Do RVU-based compensation models undervalue PCPs?
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How much is an annual physical exam worth, compared to a colonoscopy or a cataract surgery? An AMA-appointed committee of 31 members (mostly specialist physicians) called the RUC (pronounced “ruck”) essentially decides.

1) To understand how primary care office visits are valued in fee for service, let’s discuss a few terms:

   b) Relative value units (RVU), which are assigned to each CPT code
   c) The annual conversion factor set by the Centers for Medicare and Medicaid Services (CMS) that puts a dollar value for each RVU

Every billable task (office visit, procedure, image interpretation, etc.) is assigned a Current Procedural Terminology (CPT) code by the AMA. New codes are developed every year for new procedures/interventions/imaging modalities. There are over 9,000 medical services and procedures codes. Medicare pays providers based on the Relative Value Units (RVU) assigned to each CPT code. Why are RVUs assigned and not direct dollar amounts? In an effort to control costs, Medicare and Congress can vary the amount of money an RVU is worth to help keep spending down. An RVU was worth a peak of $38 in 2008, and is worth $34 in 2013.

[Image: CMS Conversion Factor year-over-year change]

(http://www.modernmedicine.com/news/infographic-how-cpts-medicare-allowable-determined; accessed 2/14/14)
2) What CPT codes are used by primary care practitioners?

Primary care providers bill typical office visits using a set of twelve CPT codes (five codes for new patients and five codes for return patients, two new codes for a new type of annual exam called an “annual wellness visit”). This small subset of CPT codes is often referred to as “evaluation and management (E&M)” codes, which distinguishes it from codes for performing a colonoscopy or interpreting an x-ray image, for example. The chart below shows the overall trend of established (return) patient E&M codes submitted to Medicare from 2001-2010. Of note, many providers besides primary care practitioners bill for some of their services using these E&M codes (e.g. a cardiologist or a general surgeon seeing a patient in the office to discuss a medical concern). Primary care physicians, however, generate the majority of their revenue from E&M codes alone. A higher code represents a more complex visit.

![Percentage of E/M Codes Billed for Established Patient Office Visits From 2001 to 2010](image)


The explanation for this trend was both that the average Medicare patient was getting older (and thus likely to have more chronic ailments), and that some physicians may have been billing for higher levels of service than their documentation (history, exam and complexity of medical decision-making) justified. For more information on what documentation is expected to reflect the complexity of a particular visit, please see, among other resources, Appendix A of the Inspector General’s report (page 16-18) noted below the image.

3) How much do you think the practitioner payment is for a “level 3” (CPT code 99213) established patient visit?

In 2013, an RVU is worth $34. A level 3 established patient visit is valued at 2.14 RVUs (or about $73). Each RVU has three components: one, the amount of “work” it takes
for a doctor to perform a given task (this is meant to include the intensity and stress of the task); two, a doctor’s practice costs to perform this task (overhead, support staff); and three, malpractice liability for doing this task. Each final RVU total is usually roughly half work and half practice expense as in the chart below.

As you see at the very top of the chart is a slight geographical practice cost adjustment to account for the variation in provider cost of living, overhead and malpractice insurance in different geographic markets. For example, in Seattle, that $73 payment is adjusted upward to 2.3 RVUs (or $78).

4) Who decided a level 3 visit is worth (only) 2.14 RVUs?

A 31-member committee called the Relative Value Scale Update Committee, or RUC, whose members are appointed by the American Medical Association (AMA), meets three times a year to discuss various RVUs assignments for some portion of the 9000 plus established CPT codes and assign RVUs to any newly developed codes. That committee then makes recommendations to the Center for Medicare and Medicaid Services (CMS) about what RVUs Medicare should assign to any given code. It’s up to CMS to accept or reject the RUC’s values, but historically the agency has accepted more than 90% of them (Laugesen MJ et. al. Health Aff, 2012).

5) Who is on the RUC?
An AMA appointed committee, the RUC is comprised of 31 members, 28 of whom vote. National medical specialty societies nominate 25 of the 28 voting members, though four of seats rotate between specialties every two years. The rotating seats are for two internal medicine subspecialties, one at large seat and one “primary care” seat. In 2013, the rotating seats are filled by representatives from infectious disease, oncology/hematology, pediatric surgery, and an internal medicine trained general practitioner representing primary care. Of note, there is no seat for a practicing hospitalist, and it was only in 2013 that a permanent seat for geriatric specialist and a rotating seat for primary care were added. Only a handful of the physicians on the committee make the majority of their income form E&M codes alone. The RUC rules require a two-thirds majority to approve any recommendation regarding relative values.

