

A SMALL GROUP OF PHYSICIANS HAS A BIG SAY IN WHAT YOU GET PAID.

# What Every Physician Should Know About the

# RUC

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To paraphrase Winston Churchill, never have so many physicians and other health care professionals owed so much to so few. The “few” in this case are the 29 members of the American Medical Association/Specialty Society Relative Value Scale Update Committee, or RUC (rhymes with “truck”) for short. The RUC’s recommendations to the Centers for Medicare & Medicaid Services (CMS) significantly influence the relative values assigned to physician services and, as a result, how much physicians are paid.

CMS expects allowed expenditures under the Medicare physician fee schedule to exceed \$76 billion this year, and the RUC will be instrumental in determining how those dollars are parceled out. CMS has historically accepted 90 percent or more of the RUC’s recommendations.<sup>1</sup> Given that the average family physician’s patient mix is 22-percent Medicare,<sup>2</sup> the RUC is likely to have a direct influence on one-fifth of your income. The real impact of the RUC is even bigger when you consider that

many other payers tie their fee structure to Medicare’s – 85 percent of private payers and 69 percent of Medicaid programs, according to one recent survey.<sup>3</sup>

## What is the RUC?

The AMA formed the RUC in 1991 to act as an expert panel in making recommendations to CMS on the relative values of *Current Procedural Terminology* (CPT) codes using the Resource-Based Relative Value Scale (RBRVS) that was mandated by Congress in 1989. For example, the RUC might propose that a 99214 is worth 2.53 relative value units (RVUs) while a left heart catheterization (code 93510) is worth 40.54 RVUs. RVUs are based on three components – physician work, practice expenses and professional liability; however, the RUC is primarily concerned with the first two (see “Anatomy of a Medicare payment,” on the next page, and “It’s all relative,” page 38). The RUC meets three times each year (February,

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April and September) for the purpose of developing its recommendations, which are then accepted, rejected or modified by CMS.

The RUC is composed of 29 members and 29 alternate members. Twenty-three of the members are appointed by major national medical specialty societies, including the AAFP, and each has one alternate member as well. Three of these seats rotate every two years; two are reserved for an internal medicine subspecialty, and the other is open to any other specialty. Representatives of the CPT Editorial Panel, the Health Care Professionals Advisory Committee and the Practice Expense Review Committee comprise three other seats. The remaining three seats are filled by representatives of the AMA, the American Osteopathic Association and the chair, who is appointed by the AMA. (See “Current RUC composition,” page 39.) The AAFP’s RUC representative and alternate are appointed by the chair of the AAFP Board of Directors based on recommendations from the AAFP Commission on Practice Enhancement.

Of the 29 members of the RUC, only five currently represent primary care specialties as defined by the AAFP. The vast majority of the representatives to the RUC are appointed by other surgical, procedural or subspecialties. As a result, the work of representing primary care issues to the RUC has often been difficult.

The RUC also has an advisory committee. Each of the 109 specialty societies seated in the AMA House of Delegates, including the AAFP, may appoint one physician to serve on the RUC Advisory Committee. The advisers attend the RUC meetings and present their societies’ recommendations, which the RUC

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evaluates. Specialties represented on both the RUC and the Advisory Committee must appoint different physicians to each committee to distinguish the role of advocate (i.e., the adviser) from that of evaluator (i.e., the RUC

## ANATOMY OF A MEDICARE PAYMENT

The following example shows the components of a Medicare payment for a level-III established patient office visit in 2008. Note that this illustration does not reflect any geographic payment adjustment that Medicare would make. Medicare uses a single conversion factor for all payments, which means that a family physician and a general surgeon would be paid the same amount for a 99213. Other payers use multiple conversion factors, which means that physicians in different specialties could be paid differently for performing the same service (see “Are Your Payers’ Fee Schedules Fair?” *FPM*, April 2007).

**Code:** 99213

**Work RVUs:** 0.92

**Work adjuster (applied to work RVUs for budget neutrality reasons):** 0.8806

**Non-facility practice expense RVUs:** 0.72

**Malpractice RVUs:** 0.03

**Total RVUs:** 1.56

**Conversion factor (in use through June 2008, based on Congressional action):** \$38.0870

**Medicare payment allowance for 2008:**

$((0.92 \times 0.8806) + 0.72 + 0.03) \times \$38.0870 = \$59.42$

member). The AAFP's RUC adviser, like the RUC representative and alternate, is appointed by the chair of the AAFP Board of Directors.

Specialty societies that are not in the AMA House of Delegates may be invited to participate in developing relative values for coding changes of particular relevance to their members.

The AMA staffs the RUC and funds some of the meeting costs (travel expenses for the chair, meeting room costs, etc.). Specialty societies staff their own involvement in the RUC process and pay expenses for their members who participate.

The RUC makes recommendations to CMS that influence how much physicians are paid.

The RUC assesses the relative values of physician services.

## HOW YOU CAN INFLUENCE THE RUC PROCESS

The AAFP makes recommendations to the RUC about the relative values of services based on the results of surveys completed by AAFP members. If you are willing to help with this important work, contact Kent Moore, the AAFP's manager of health care financing and delivery systems, at [kmoore@aafp.org](mailto:kmoore@aafp.org). Volunteers will occasionally receive a RUC-related survey from AAFP staff. The length and complexity of the survey will depend on the number of codes involved.

