WHAT THE RUC?! CODING & PAYMENT CHANGES FOR 2021

William Fox MD FACP
DISCLOSURES

- Resell Obagi Products in office
- RUC Alternate Member 2012-2014, 2015-2018
- RUC Advisor 2014-2015, 2019
- I am an internist and primary care physician who does mostly cognitive work and few procedures
<table>
<thead>
<tr>
<th>Name</th>
<th>CPT Code #</th>
<th>Work RVUs</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKG</td>
<td>93000</td>
<td>0.17</td>
<td>$17.30</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>17000</td>
<td>0.61</td>
<td>$66.67</td>
</tr>
<tr>
<td>E/M mod complx</td>
<td>99214</td>
<td>1.5</td>
<td>$110.28</td>
</tr>
<tr>
<td>Cataract</td>
<td>66984</td>
<td></td>
<td>$654.47</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>27447</td>
<td>20.72</td>
<td>$1408.05</td>
</tr>
</tbody>
</table>
LEARNING OBJECTIVES

- Review the historical Context of Physician Payment
- Discuss process by which codes are valued by the RUC (Relative Value Update Committee)
- Learn the new E/M documentation and coding requirements and valuation that will go into effect January 1, 2021
Fixing Medical Prices
How Physicians Are Paid
by Miriam Laugesen
A BRIEF HISTORY OF PHYSICIAN FEES

A tragedy (?) in three acts
ACT I: IN THE BEGINNING...
ACT I: IN THE BEGINNING...

Usual and customary charges

- Limited regulatory framework
- Common minimum fee schedules served to protect physicians
- Physicians were exempt from anti-trust laws.
- Limited pushback from insurance companies
ACT II: AFTER THE WAR
ACT II: AFTER THE WAR

The origin of a standardized nomenclature

- Third party payers on the rise
- The House of Medicine recognizes the need to standardize
- Physicians are proactive to maintain control
- The California Medical Society (CMS) develops a relative value system
ACT III: MODERN TIMES
ACT III: MODERN TIMES

Development of the RBRVS
(Resource Based Relative Value Scale)

- In the 1970s Medicare expenditures began to grow
- Supreme Court finds that physicians were no longer exempt from anti-trust laws
- Beginning of the end of the CMS RVS system
- In the 1980s William Hsiao’s work forms the blueprint of this new system
- In 1989 with passage of Omnibus Budget Reconciliation Act HCFA permanently switches Medicare to an RBRVS payment schedule
We surveyed approximately 850 physicians in eight surgical specialties to investigate physicians' work in performing invasive services. Building on our analysis of physician work, we developed a relative value scale of physicians' services based on resource costs. We found that physician charges are not set in proportion to the resources required to perform a given procedure.
DEFINITIONS

• **Relative Value Scale**: A system of assigning value to something in comparison to other similar items.

• **Resource Based Relative Value Scale (RBRVS)**: System of assigning unit values to medical services (in relation to one another) based on the skill, time, and equipment required by clinicians to complete a given service.
WHAT IS RBRVS

- **Resource Based Relative Value Scale**
  - What are the resources that go into a particular procedure?
  - When Hsaio et al. studied these resources, he included
    1. The *physician time* spent on the service or visit
    2. The *intensity* during the service (mental effort)
    3. The *practice costs* necessary to provide the service
       - Supplies, equipment, and non-physician manpower
    4. The opportunity costs of training (income forgone when additional years of training are pursued). This has now been replaced by *malpractice costs*
WHAT IS RBRVS

- Resource Based Relative Value Scale
  - Each of the following components is assigned an RVU:
    - **Time & Intensity** (AKA work) = work RVU or wRVU
    - **PE** (Practice Expense) = PE RVU
    - **Malpractice Expense** = LI RVU
  - These RVUs are simply added together to give the total RVU of a service
  - The RVU is multiplied by the Medicare conversion factor to give the reimbursement of the procedure (current conversion factor = $36.09)
## Example of RBRVS RVU

- **99214**

<table>
<thead>
<tr>
<th>Work RVU</th>
<th>PE RVU</th>
<th>Malpractice RVU</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.50</td>
<td>1.46</td>
<td>0.10</td>
<td>3.06</td>
</tr>
</tbody>
</table>

\[
3.06 \times 36.09 = 110.44
\]
WHAT THE RBRVS IS NOT

It is not a way to incentivize value in the health care system
WHAT THE RBRVS IS NOT