6) How did Medicare arrive at the RVU system, and who decided it should be the RUC who updates it?

When Medicare began in 1965, reimbursements were based on physicians’ historic “usual, customary and reasonable” charges – that is, whatever the physician charged, as long as it wasn’t outrageous, Medicare paid. This led to quickly rising costs for the
federal government, so in the late 1980s, a team led by William Hsiao, Ph.D., a Harvard economist, devised what eventually took shape as the Resource-Based Relative Value Scale (RBRVS). The goal of the RBRVS was to benchmark every visit, procedure, etc. against each other in terms of stress, intensity, time, overhead using a newly created measure, the RVU. This system was enacted into law as part of the Omnibus Budget Reconciliation Act of 1989 and took effect at the start of 1992.

In theory, procedures that take longer, or require more skill, or require more equipment or overhead, are assigned higher RVU numbers. Hsiao created initial estimates by interviewing hundreds of doctors from dozens of specialties and carefully comparing thousands of medical procedures. However, it was clear that a structure was needed to update the initial RBRVS values. The first Bush administration, loathe to create a government body who could be seen as setting prices for healthcare, looked outside CMS to update RVUs. The AMA offered to provide such a council of experts in 1991, and with that, the RUC was formed.

7) Major criticisms of the RUC include:

a) RUC updates to RVUs are too slow to incorporate advances in technology

The amount of time and intensity attributed to many procedures is set with the initial CPT code RVU assignment. However, technology has allowed previously complex, laborious procedures to become faster, easier and less risky. Colonoscopies are a prime example.

In 1992, when the code for a colonoscopy was codified, the AMA estimated that the basic colonoscopy took 75 minutes of a physician’s time, including work performed before and after the scoping. However, the total time the physician spends with each patient is about half that estimate today. The scopes are now far easier to move through the colon and digital technology has vastly improved the doctor’s view. In the early 1990s, doctors had to hunch over an eyepiece rather than have the images displayed on a large screen. Yet the work component of a screening colonoscopy has remained at 3.69 since 1992 (compared to the work RVU component of a level 3 return visit today, which is 0.97). For a cataract extraction, the work RVU is 8.52, with a time justification of 84 minutes. Cataract surgery has been enormously simplified and now takes an estimated 30 minutes (nearly tripling the effective payment rate per surgery).

A 2013 JAMA internal medicine study compared the hourly revenue generated by a physician performing a complex (level 4) office visit (CPT 99214) with that generated by a physician performing a screening colonoscopy (CPT G0121) or cataract extraction (CPT 66984) for Medicare beneficiaries. The findings? Based on the work RVU portion alone, hourly revenue for physician time spent on the colonoscopy and cataract extraction was 368% and 486% of that spent on a complex office visit, respectively. (Sinsky and Dugdale, JAMA Intern Med. 2013)
b) Specialist heavy representation

While the primary care physicians make up roughly 40 percent of physicians nationwide and provide nearly half of Medicare physician visits, they have less than 20 percent of the votes on the RUC.

c) Specialist societies survey their own members to determine what work RVU should be recommended to the RUC, a possible conflict of interest

To decide that freezing a skin lesion should been assigned 1.22 work RVUs (while a level 3 office visit is 0.97 work RVUs), a national dermatology society surveyed its members and this was their recommendation. There are no good mechanisms to reduce the conflict of interest in asking providers how difficult their own work is relative to other medical fields. Moreover, the surveys tended to be conducted using inconsistent methods and small sample sizes (though the AMA is trying to standardize survey methodologies given public pressure).

A quote from Tom Scully, CMS’ Administrator under George W. Bush: “One of the biggest mistakes we made ... is that we took the RUC...back in 1992 and gave it to the AMA. ...It’s very, very politicized. I think that was a big mistake...When you go back to restructuring this, you should try to make it less political and more independent. I’ve watched the RUC for years. It’s incredibly political, and it’s just human nature...the specialists that spend more money and have more time have a bigger impact...So it’s really, it’s all about political representation, and the AMA does a good job, given what they are, but they’re a political body of specialty groups, and they’re just not, in my opinion, objective enough. So when you look at the history of it, CMS is starting to push back more, which is a good thing, I think it would be much better to have an arms-length transaction where the physician groups have a little more of an objective approach to it. And, look, that is the infrastructure of $80 billion of spending. It’s not a small matter. It’s huge.”


d) RUC committee meetings are not open for public comment and the minutes are not published.

