payment contributed materially"* to your income?

- Yes
- No

COI exclusions

Survey!

The American Medical Association/Specialty Society RVS Update Committee

PHYSICIAN WORK RVS Update Survey

Surveyed CPT Code: 94060

Global Period: XXX Imaging and Diagnostic

CPT Code Descriptor:

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

Typical Patient/Service:

A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath

vignette

TYPICAL PATIENT

Is your typical patient for this procedure similar to the typical patient described above? **typical?**

Yes

Survey

Typical Patient/Service:

A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

94060 Selected Reference Service

Reference Service List for Bronchodilator Spirometry 94060 **Pick a reference service**

Code	Descriptor	2011 RVW	Global
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	0.17	XXX
99406	Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes	0.24	XXX
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	0.26	XXX
G0424	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day	0.28	XXX
94375	Respiratory flow volume loop	0.31	XXX
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.48	XXX
94620	Pulmonary stress testing, simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre and post spirometry and oximetry)	0.64	XXX
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management	0.76	XXX
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	0.90	XXX
	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key		

Survey

(2) How much of your own time is required per patient undergoing CPT 94060 Bronchodilator Spirometry for each of the following steps in patient care related to this procedure? The entire survey should be based on your TYPICAL patient as described below. Indicate your time (in minutes). Refer to definitions of pre-, intra-, and post-service work. Please only enter a numeric value for pre-, intra-, and post service work for 94060.

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

Typical Patient/Service: A 60 year old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

Pre-service time (in minutes):	
Intra-service time (in minutes):	
Post-Service time (in minutes):	

State your time…

(3) For the surveyed CPT 94060 Bronchodilator Spirometry and for the selected reference service you chose, rate the AVERAGE pre-, intra- and post-service *complexity/intensity* on a scale of 1 to 5 (click on drop down box and select one: 1 – low; 3 – medium; 5 – high). Please base your rankings on the universe of codes your specialty performs.

Please be sure to maximize your screen and scroll to the far right in order to view all answers.

	94060	Selected Reference Code for 94060
Pre-service time		
Intra service time		
Post-service time		

…and your perception of complexity

Survey

(4a) Mental Effort and Judgment

Please be sure to maximize your screen and scroll to the far right in order to view all answers.

	94060	Selected Reference Code for 94060
The range of possible diagnoses and/or management options that must be considered		
The amount and or complexity of medical records, diagnostic tests, or other information that must be analyzed		
Urgency of medical decision making		

Mental Effort/Judgment

(4b) Technical Skill/Physical Effort*Please be sure to maximize your screen and scroll to the far right in order to view all answers.*

	94060	Selected Reference Code for 94060
Technical skill required		
Physical effort required		

Technical Skills/ Physical Effort

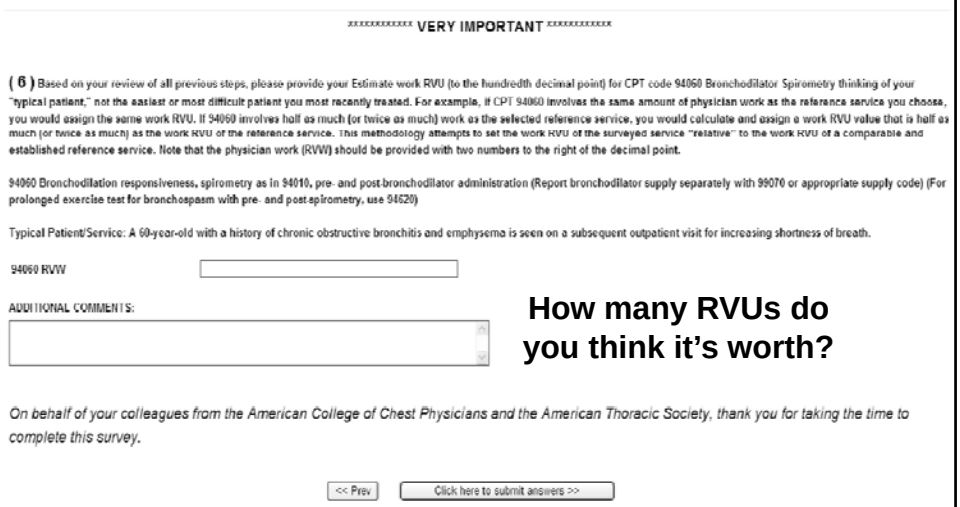
(4c) Psychological Stress

Please be sure to maximize your screen and scroll to the far right in order to view all answers.

	94060	Selected Reference Code for 94060
The risk of significant complications, morbidity, and/or mortality		
Outcome depends on skill and judgment of physician		
Estimated risk of malpractice suit with		

Stress

Survey



********** VERY IMPORTANT **********

(6) Based on your review of all previous steps, please provide your Estimate work RVU (to the hundredth decimal point) for CPT code 94060 Bronchodilator Spirometry thinking of your "typical patient," not the easiest or most difficult patient you most recently treated. For example, if CPT 94060 involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If 94060 involves half as much (or twice as much) work as the selected reference service, you would calculate and assign a work RVU value that is half as much (or twice as much) as the work RVU of the reference service. This methodology attempts to set the work RVU of the surveyed service "relative" to the work RVU of a comparable and established reference service. Note that the physician work (RVW) should be provided with two numbers to the right of the decimal point.