It is not a way to incentivize value in the health care system

I do more (unnecessary?) work because I get paid more for it...
Katina Mulilo

Katina Mulilo
THE RUC

- The RUC (Relative Value Scale Update Committee) is a multispecialty committee of the AMA
- Formed in 1992
- It is a zero-sum game.
THE RUC

- 31 physicians and 300 medical advisors
  - Chairperson (1)
  - Practice expense subcommittee chair (1)
  - 21 physicians major medical societies (anesth, cards, derm, ER, Fam Med, Gen Surg, Geriatrics, IM, Neuro, Nsgy, Ob/Gyn, Ophtho, Ortho, ENT, Path, Peds, Plastics, Psych, Radiology, Thoracic, Urology)
  - 4 Rotating members: IM subspecialty (2), Primary Care (1), any surgical subspecialty (1)
  - Also slots for the AMA rep, CPT rep, HCPAC rep, and AOA
- Use Hsaio methodology (surveys of time, intensity, etc)
- Takes a 2/3 majority to approve the value of a code
“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”
SO WHAT IS NEW IN BILLING AND DOCUMENTATION FOR 2021?

• A lot!
HOW DID WE GET HERE?

• Tom Price and specialty societies agreed to focus on easing documentation burdens for outpatient visits.

• CMS held a series of listening sessions in 2017-2018.

• In 2018, CMS released its plan: collapse all the E/M codes.

• Specialty societies (including ACP and AMA) were not happy with this proposal.
HOW DID WE GET HERE?

• AMA/ACP lobbied CMS to delay the plan and put together a workgroup to come up with an alternative proposal.

• The AMA workgroup convened in 2018-2019 to develop new coding guidelines

• The new coding guidelines were approved by the CPT committee and presented to RUC April 2019.

• It passed and was accepted by CMS
YOU NOW HAVE 2 OPTIONS TO CHOOSE A LEVEL OF SERVICE

Select the appropriate level of E/M services based on the following:

**OPTION 1**

The level of the *medical decision making* as defined for each level of service; or

**OPTION 2**

The *total time* spent on the date of the encounter.
HISTORY & PHYSICAL

- “Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. “

- The nature and extent of the history and/or physical examination is determined by the treating physician

- The history and physical will not longer be elements in determining level of visit
TWO MORE POINTS

- Code 99201 has been eliminated

- The criteria for coding for a new patient and an established patient are now identical
MEDICAL DECISION MAKING

- When billing is based on Medical Decision Making...
- MDM will be based on three domains as it is now
  - 1. Number & Complexity of Problems
  - 2. Amt & Complexity of Data to Review
  - 3. Risk of Complications/ Morbidity
- You need to 2 of the three domains to bill at a given level
## MEDICAL DECISION MAKING

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>Minimal or none</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A self limited or minor problem runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Most Viral URIs will be level 2 visits.
<table>
<thead>
<tr>
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<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203 99213</td>
<td>Low</td>
<td>Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>
MEDICAL DECISION MAKING

TIP
Almost anything more than the common cold will be at least a level 3

A single stable chronic illness (HTN or DM) on medication

TIP
A single stable illness where two labs are obtained is a level 3
  • DM with HgA1c and urine M/C ratio
  • Hyperlipidemia with Lipids and LFTs

TIP
An acute uncomplicated illness where a med is prescribed is a level 3 (cystitis, allergic rhinitis, simple sprain)
<table>
<thead>
<tr>
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<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Moderate (Must meet the requirements of at least 1 out of 3 categories)</td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
<td>Any combination of 3 from the following:</td>
<td>Category 2: Independent interpretation of tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td>Category 3: Discussion of management or test interpretation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review of the result(s) of each unique test*;</td>
<td>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ordering of each unique test*;</td>
<td>• Prescription drug management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assessment requiring an independent historian(s)</td>
<td>• Decision regarding minor surgery with identified patient or procedure risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
<td>• Decision regarding elective major surgery without identified patient or procedure risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Category 2: Independent interpretation of tests</td>
<td>• Diagnosis or treatment significantly limited by social determinants of health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL DECISION MAKING

