The value of time and its relationship to compensation for surgical procedures

What is an RVU?

Under the Social Security Act, Medicare has established a national fee schedule for physicians based on Relative Value Units, also known as RVUs. RVUs are part of the Resource Based Relative Value Scale (RBRVS), which was adopted by Medicare in 1992. To understand this system, one must understand exactly what an RVU is. The total RVU consists of 3 distinct components:

1) Work (RVUw)
2) Practice Expense (RVUpe)
3) Malpractice (RVUm)

The major component of the total RVU is the work RVUs or RVUw, which accounts for 50-53% of the total RVU. Work RVUs specifically relate to the work performed by a physician for a specific task and reflects an estimation of time and effort put forward by that physician.

The RVUpe reflects the practice expenses and accounts for about 45% of the total RVU, and this includes all non-physician and administrative costs, office expenses, and other miscellaneous expenses such as accounting and legal.

The RVUm reflects an estimation of risk or “malpractice expense” and accounts for the smallest portion of the total RVU.

Additionally, Medicare adjusts payment geographically by designating a geographic practice cost index, or GPCI. The RVU is then converted into a monetary value via a conversion factor, CF. The CMS Medicare CF varies from year to year, with the current CF being $35.8279. Thus, the payment formula is:

\[ \left( (RVUw \times \text{work GPCI}) + (RVUpe \times \text{PE GPCI}) + (RVUm \times \text{malpractice GPCI}) \right) \times \text{CF for that particular year} \]

The Social Security Act mandates the RVUs for each CPT code be reviewed and updated every 5 years to adjust for changes in clinical practice. This process is done in coordination with the American Medical Association’s Relative Value Update Committee, also known as RUC, providing the appropriate stakeholder input for code value determination. Additionally, the Affordable Care Act (ACA) provides for code review through the RUC that are potentially misvalued as determined by CMS audit.
What is the Work RVU (RVUw) comprised of?

The RVUw, or physician work RVUs, consists of two elements: Time, which accounts for about 70%, and effort, which accounts for about 30%. It is important to understand what “time” and “effort” actually mean. The effort portion of the RVUw includes physical effort, skill and stress involved. It is therefore also a reflection of the training necessary to perform the service. Thus, more complex services equate to higher RVUw values. Time is determined by the minutes a physician spends preparing for a service, the time spent performing a service and time spent following a service. So, for a surgical procedure, this would include time spent in pre-operative, intra-operative, and post-operative services. For Urogynecologic procedures, this often includes hospital and outpatient visits out to 90 days after surgery. The components of RVUw are broken down as follows:

Pre-service work
Pre-admission orders, history and physical, review of consent, communication with patient and staff, patient preparation, positioning and draping, equipment setup
Scrubbing, waiting (i.e. while nursing/anesthesia procedures occur), site marking and time out

Intra-Service Time
“Skin to skin” time, including actual procedure time, wound closure, application of necessary dressings

Post-Service Time
Day of procedure – transport, orders, paperwork, dictation, communication with family, staff postoperative facility visits from date of service through discharge and related office visits within global period.

For example, typically there are 2-3 office visits during the global period that are actually pre-paid. This would encompass postoperative visits for things like voiding trials, staple removal, UTIs, constipation, and other postoperative concerns as well as completion of surgery related paperwork. Thus, it is important to keep in mind that when we are being reimbursed for a surgical procedure, intraservice time accounts for only about half of the total payment. In other words, physician payment for a procedure includes not only payment for the procedure but a “pre-paid” amount to compensate for a set number of postoperative visits, both in the hospital/ambulatory setting and in the office as well, up to the designated limit of the global period. Specifically, these are payments made to the physician for work that is expected to be performed by the physician as part of the initial valuation of the service, not support staff or resident physicians.

Last Updated by the AUGS Coding and Reimbursement Committee in February 2019
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What is the global surgical package?

Medicare has established the concept of “the global surgical package”. The global surgical package includes all necessary services normally provided by a surgeon prior to, during, and following a procedure. Thus, Medicare payment for a surgical procedure includes the pre-, intra- and post-operative services which are generally performed by the surgeon or by members of the same group within the same specialty. This means that physicians in the same specialty who belong to the same group practice must bill as though they ARE a single physician. Physicians (including partners or covering physicians) are expected to provide these services which are related to the procedure without generating additional charges. There are 3 types of global surgical packages:

**Zero Day Post-Operative Period**, (endoscopies and some minor procedures).

- No pre-service work is paid for
- No post-operative visits
- Visit on day of procedure is generally not payable as a separate service

**10-Day Post-Operative Period**, (other minor procedures).

- No pre-service work is paid for
- Visit on day of the procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.

**90-Day Post-Operative Period**, (major procedures)

- One-day pre-service work is included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery

Payment is based upon the “typical” patient, with the understanding that some patients may require fewer services while some patients will require more related services for the same procedure. Physicians cannot bill for related services, including critical care services, or additional related visits, during the global surgical period.
What does RUC stand for?

RUC stands for Relative Value Scale Update Committee. The AMA established this committee to act as an expert panel in making relative value recommendations to CMS. The RUC involves not only the AMA, but also medical Specialty Societies as an opportunity for physician input to impact relative values. As a physician, one may be asked to participate in the RUC survey process, which aids in the valuation of CPT codes. The primary purpose of the RUC survey is to obtain an estimate of physician time involved with and complexity of a particular CPT code, i.e. the RVUw value. For a CPT code that is being surveyed, a representative group of at least 30 physicians familiar with the service or procedure is surveyed; a higher response rate gives greater credibility to the RVUw recommendation and facilitates improved support for the code values. RUC survey results are then discussed with a specialty-specific expert consensus panel. The panel then makes specific recommendations for physician work value, procedure times, and number/level of visits. These recommendations are subsequently submitted to the AMA and reviewed at a RUC meeting. The RUC then makes recommendations to CMS for consideration. Recommendations, if approved, go into effect in January of the following year.

It is critically important physicians understand the RUC process. The survey instrument is based on the typical patient. The survey asks for time estimates and it is very important to keep in mind the global surgical period when evaluating a new or revised code. Additionally, when the survey asks for the time required to perform a procedure, the physician should provide an accurate estimate of a typical case based on personal experience so the CPT code can be fairly valued. For example, CMS currently assigns the following “intra-service” times to the following commonly performed procedures:

Total Abdominal Hysterectomy (CPT 58150): 120 minutes

Total Vaginal Hysterectomy, <250g (CPT 58260): 60 minutes

Sling operation (CPT 57288): 60 minutes

From a practice management perspective and continuing with the above examples, if a surgeon takes twice as long to perform 58260, 120 minutes, then reimbursement per minute is half that provided to the average physician per minute because of the RUC valuation. However, when physicians are asked to complete RUC services, it is imperative to list surgical times accurately for the typical patient.

Purposefully underestimating or overestimating procedure times invalidates the data and provides inaccurate data for appropriate value determination.
The RVUs and included times for all CPT codes are publicly available through the CMS website. In addition, specialty societies, such as ACOG, have publications that list both the RVUs and time elements for common CPT codes. These are included in the ACOG coding manual, available through the ACOG website, and is updated annually, to reflect the ongoing re-surveying of CPT codes.

References:


Additional Useful Links:

Medicare Claims Processing Manual:

CMS Physician Fee Schedule Search:
[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html)