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

Typical Patient/Service: A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

94060 RVW

ADDITIONAL COMMENTS:

How many RVUs do you think it's worth?

On behalf of your colleagues from the American College of Chest Physicians and the American Thoracic Society, thank you for taking the time to complete this survey.

<< Prev Click here to submit answers >>

Practice Expense Component of the RBRVS

- **PE accounts for an average of 44.8% of the total relative value for each service.**
- **Data used to calculate:**
  - **Indirect practice costs**
    - **Non-clinical staff**
    - **Overhead**
  - **Direct practice expenses**
    - **Clinical labor**
    - **Supplies**
    - **Equipment**
  - **Malpractice**

RUC Process
Steps 4-8

- **Step 4: The specialty RVS committees review the results, and prepare recommendations to the RUC.**
- **Step 5: Recommendations presented to the RUC by the The Specialty Advisors.**
- **Step 6: The RUC evaluates specialty society's recommendation and accepts it (by 2/3 majority), refer it back to the specialty society, or modify it before submitting it to CMS.**
- **Step 7: The RUC's recommendations are forwarded to CMS in May and reviewed by CMS Medical Officers and Contractor Medical Directors.**
- **Step 8: The Medicare Physician Payment Schedule, including CMS's review of the RUC recommendations, is published late Fall.**

Controversies

Noerr-Pennington Doctrine

- **Allows all persons to exercise their right to petition the government free from potential antitrust liability.**
  - **Allows competitors to engage in joint petitions to the government and to ask the government to mandate or authorize activities that would ordinarily violate federal antitrust laws.**
- **Based on 3 United States Supreme Court decisions**
  - ***Eastern Railroad Presidents Conference v. Noerr Motor Freight Inc*.**
  - ***United Mine Workers v. Pennington***
  - ***California Motor Transport Co. v. Trucking Unlimited***
- **RUC activities are a <u>request</u> for government action therefore not price fixing.**

Washington Post: "How a Secretive Panel Uses Data that Distorts Doctors' Pay" (7/21/13)

- **Real life times inconsistent with RVU service times**
  - **"the AMA's estimates of the time involved in many procedures are exaggerated, sometimes by as much as 100 percent"**
  - **More likely to raise estimates of work despite productivity/technology advances**
- **AMA and specialty societies have too much influence over physician pay.**
  - **The AMA/medical societies, not government, develop the raw data for analysis**
  - **Estimated costs - $7 million in time and expense annually.**
  - **Raw data comes from doctors providing the procedure**
- **CMS ill equipped to oversee process – insufficient manpower**
  - **AMA not considered advisory committee - not subject to the Federal Advisory Committee Act**
- **Meetings are secret and confidential**
- **Skews toward specialists and away from primary care**

http://www.washingtonpost.com/business/economy/how-a-secretive-panel-uses-data-that-distorts-doctors-pay/2013/07/20/ee134e3a-eda8-11e2-9008-61e94a7ea20d_story.html

How You Can Get Involved?

- **Understand the process**
- **Suggest new CPT codes**
- **Respond to e-mail queries**
- **Participate in surveys**
- **Participate in your professional societies**

Outpatient New Visit (99203)

Work RVU	**1.42**
Expense RVU	**0.60**
Malpractice RVU	**0.13**
Total RVU:	**2.15**

- **Conversion factor = $35.82**
- **Medicare reimbursement = $77**

The RVU system and physician specialty choice

Revenue Discussion

Richard Sobieray
Associate Executive Director
Faculty Group Practice Administration
The Ohio State University Wexner Medical Center

Categories of Revenue

- Patient Service Revenue
  - Gross Patient Service Revenue (GPSR) vs. Net Patient Service Revenue (NPSR)
  - Patient Service Revenue Payment Methodologies
  - Other Patient Service Revenue
- Other Revenue
- Academic Revenue
  - Research
  - Teaching

Patient Service Revenue

- Today, patient service revenue is mostly about price and volume versus negotiated contract rates.
- Tomorrow, patient service revenue will become more value based (price and outcomes).
- Gross Patient Service Revenue (GPSR)
  - The total amount of charges that result from the provision of health care services to patients.
  - Your charge per service times # of services provided.
  - "Sticker Price"

Patient Service Revenue

- **Net Patient Service Revenue (NPSR)**
  - **The amount of patient revenue that is collectable as cash after reducing charges to contractual rates and other deductions such as bad debt, charity care and insurer denials.**
  - **GPSR times write-off %**
  - **“Actual Payments” or “Cash Inflows”**

