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## What Is the RUC?

W.D. Donovan

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W.D. Donovan

## What Is the RUC?

**SUMMARY:** We describe a crucial but little-known constituent of the Medicare payment system.

**ABBREVIATIONS:** ACR = American College of Radiology; AMA = American Medical Association; ASNR = American Society of Neuroradiology; CMS = Centers for Medicare and Medicaid Services; CPT = current procedural technology; MedPAC = Medicare Payment Advisory Commission; RBRVS = RVS: Resource-Based Relative Value Scale; RUC = AMA/Specialty Services RVS Update Committee; RVU = relative value unit

Assuming that you are not asking about the Royal Ulster Constabulary, RUC is an acronym for the AMA/Specialty Society RVS Update Committee.<sup>1-3</sup> RVS, also known by its longer acronym RBRVS, is short for the Resource-Based Relative Value Scale. The RUC (verbalized colloquially as “the ruck”) debates the RVU values for medical/surgical procedures and makes recommendations to the CMS. It is a crucial but little-known component of the Medicare payment system.

A RUC meeting resembles a group of concentric circles. The actual RUC (the central circle, if you will) is a committee including 23 practicing physicians and a few allied health specialists. Representatives from the CPT panel and from the AMA are also on the committee. CMS representatives are nonvoting members.

A larger concentric circle consists of individuals (advisors and alternate advisors) who are sent by more than 100 medical specialty societies (including the American Society of Neuroradiology, ACR, the Society of Interventional Radiology, and the Association of University Radiologists) as representatives to the RUC meetings. These advisors present specific code summaries and recommendations to the central committee but cannot themselves vote on final valuation. This second circle also includes nonphysician staff representatives from the societies, who are essential in preparing the presentations.

An outer circle includes observers from other groups interested in medical payment policy who attend at the request of or through permission of the RUC: These can include the Government Accountability Office, MedPAC, and Medicare carriers.

### Who Is On the RUC?

Twenty of the 29 seats on the RUC are assigned to specific medical specialty societies, including 1 for radiology. The specialty society (ACR for radiology) nominates a RUC member (as well as an alternate member), who serves at the approval of the AMA. There are 3 rotating seats on the RUC, which are filled by election, and there are additional seats assigned to representatives from the AMA, CPT Panel, the American Osteopathic Association, and 1 seat for a group representing allied health care professionals (eg, podiatry, physician assistants, speech-language pathology, and so forth).

From the Department of Diagnostic Imaging, The William W. Backus Hospital, Norwich, Connecticut.

Please address correspondence to William D. Donovan, MD, MPH, FACR, Former ASNR Advisor to the RUC, Department of Diagnostic Imaging, The William W. Backus Hospital, 326 Washington St, Norwich CT 06360; e-mail: william.donovan@snet.net

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### How Does the RUC Interdigitate with CPT? (Wait, What's CPT?)

The CPT panel meets 3 times a year in sequence with the thrice-yearly RUC meetings. The CPT panel debates and approves new procedural codes, revises codes that are already in use, and deletes obsolete ones. Typically, a code that has been revised or newly approved by the CPT will then be reviewed at the next RUC meeting for new or revised valuation.

### How Are Codes Brought Before the RUC?

A society may present a new procedure or new technology to the CPT Panel, where its description is finalized and a CPT number is assigned, and then to the RUC for valuation. This is now a small part of what the RUC does. More commonly, a code is identified by the CMS as being “potentially misvalued,” and CMS requests that the RUC re-examine the service; and the RUC itself also has mechanisms by which it identifies codes as being potentially misvalued.

### How Does the RUC Value the Services That Are Brought Before It?

Societies conduct surveys of their memberships. The data are analyzed by society staff and by the society's advisors to the RUC, and a standardized “Summary of Recommendations” is generated with the society's opinions as to the value of the procedure. This includes, but is not limited to, the amount of time required for the procedure and comparison with other procedures that have previously been RUC-valued, to maintain rank order. The society's advisor then presents their recommendations to the RUC itself, whose members debate and vote on the RVU value.