### How does the RUC work?

Advisory committee members, working with other members of their specialty, are responsible for generating relative value recommendations using a survey method developed by the RUC.

The RUC's survey instrument collects information on how practicing physicians view the physician work of the service(s) in question relative to other services on the RBRVS. Each specialty society relies on members to complete these surveys (see "How you can influence the RUC process," above). The survey results are then presented to the RUC as new "work RVU" values to be approved by the RUC.

The RUC's deliberations are complicated by the fact that the size of the Medicare payment pie is fixed; a bigger slice for primary

care means a smaller slice for surgery, and vice versa. The following quote from Tom Scully, former administrator of CMS, captures the essence of the process: "Essentially, we sit down with [RUC] every year and say, 'Here's \$43 billion and growing, how do you want to [divide it]? What's the relative value of weights between anesthesiologists, gastroenterologists, surgeons?' and set the relative values at what the physician community thinks the relative payment should be."<sup>1</sup>

At times, the debate can be vigorous – particularly when a specialty society presents work values that appear obviously inflated. However, the vast majority of work values are approved as presented by the specialty society. RUC rules require a two-thirds majority to approve any recommendation regarding relative values. When specialty society recommendations fail to pass the RUC on an initial vote, they are generally referred to a "facilitation" committee of the RUC (i.e., an ad hoc sub-committee appointed by the RUC chair) to develop a recommendation that is acceptable to both the presenting specialty and the RUC.

### IT'S ALL RELATIVE

In 2008, the total value (unadjusted for budget neutrality or geography) for a 99214 is 2.53 RVUs. For a left heart catheterization (code 93510), the value is 40.54 RVUs, the bulk of which – 33.61 RVUs – is related to practice expenses. A family physician would have to do approximately 16 99214s to generate the same RVUs (and thus comparable Medicare income) as a cardiologist doing one 93510. Put another way, a cardiologist doing five 93510s would generate RVUs and Medicare income comparable to approximately 80 99214s. The typical family physician provides approximately 84 office visits a week<sup>1</sup>, most of which are likely lower levels of service than 99214.

1. American Academy of Family Physicians. Facts about family medicine. Available at: <http://www.aafp.org/online/en/home/aboutus/specialty-facts/5.html>. Accessed Jan. 9, 2008.

### Is the RUC the right approach?

Family medicine gained some ground in 2007 as a result of the RUC's five-year review of the Medicare physician fee schedule. CMS accepted RUC recommendations that increased RVUs for level-III and level-IV established patient office visits. Payment increased by 13 percent for 99213 and 9

percent for 99214. Other values changed as well, not all of them in family physicians' favor, but the net effect of all the changes was a 5 percent increase, according to a CMS estimate.

Whether the RUC is the right approach for determining the relative values of physician services has been the subject of much debate and is beyond the scope of this article. The AAFP, through its RUC representation, is attempting to ensure that the process serves family medicine as well as it possibly can.

There is much work to be done. 

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

1. Hawryluk M. Panel marks 10 years shaping Medicare policy. *Am Med News*. Dec. 16, 2002.
2. American Academy of Family Physicians. Facts about family medicine. Available at: <http://www.aafp.org/online/en/home/aboutus/specialty/facts/4.html>. Accessed Jan. 9, 2008.
3. Smith SL, Fischhoff R, eds. *Medicare RBRVS: The Physicians' Guide 2007*. Chicago: American Medical Association; 2007.

## CURRENT RUC COMPOSITION

The RUC has 29 members, each of whom has one vote. Recommendations regarding relative values must be approved by a two-thirds majority. Only five seats are currently occupied by physicians in what the AAFP considers primary care specialties. Those are highlighted below.

Chair (appointed by the AMA)	CPT Editorial Panel Representative
American Medical Association Representative	Health Care Professionals Advisory Committee Representative
American Osteopathic Association Representative	Practice Expense Review Committee Representative
Anesthesiology (American Society of Anesthesiology)	Ophthalmology (American Academy of Ophthalmology)
Cardiology (American College of Cardiology)	Orthopaedic Surgery (American Academy of Orthopaedic Surgeons)
Dermatology (American Academy of Dermatology)	Otolaryngology (American Academy of Otolaryngology, Head and Neck Surgery)
Emergency Medicine (American College of Emergency Physicians)	Pathology (College of American Pathologists)
Family Medicine (American Academy of Family Physicians)	Pediatric Surgery* (American Pediatric Surgical Association)
Gastroenterology* (American Gastroenterological Association)	Pediatrics (American Academy of Pediatrics)
General Surgery (American College of Surgeons)	Plastic Surgery (American Society of Plastic Surgeons)
Geriatric Medicine* (American Geriatrics Society)	Psychiatry (American Psychiatric Association)
Internal Medicine (American College of Physicians)	Radiology (American College of Radiology)
Neurology (American Academy of Neurology)	Thoracic Surgery (Society of Thoracic Surgeons)
Neurosurgery (Congress of Neurological Surgeons)	Urology (American Urological Association)
Obstetrics/Gynecology (American College of Obstetricians and Gynecologists)	

 The structure of the RUC makes primary care representation difficult.

 Any recommendation regarding relative values must be approved by a two-thirds majority.

 Volunteers are needed to complete surveys that guide the AAFP's recommendations to the RUC.

\*rotating seat