The RUC is not officially designated as a federal advisory committee and thus not subject to mandatory open, public comments. Its minutes are also not made public (until late 2013, when, under pressure, it agreed to start to release partial minutes). Officially, anyone is allowed to attend the RUC meetings, but one must sign a confidentiality agreement and one must get permission from the AMA chairperson in advance.

e) Private insurance contracts amplify RVU discrepancies by basing prices on Medicare fee schedules
On average, private insurance pays office visits at 104% of Medicare fees. Surgery, procedures, and imaging interpretation fees are paid on average at 120% of Medicare fees and can be 200-300% in markets where specialists are well organized (Dyckman and Associates, Washington DC, August 2003 as quoted here, http://www.familymedicine.medschool.ucsf.edu/pdf/cepc/0406_pres/BodenhPPSlides.pdf, accessed 2/14/14). Primary care practitioners constitute several provider groups, from internal medicine to family medicine to pediatrics, and to date has been less well organized to negotiate with insurers as a whole. Governmental payments are thus felt, in large part, to be responsible for the specialist–generalist income gap (Lasser KE., et al., Sources of U.S. physician income: the contribution of government payments to the specialist-generalist income gap. J Gen Intern Med. 2008 Sep; 23(9):1477-81.)

f) Medicare attempts to cap parts of its spending, so fast growth of non-E&M services drives down the amount of money left over for E&M services.

In 1997, Congress created the sustainable growth rate (SGR) formula to control Medicare spending by setting yearly targets for total Medicare physician expenditures. Each year, if total physician expenditures exceed the target for that year, the SGR mandates Congress to reduce the conversion factor (CF) in order to bring Medicare physician spending back into line. Pressured by the physician lobby, Congress has repeatedly overridden the SGR targets, preventing reductions of the CF and allowing rapid increases in physician expenditures. However, the volume of non-E&M services has grown far more rapidly that the volume of E&M services. In 2006, for example, non-E&M codes accounted for 86% of physician payment overruns above the SGR target (Matin, M. Splitting Medicare’s Sustainable Growth Rate: A Proposal to Strengthen Medicare and Primary Care. February 14, 2008. http://healthaffairs.org/blog/author/matin accessed 2/14/14).

g) There is no element of the RVU determination that speaks to the value to the patient of a given service.

8) How would you reform the RUC? What might be an alternative?

The American Academy of Family Physicians has made the case that evaluation and management services provided by primary care physicians today are substantially different from services billed under the same codes by specialists (e.g. a follow up cardiology visit, which uses the same E+M codes) and thus should receive distinct codes and relative values.

Others have asked for the RUC to become a formal federal advisory committee whose members are appointed by the federal government; which accepts open, public comments; and which includes “some representation by patients and taxpayers.”

U.S. Representative (and psychiatrist) Jim McDermott (D-Wash.) introduced a bill (Accuracy in Medicare Physician Payment Act of 2013, HR 2545) that would make the
RUC an official federal advisory committee subject to standard federal committee oversight, add patients, purchasers and economists to the committee, and give more support to CMS to oversee the RUC.

To account for the quick evolution of technology, some have argued we should establish a schedule of RVU reductions in advance for codes that are likely to become less risky and less difficult as technology improves. These reductions would be subject to modification later if evidence shows that the reductions have been too large or too small.

The Affordable Care Act officially tasked CMS to hire a third party (RAND and the Urban Institute were chosen) to do independent data collection and analysis to correct, corroborate, or reject RUC’s recommendations. The ACA also included a 10 percent bonus paid quarterly—effective in 2011–15—for most primary care services.

Finally, this pay disparity is based on a fee for service payment modality, and the hope is new models like capitated care under ACOs or additional reimbursements for being a medical home can increase the funding of primary care physicians based on their value to the system.

From Haley Edwards Washington Monthly article in 2013: “CMS is in a no-win situation,” says former CMS head Bruce Vladeck. “They’ve got extremely powerful forces making extraordinary amounts of money, and if CMS tries to change that, it’s really easy for the providers to say, ‘This is going to impair access,’ or ‘This is going to hamper care,’ even if there’s zero reality to that claim. People like doctors and nurses, and they don’t like government bureaucrats.”

**General References:**
1) Peter Whoriskey and Dan Keating, How a secretive panel uses data that distort doctors’ pay, Published: July 20, 2013, Washington Post

2) Haley Edwards, Special Deal: The shadowy cartel of doctors that controls Medicare. Washington Monthly, July/August 2013


8) http://www.modernmedicine.com/RUC-2013

9) http://replacetheruc.net/