Patient Service Revenue

- **Today, it’s essentially Price X Volume.**
- **When analyzing this you must understand volume at the macro and micro-levels:**
  - **What is happening to my overall volume?**
  - **CPT mix, including potential shifts in services or coding patterns**
  - **Provider capacity, including effect of ramp ups and shifts in provider schedules**
  - **Provider productivity expectations**
- **For payment rates (Price) you must understand:**
  - **Who is paying you and what they will pay you?**

Payment Methodologies

- **Medicare**
  - **Funded through tax and premium dollars.**
  - **Physician fee schedule determined annually based upon RVU assignments to CPT codes and conversion factor.**
  - **Traditional versus Managed Care**
  - **Non-negotiable.**
  - **Some pay for performance beginning to take shape (i.e. Medical Homes).**

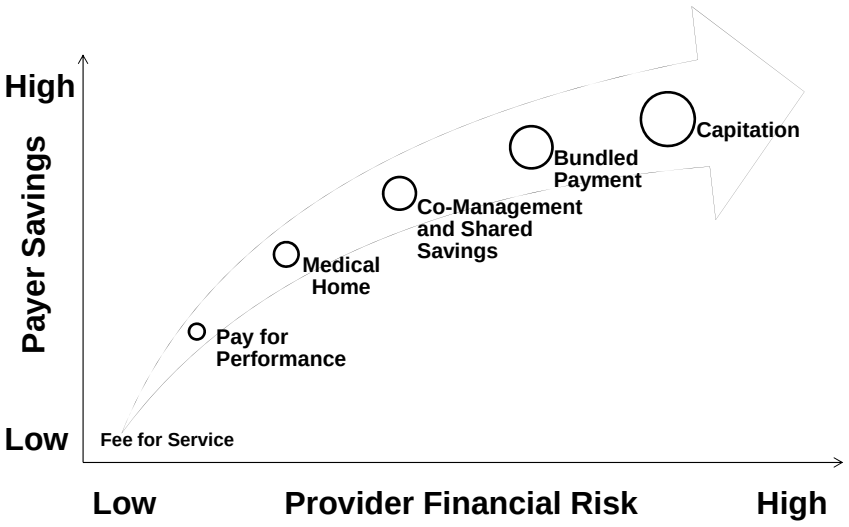
Payment Methodologies

- **Medicaid**
  - **Funded with state and federal dollars.**
  - **For low income people.**
  - **Fee schedule determined similarly to Medicare except the ultimate payment rates are determined by state budget constraints.**
  - **Traditional versus Managed Care**
  - **Non-negotiable**

Payment Methodologies

- **Commercial**
  - **Funded through premium dollars.**
  - **Generally employer-based, however exchanges are beginning to change the landscape.**
  - **Fee schedule typically negotiated as a % of Medicare.**
  - **It is important to be as diligent on contract language as you are on rates.**
  - **Negotiable**
  - **Some pay for performance beginning to take shape (i.e. Medical Homes).**

Payment Methodologies

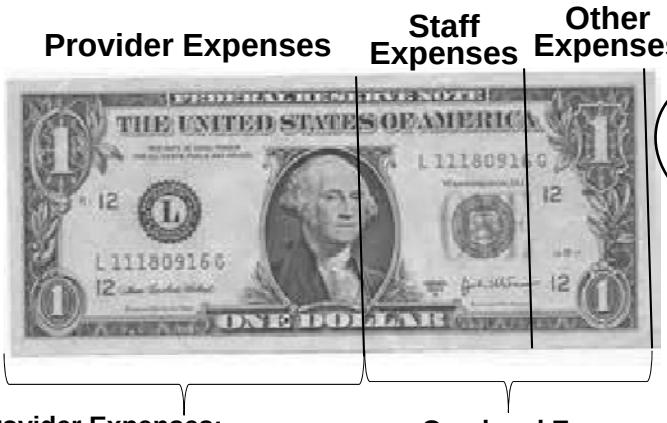


Expense Discussion

Categories of Expenses

- **Expenses = “Cash Outflows”**
- **Expenses fall into two categories:**
  - **Provider expenses**
    - **Salaries and Benefits**
    - **Malpractice**
    - **Travel and CME**
  - **Overhead expenses**
    - **Staff salaries and benefits**
    - **Supplies and pharmaceuticals**
    - **Space and Utilities**
    - **Purchased Services**
    - **Corporate Allocations**
    - **Amortization and Depreciation**
    - **Interest**
    - **Other**

How are Provider Resources Spent?



Provider Expenses:
- **40% - 80%**
- **Benchmark using MGMA Cost Survey or RVU split as determined by CMS (wRVU and malRVU)**

Overhead Expenses:
- **20% - 60%**
- **Benchmark using MGMA Cost Survey or RVU split as determined by CMS (peRVU)**

Improving Financial Performance

Improving Financial Performance

To improve the operating results, one can either increase revenues, decrease expenses, or both.

- **One can increase revenue either by growing volume or increasing revenue per unit (payment rate)**
  - **Difficult to increase volume in the short run**
  - **Under the new payer landscape, opportunities are also limited with increasing revenue per unit unless its found in the provider coding patterns**
- **Expense control has become the new norm for improving profitability in the short run**