CHEST

The Resource-Based Relative Value Scale and Physician Reimbursement Policy

Miriam J. Laugesen, PhD

Most physicians are unfamiliar with the details of the Resource-Based Relative Value Scale (RBRVS) and how changes in the RBRVS influence Medicare and private reimbursement rates. Physicians in a wide variety of settings may benefit from understanding the RBRVS, including physicians who are employees, because many organizations use relative value units as productivity measures. Despite the complexity of the RBRVS, its logic and ideal are simple: In theory, the resource usage (comprising physician work, practice expense, and liability insurance premium costs) for one service is relative to the resource usage of all others. Ensuring relativity when new services are introduced or existing services are changed is, therefore, critical. Since the inception of the RBRVS, the American Medical Association's Relative Value Scale Update Committee (RUC) has made recommendations to the Centers for Medicare & Medicaid Services on changes to relative value units. The RUC's core focus is to develop estimates of physician work, but work estimates also partly determine practice expense payments. Critics have attributed various health-care system problems, including declining and growing gaps between primary care and specialist incomes, to the RUC's role in the RBRVS update process. There are persistent concerns regarding the quality of data used in the process and the potential for services to be overvalued. The Affordable Care Act addresses some of these concerns by increasing payments to primary care physicians, requiring reevaluation of the data underlying work relative value units, and reviewing misvalued codes. CHEST 2014; 146(5):1413-1419

ABBREVIATIONS: ACA = Affordable Care Act; AMA = American Medical Association; CHEST = American College of Chest Physicians; CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; E&M = evaluation and management; HCFA = Health Care Financing Administration; MPFS = Medicare Physician Fee Schedule; RBRVS = Resource-Based Relative Value Scale; RUC = Relative Value Scale Update Committee; RVU = relative value unit; SGR = sustainable growth rate

Medicare physician payment policy touches almost all physicians and practices. Medicare's Resource-Based Relative Value Scale (RBRVS) is used, with adaptations, by most private payers,[1] and increasingly, the RBRVS is used in salary-based practices to estimate productivity[2] and in new payment models, such as Accountable Care Organizations. Not unexpectedly, most physicians are unfamiliar with the details of the RBRVS and how it affects Medicare Physician Fee Schedule (MPFS) payments. Physicians may also not be aware of the yearly update process where physician

Manuscript received October 4, 2013; revision accepted May 9, 2014.

AFFILIATIONS: From the Department of Health Policy and Management, Columbia University, New York, NY.

FUNDING/SUPPORT: This work was supported by the Robert Wood Johnson Investigator Award in Health Policy Research Program.

CORRESPONDENCE TO: Miriam J. Laugesen, PhD, Department of Health Policy and Management, Columbia University, 600 W 168th St, Sixth Fl, New York, NY 10032; e-mail: ml3111@columbia.edu

DOI: 10.1378/chest.13-2367

organizations provide input on changes to the fee schedule. Finally, many physicians may not fully understand the role of the Centers for Medicare & Medicaid Services (CMS) in relation to the American Medical Association (AMA) organization called the Relative Value Scale Update Committee (RUC). This article explains the origins, underlying rationale, and process by which specialty societies, such as the American College of Chest Physicians (CHEST), are involved in regularly updating the RBRVS. In the concluding section, the fairness and relativity of the RBRVS are discussed alongside three important components of the Affordable Care Act (ACA) that aim to address these concerns.

History of the RBRVS

During the early 1980s, policymakers were concerned about two issues: (1) the persistent growth in Medicare expenditures and (2) low reimbursement rates for primary care physicians. These concerns, which are strikingly similar to those discussed today, prompted the Health Care Financing Administration (HCFA) (now called CMS) to explore new payment models, including the development of a new Medicare fee schedule.[3] HCFA awarded a contract to William C. Hsiao, an economist at the Harvard School of Public Health, to develop a new payment model.

Hsiao and colleagues[4] suggested three kinds of resource inputs that should determine physician reimbursement levels: a physician's time or work associated with providing a service, which is relatively consistent with the definition used today (Table 1); the costs of running a practice, including professional liability insurance premiums; and the opportunity cost of training amortized over a career. In the resource model that was actually implemented, training costs were not included.

Study researchers developed resource cost estimates for around 460 services described in the Current Procedural Terminology (CPT) and a method to extrapolate this to other services.[4] The CPT coding system was just one of many used by physicians, but HCFA was already using CPT in its nomenclature, the Healthcare Common Procedure Coding System. The Healthcare Common Procedure Coding System and CPT became the standard way of coding and billing for physician services across all payers partly because HCFA began using CPT. In retrospect, neither HCFA nor payment reformers understood the implications of linking RBRVS to the CPT system, which is coordinated and copyrighted by AMA. Procedural and surgical services lend themselves more easily to description as discrete CPT codes, which may have been a disadvantage to primary care services.[5]

Congress authorized a new resource-based payment system in 1989. The resources in the model would be measured in a new "coin of the realm"[5] of relative value units (RVUs), and HCFA implemented RVUs and the MPFS in 1992. Initially, the practice expense and liability insurance RVUs were based on historical costs.

The Update Process Today

Today, > 7,400 Medicare[6] services in the MPFS make up a subset of the larger pool of CPT codes. Some codes in the MPFS do not have RVUs, but for the majority that do, the total RVU comprises work, practice expense, and professional liability insurance units. The Medicare payment equals the total RVU multiplied by a dollar conversion factor, which is adjusted for geographic variations in costs. One can look up relative values and payment information for specific CPT codes on the CMS website.[7]

CMS publishes a new MPFS every year to account for several hundred new and revised CPT codes, usually with RVUs for each service. Before the ACA was implemented, CMS also asked for nominations of potentially misvalued services every 5 years.[8]

Specialty societies play a key role in the CPT revision process and subsequent RVU determination (Fig 1). The AMA convened the RUC before the RBRVS was fully implemented, and RUC has provided work RVU recommendations to HCFA and CMS since 1993. The RUC is sponsored by the AMA and has a chair and 31 members.[1] The committee comprises specialty society representatives, the chair of the RUC Practice Expense Subcommittee, and one representative each of other (nonphysician) health professions, the AMA CPT Editorial Panel, and the AMA. The chair of the RUC does not vote unless in the case of a tie. The Practice Expense Subcommittee and the CPT Editorial Panel members do not vote. Most of the societies represented on RUC have been members since its inception, although more seats have been added (for example, neurology). In 2011, a seat in geriatrics and a rotating seat in primary care were added to address criticisms that the RUC was inadequately representing primary care organizations. Additionally, > 100 other specialty and subspecialty societies are members of a larger RUC advisory committee.