

COMMENTARY

Do RVU-based Compensation Models Undervalue Primary Care Physicians?

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The service codes used by most internists, each with a five-digit billing number, are part of a convention that lies at the core of physician compensation. Each code, as defined in the American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*, is associated with a narrative description. The Centers for Medicare and Medicaid Services (CMS) issues valuations for each of these codes annually on January 1. Few physicians are aware of how these assigned values are determined. The AMA-sponsored Relative Value Scale Update Committee (RUC) of 31 (mostly specialist) members substantially influences this process. Understanding the seminal role and composition of the RUC is critical for internists to persuasively advocate for primary care payment reform.

Overview of RBRVS/RVUs

There are thousands of CPT codes, and new codes are created every year. Office-based visits use a small subset of CPT codes, often referred to as evaluation and management (E&M) codes. Medicare pays providers based on the relative value units (RVU) assigned to each CPT code multiplied by a dollar amount called the conversion factor (2014 CF = \$35.82). The conversion factor is adjusted up or down each year by Medicare and Congress based on budget targets and past Medicare spending in an effort to control total Medicare costs. Each RVU has three components: 1) the amount of "work" (e.g. stress, intensity) it takes to perform the task; 2) the associated overhead for said task; and 3) a small additional amount for mal-

practice liability. Most RVUs are roughly half work and half overhead. For example, a level 3 established patient visit (CPT 99213) is valued by Medicare at 2.14 RVUs.

When Medicare began in 1965, RVUs did not exist. Reimbursements were based on physicians' "customary, prevailing, and reasonable" charges. This led to variability in charges and quickly rising costs. In the late 1980s, a team led by William Hsiao, a Harvard economist, devised the resource-based relative value scale (RBRVS). The goal of the RBRVS was to benchmark every visit, procedure, and service against one another in terms of stress, intensity, time, and practice expense by using a newly created measure, the RVU. Hsiao created initial estimates by aggregating doctors from dozens of selected specialties into advisory groups to define services, interviewing thousands of doctors by questionnaire and then compiling the data into a master fee schedule. The AMA established a council of experts to give advice on updating RVU values, and thus the RUC was formed. The AMA claims to do so under its First Amendment right to petition the federal government as part of its research and data collection activities and in connection with the CPT development process.

RUC Structure

The RUC currently has 31 members. They meet three times a year to adjust the RVU value of existing codes and assign values to new codes. The RUC then makes non-binding recommendations to CMS, but CMS has accepted the recommendations more than 90% of the time since

1992 (though this proportion dropped to 76% in 2014). Only six current representatives (21% of the voting members) make most of their income from office-based, non-procedural visits. The RUC rules require a two-thirds majority to approve any recommendation, making any substantial change difficult to achieve.

Comparison of RVUs of Non-procedural vs. Procedural Services

The RUC-documented processes for assigning and updating the valuations assigned to services have failed to account for the efficiencies that arise as procedures become faster, easier, and less risky. For example, in 1992, when the code for a diagnostic colonoscopy was valued, the AMA estimated that the basic colonoscopy took 75 minutes of a physician's time. Today the total time the average physician spends performing a colonoscopy is about half what it was in 1992, although the work component of a screening colonoscopy has remained at 3.69 since 2000. As a comparison, the work RVU component of a level 4 return office visit is 1.5, which when billed based on time requires 25 minutes of face-to-face time. The work RVU of cataract extraction is 8.52 with a time justification of 84 minutes. More recent published estimates show the surgery is typically performed in 30 minutes today (nearly tripling the effective payment rate per surgery). There is room for debate as to the comparable intensity and stress of these procedures compared to an office visit, but given the growing complexity of primary care for an aging Medicare

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population, this payment discrepancy is remarkable.

Major Criticisms of the RUC

For a committee that influences how \$87 billion is allocated, there is little transparency. RUC meetings are not open for public comment. Only partial minutes are published; even these are delayed. The RUC relies heavily on specialist society surveys to determine what work RVU should be used for new codes, creating an inherent conflict of interest. While primary care physicians make up 40% of physicians nationwide and provide nearly half of Medicare physician visits, they have less than 20% of the votes on the RUC. Beyond Medicare, the service code valuations are used by virtually all commercial carriers and have been the basis for payment models in the evolving accountable care organizations (ACOs). Inequalities in RVU-based payments are felt in large part to be responsible for the specialist-generalist income gap.

Reforms or Alternatives to the RUC

Multiple alternatives or reforms to the RUC have been proposed. The American Academy of Family Physicians has made the case that E&M services provided by primary care practitioners today are substantially different from specialist office visits—all of which are billed currently under the same codes. Thus, primary care should receive distinct codes and relative values. US Representa-

tive (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, adding patients, purchasers, and economists to the committee; making meeting notes open and available for comment; and giving more support to CMS to oversee the RUC. The Affordable Care Act officially tasked CMS to study its own valuations processes, but the results of these studies have not been made public. To account for the quick evolution of technology, some have argued there should be an established schedule of RVU reductions set in advance for new procedures 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. Finally, this pay disparity is based on a fee-for-service payment modality. It is possible that bundled payments, such as those that occur in ACOs, will allow for more equitable payment schemes. However, these payments will only become more equitable if current biases are recognized. Using RBRVS benchmarks as they currently exist will perpetuate the undue influence of the RUC on physician payments.

Suggested Reading

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