**TIP**
Two stable chronic illness (HTN, Hyperlipidemia) on medication is a level 4

**TIP**
A single chronic illness that has progressed, on medication, is a level 4 (DM or COPD that has worsened)

**TIP**
An undiagnosed new problem where three labs are ordered/reviewed, or you need to discuss case with another physician

**TIP**
An undiagnosed new problem of uncertain prognosis where prescription drug management is used
## Medical Decision Making

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205 99215</td>
<td>High</td>
<td>High 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Extensive <em>(Must meet the requirements of at least 2 out of 3 categories)</em>  <strong>Category 1: Tests, documents, or independent historian(s)</strong>  <em>Any combination of 3 from the following:</em>  1. Review of prior external note(s) from each unique source*;  2. Review of the result(s) of each unique test*;  3. Ordering of each unique test*;  4. Assessment requiring an independent historian(s)  <strong>Category 2: Independent interpretation of tests</strong>  1. Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);  <strong>Category 3: Discussion of management or test interpretation</strong>  1. Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment  <strong>Examples only:</strong>  1. Drug therapy requiring intensive monitoring for toxicity  2. Decision regarding elective major surgery with identified patient or procedure risk factors  3. Decision regarding emergency major surgery  4. Decision regarding hospitalization  5. Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
The definition of severe is when the doctor says (documents) it is severe (COPD or CHF exacerbation)

A severe exacerbation requiring a med that will require monitoring within three months is a level 5

A severe exacerbation where a decision is made to send to ED or directly admit is a level 5
BILLING BASED ON TIME

- When billing is based on time, the total time spent on patient activities on the day of service is used.

- This sunsets "greater than 50% of the face-to-face time is spent on counseling and/or coordination of care."

- Examples of activities that count toward total time
  - Prepping to see patient (reviewing notes or tests)
  - Documenting the encounter
  - Face-to-face time with the patient
  - Consulting point of care resources
BILLING BASED ON TIME

<table>
<thead>
<tr>
<th>New Patients</th>
<th>Time required to bill (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td>45-59</td>
</tr>
<tr>
<td>99205</td>
<td>60-74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Established Patients</th>
<th>Time required to bill (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10-19</td>
</tr>
<tr>
<td>99213</td>
<td>20-29</td>
</tr>
<tr>
<td>99214</td>
<td>30-39</td>
</tr>
<tr>
<td>99215</td>
<td>40-54</td>
</tr>
</tbody>
</table>
PROLONGED SERVICE CODE

- When billing based on time, for every 15-minute increment above and beyond a level 5 code, you can add a 99XXX.
- Each 99XXX is worth 0.61 wRVU.
**PRIMARY CARE/COMPLEXITY ADD-ON**

| GPC 1X | Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. | Value = 0.33 RVU |

- This code can be added to any level of E/M code for the appropriate patient.
## Proposed Work RVU Increases

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Current Work RVU</th>
<th>New Work RVU</th>
<th>Work RVU Increase</th>
<th>wRVU Inc. w/ Add-on</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Deleted</td>
<td>Deleted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>0.93</td>
<td>0.93</td>
<td>No change</td>
<td>35%</td>
</tr>
<tr>
<td>99203</td>
<td>1.42</td>
<td>1.6</td>
<td>13%</td>
<td>36%</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
<td>2.6</td>
<td>7%</td>
<td>21%</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
<td>3.5</td>
<td>10%</td>
<td>21%</td>
</tr>
<tr>
<td>99211</td>
<td>0.18</td>
<td>0.18</td>
<td>No change</td>
<td>183%</td>
</tr>
<tr>
<td>99212</td>
<td>0.48</td>
<td>0.7</td>
<td>46%</td>
<td>115%</td>
</tr>
<tr>
<td>99213</td>
<td>0.97</td>
<td>1.3</td>
<td>34%</td>
<td>68%</td>
</tr>
<tr>
<td>99214</td>
<td>1.5</td>
<td>1.92</td>
<td>28%</td>
<td>50%</td>
</tr>
<tr>
<td>99215</td>
<td>2.11</td>
<td>2.8</td>
<td>33%</td>
<td>48%</td>
</tr>
<tr>
<td>99xxx</td>
<td></td>
<td>0.61</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>