How Is Physician Work Valued?

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Strategies to value physician work continue to evolve. The Society of Thoracic Surgeons and The Society of Thoracic Surgeons National Database have an increasingly important role in this evolution. An understanding of the Current Procedural Terminology (CPT) system (American Medical Association [AMA], Chicago, IL) and the Relative Value Scale Update Committee (RUC) is necessary to comprehend how physician work is valued.

In 1965, with the dawn of increasingly complex medical care, immense innovation, and the rollout of Medicare, the need for a common language describing medical services and procedures was recognized as being of critical importance. In 1966, the AMA, in cooperation with multiple major medical specialty societies, developed the CPT system, which is a coding system for the description of medical procedures and medical services.

The RUC was created by the AMA in response to the passage of the Omnibus Budget Reconciliation Act of 1989, legislation of the United States of America Federal government that mandated that the Centers for Medicare & Medicaid Services adopt a relative value methodology for Medicare physician payment. The role of the RUC is to develop relative value recommendations for the Centers for Medicare & Medicaid Services. These recommendations include relative value recommendations for new procedures or services and also updates to relative value recommendations for previously valued procedures or services. These recommendations pertain to all physician work delivered to Medicare beneficiaries and propose relative values for all physician services, including updates to those based on the original resource-based relative value scale developed by Hsaio and colleagues. In so doing, widely differing work and services provided can be reviewed and comparisons of their relative value (to each other) can be established. The resource-based relative value scale assigns value to physician services using relative value units (RVUs), which consist of three components: work RVU, practice expense RVU, and malpractice RVU, also known as professional liability insurance RVU. The Centers for Medicare & Medicaid Services retains the final decision-making authority on the RVUs associated with each procedure or service.

The purpose of this article is to discuss the role that the CPT codes and the RUC play in the valuation of physician work and to provide an example of how the methodology for valuation of physician work continues to evolve.

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Background

TheAmerican Medical Association (AMA) created the Relative Value Scale (RVS) Update Committee (RUC) to serve as an expert panel representing many of the medical and surgical subspecialties and to develop recommendations to the Centers for Medicare & Medicaid Services (CMS) about the relative value of physician work

The Society of Thoracic Surgeons Executive Committee approved this document.

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and practice expense. The RUC is a panel of 31 physicians that generates recommendations regarding the relative value for all physician services provided to Medicare beneficiaries based on the resource utilization associated with these services. As a result of legislation of the United States of America (U.S.) Federal government (Omnibus Budget Reconciliation Act of 1989), in 1989, Medicare began a process of converting the method by which physicians' services were reimbursed from a payment model based solely on physician average and customary charges submitted to Medicare to a standardized physician payment schedule based on a resource-based RVS (RBRVS). The overall methodology of estimation of RBRVS has been published (https://download.ama-assn.org/resources/doc/rbrvs/introduction-to-the-ruc.pdf).

In the RBRVS system, payments for services are predicated on the resource costs involved in providing such services. The cost of providing each service is divided into three components:

- physician work,
- practice expense, and
- professional liability insurance (PLI), also known as malpractice insurance.

The physician work component accounts for an average of 50.9% of the total relative value for each service. The initial physician work relative values were based on results of a 1989 Harvard University School of Public Health study [1, 2]. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment, and the stress caused by the potential risk to the patient. In 1992, CMS established a fixed payment system based on a Medicare Fee Schedule, which catalogs the relative value units (RVUs) for every Current Procedural Terminology (CPT) code (AMA, Chicago, IL) describing all physician work. The physician work relative values found in the Medicare Fee Schedule are updated each year to account for changes in medical practice and are published in the Federal Register. Furthermore, legislation enacting the RBRVS requires CMS to review or refine the work value components of the Medicare Fee Schedule; this review initially took place no less frequently than every 5 years but now takes place on a rolling basis. Individual medical and surgical specialty societies also have the opportunity to submit codes to CMS for review, and CMS, in turn, can forward these codes (and others) back to the RUC for possible revaluation. The specialty societies are then obligated to provide the RUC with compelling evidence of misvaluation if an increase in value is proposed. (The RUC has strict rules documenting what constitutes "compelling evidence.")

The practice expense component of the RBRVS accounts for an average of 44.8% of the total relative value for each service. Practice expense relative values were initially based on a formula using average Medicare-approved charges from 1991 (the year before the RBRVS was fully implemented) and the proportion of each specialty's revenues that is attributable to practice expenses. In January 1999, however, CMS began a transition to resource-based practice expense relative values for each CPT code that, based on the site of service (ie, in-patient vs out-patient), can differ significantly. The resource-based practice expenses were fully transitioned to a relative value scale in 2002.

On January 1, 2000, CMS implemented the resource-based PLI RVU. The PLI component of the RBRVS accounts for an average of 4.3% of the total relative value for each service. With this implementation and final transition of the resource-based practice expense relative units on January 1, 2002, all components of the RBRVS are resource based.

The RBRVS uses RVUs to assign value to physician services. As described above, total RVU is the sum of three components:

- the work RVU
- the practice expense RVU
- the malpractice RVU (also known as PLI RVU)

Final Medicare payments are determined by multiplying the total RVUs of a service by a conversion factor established annually to accommodate the constraints of mandated budget neutrality within a CMS budget approved by Congress each year. Payments are also adjusted for geographic differences in resource costs. The RVUs published by CMS are used almost universally by other payors, with differing conversion factors or methods to convert RVUs to payment. Health care organizations also use the RVUs to allocate capitated or bundled payments among physicians.

The purpose of this article is to discuss the role that (CPT) codes and the RUC play in the valuation of physician work and to provide an example of how the methodology for valuation of physician work continues to evolve.

CPT codes and the CPT Editorial Panel

CPT has just finished celebrating its 50th birthday. In 1965, with the dawn of increasingly complex medical care, immense innovation, and the rollout of Medicare, the need for a common language describing medical services and procedures was recognized as being of critical importance. In 1966, the AMA, in cooperation with multiple major medical specialty societies, developed a coding system for the description of medical procedures, and later medical services, using uniform language, the CPT system [3–7].

The first edition of CPT was published in 1966 and primarily was focused on surgery. CPT First Edition was initially a 3-digit coding system that has evolved into today's current 5-digit version (CPT Fourth Edition). More than 9,400 codes are defined in CPT 2016, describing procedures and services performed by physicians and other health care professionals or entities. The use of CPT codes simplifies the reporting of procedures and services and is a fundamental building block in medical claims reporting and reimbursement. CPT and its maintenance have gone far beyond its readily accepted role in

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