Inherent in the valuation process is the knowledge that spending by CMS is fixed by law. Thus, increasing the value of a particular code would result in a corresponding across-the-board decrease in reimbursement for all other procedures.

### Once the RUC Values a Code, What Happens Then?

After every RUC meeting, the RUC sends its recommendations to CMS. Over the past 20 years, more than 93% of the recommendations of the RUC have been adopted by the CMS in its annual final rule. Unfortunately, this fraction has been slipping, with an increasing number of RUC recommendations being changed unilaterally (down-valued, of course) by CMS. In the most recent proposed rule, released in May 2011, CMS disagreed with almost 50% of RUC recommendations. In most cases, it proposed only a slight difference in value.

### ***Have All the Codes in the CPT Universe Been RUC-Valued?***

Given the large number of procedure codes in use (more than 7000), it has not been feasible for the RUC to review them all. In fact, RUC-reviewed procedures represent about two-thirds of all CPT procedures. The rest fall into 2 categories: so-called “Harvard-valued” codes and “CMS/Other” codes. Harvard-valued codes (numbering about 2700) date back to the origin of the RBRVS and are based on the work of Hsiao et al.<sup>4</sup> A description of that history is beyond our scope here, but it is an interesting story.<sup>5</sup> “CMS/Other” valuations (numbering about 400) were determined by CMS in consultation with society input and also date back to the 1990s. The RUC continues to plow through these sizable categories in an effort to validate or revise their values.

### ***Does the RUC Ever Go Back and Review Values It Has Previously Established?***

The 5-year review process was instituted as a means of reviewing codes that may have changed in value due to maturation of a procedure (implying that the physician is more efficient than when the code was originally valued), introduction of improved technology (which could result in the procedure taking a shorter or a longer amount of time), or significant increase in use (which CMS believes might indicate an overly generous reimbursement schedule, leading to overuse/preferential coding). The 5-year review process was originally supposed to happen every 5 years, but in fact, a rolling ongoing review began after the third official 5-year review in 2005. This was partly in response to MedPAC criticism that the RUC was not reviewing existing code valuations efficiently enough.<sup>6</sup> The 5-year review workgroup of the RUC (now the Relativity Assessment Workgroup) began to evaluate a large number of “potentially misvalued” codes by CMS that met a number of screens or filters. This process is ongoing, with new codes identified for review at every RUC meeting. See the May 2011 *Journal of the American College of Radiology* for a detailed example of how the review process affected radiology directly.<sup>7</sup>

### ***What about Practice Expense?***

The presenting society submits a list of equipment and supplies that they consider essential to the performance of the procedure in question. Note that these are “direct” expenses only; so-called “indirect” practice expenses (office overhead such as utilities and secretarial staff, for example) are not reimbursed by CMS. These direct expenses are reviewed by the Practice Expense Advisory Committee of the RUC, debated, and amended if necessary. After approval by the RUC itself, the practice expense information is then submitted to CMS for inclusion in the payment formula used to reimburse that code.

### ***What's with All the Media Scrutiny of the RUC Lately?***

In brief, primary care physicians believe they are under-represented at the RUC, contributing to undervaluation of codes

they frequently perform. This has led to the rumored resignation of the American Academy of Family Physicians from the RUC and threats of a lawsuit against the AMA.<sup>8</sup> Moreover, the less-than-transparent nature of the proceedings of the RUC has engendered conspiracy theories. The AMA has strongly countered these arguments, and reaffirmed its belief that the RUC represents the best means available for evaluating the relativity of physician work. See the references for further elucidation.<sup>9-11</sup>

ASNR staff and volunteer physicians have devoted countless hours to preparing and analyzing surveys and making code presentations before the RUC, in most cases to the benefit of the society. This process has become increasingly more challenging as CMS budgetary concerns escalate. Please fill out code surveys if asked. Please join or maintain your membership in the AMA—that allows ASNR to maintain its presence at the RUC/CPT meetings. And please attend the socioeconomic talks at ASNR, to remain informed on the payment issues of the day.

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