THE RUC PROCESS

Or, How We Get Paid and What Are All These Initials

In 1992 physician payments transitioned from UCR (usual, customary, and reasonable) fees worked out between physicians and insurers to the current RBRVS (resource based relative value scale). The original relative value units (RVUs) were based on research from Harvard. The RUC (Relative value scale Update Committee) began its work at that time. The RUC is a committee of the AMA that reports its recommendations to the Centers for Medicare and Medicaid (CMS) which is a part of the federal Dept of Health and Human Services (HHS). CMS publishes its "final rule" (regulations that include RVUs) every year that goes into effect every Jan 1.

In the "COVID era," legislation by Congress has impacted this by altering the CMS "conversion factor" which has been helpful to physicians and patients. What we get paid in $ = RVU x conversion factor. Per prior federal law, payments must remain budget neutral (again until the "COVID era"). Thus, if there is a net increase (this can happen with codes that are used very frequently that increase a small amount in value) in RVUs amongst all the codes in the CPT book (Current Procedural Terminology), then CMS decreases the conversion factor. This usually means that any procedural based physician will have lower reimbursements as a result (procedures generally have higher RVUs than E/M – evaluation and management – codes). Commercial payers accept the CMS RVUs as do the states (who set their own Medicaid rates), but the conversion factors are what differ from Medicare.

All specialties are represented by advisors to the RUC Including APSA (we are the only pediatric surgical sub-specialty with a designated advisor). Non-physicians are also represented (OT/PT, podiatry for example). Payers including CMS attend the meetings and are allowed to speak. The committee itself that decides the actual RVUs has 31 members with alternates for each. They are from major specialties such as general surgery. Advisors present codes for valuation to the RUC at the three yearly meetings. Many codes are referred from the CPT Editorial Panel (another AMA committee) to the RUC. Codes may also be requested for valuation by CMS and other insurers. Some are referred if they are felt to be misvalued.

An example of the process:

A new procedure in a specialty is referred by that specialty to the CPT Editorial Panel for a code and a description. CPT which also meets several times per year sends this on to the RUC to develop an RVU. Physicians within the specialty or specialties who perform the procedure are then surveyed about how long it takes and how intense the work is (by comparing it to other similar codes). RVUs are derived from time and intensity as well as relativity to other codes----this is an objective process with a defined methodology, but controversies about it do arise such as that raised by a New England Journal of Medicine article in the past few years. The specialty society uses the survey results to present a proposed RVU to the RUC at the meeting. In some instances, there is a short discussion and in quite a few, a much longer discussion. The RUC then votes and if passed the code with its RVU is sent to CMS who makes the final decision. RUC decisions may be what the specialty society recommends, but that is definitely not always the case. RUC recommendations are accepted by CMS 75%-100% of the time.

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