

# What surgeons should know about . . .

## The “five-year review”

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**W**hen Congress passed the legislation that established the resource-based relative value scale (RBRVS) for payment of physician services provided to Medicare patients, it mandated that the reimbursement system undergo regular review every five years. The RBRVS went into effect in 1992, so, the results of the first five-year review were implemented in 1997. In order to complete the first review in time for implementation, the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) began its review process in 1995. The RUC had been formed in 1991 to make recommendations to the Health Care Financing Administration (HCFA) on the physician work relative value units (RVUs) to be assigned to new or revised codes in the AMA *Physicians' Current Procedural Terminology (CPT)*.

For the second five-year—or as some call it, the 10-year—review, RUC has begun the process even earlier. Modifications to the Medicare Physician Fee Schedule stemming from the second five-year review are expected for 2002.

**Q. What is the purpose of the five-year reviews?**

**A.** The purpose of the reviews is to identify physician work RVUs that are misvalued relative to other procedures and services in the Medicare physician fee schedule. The first review focused on identifying those procedures with work values that had increased or decreased since the initiation of the RBRVS in 1992, ei-

ther due to advances in technology or a change in patient severity of illness.

**Q. How did the first five-year review function? How do the two reviews compare?**

**A.** The review focused on the RBRVS physician work component, because practice expense and malpractice RVUs were not yet “resource based.” HCFA’s finalized work RVUs agreed with the RUC recommendations for 93 percent of the codes. Since the practice expense RVUs are in the middle of transitioning to a fully resource-based system by 2002, and resource-based malpractice RVUs were only implemented in 2000, these values are not part of the second review either. Eventually both of these components will be subject to review.

For the first review, the process for reviewing comments on physician work values that are in need of refinement was published in the December 8, 1994, *Federal Register*, and the results of the first review were published in the November 22, 1996, *Federal Register*. We expect a comparable process for completion of the second five-year review.

**Q. What were the College’s results for the first five-year review?**

**A.** Of the codes submitted by the College for the first five-year review, the physician work RVUs were increased for 10 codes, such as appendectomy (CPT 44950, 56315—now

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44970—via laparoscope) and repair of the abdominal wall (CPT 49900). Details of the results were included in a feature article in the March 1997 issue of the *Bulletin* entitled “The 1997 Medicare fee schedule and results of the five-year review” (82(3):18-22). Also, the article “What surgeons should know about...HCFA’s proposed Medicare five-year review regulations” was published in the September 1996 issue of the *Bulletin* (81(9):8-10).

**Q. Would you please describe the process followed in a five-year review, so I can fully understand why it takes so long for changes to be made in RVUs?**

**A.** The process is very lengthy, indeed. As mentioned previously, two years before new values are implemented, HCFA publishes a proposed rule, which describes the intent and a suggested format for the RUC to follow in its review. The proposed rule also contains the following pieces of information: 1) a process for submitting data to the RUC for review and for submitting final recommendations to HCFA; 2) values in the spring of the year prior to implementation; and 3) a comment period, including a deadline and instructions on where written comments (in triplicate) should be submitted. HCFA then reviews the comments using a “refinement process.” A final rule is published in the fall prior to implementation of values; the final rule includes an Appendix that gives the resultant physician work values per CPT code. The College and the surgical specialty societies perform a significant amount of work during the period between the proposed and final rules, in addition to the survey work completed by selected members of each specialty, in order to provide data through the RUC process.

**Q. I received a request to complete some rather daunting AMA RUC**

**surveys for surgical CPT codes. Is my participation in this survey process useful?**

**A.** Your individual participation is essential to the AMA RUC process. RUC survey responses from at least 30 physicians are needed for each code. Ideally, these responses should come from a geographically diverse group of physicians representing a broad spectrum of practice types (solo, small group, large group, academic, and military practices). A sample vignette or an example of the typical patient—not the most complicated patient a surgeon operated on recently—under the procedure that is being reviewed is provided as a guideline. Survey participants select a reference service (from a list provided by your specialty society) to compare the pre-, intra-, and post-service components (including all the inpatient and office post-procedure visits) of the operative procedure under review. Survey data are tabulated and the median values, as well as the 25th and 75th percentiles, are identified. The aggregated data are then reviewed by the specialty’s committee charged with this process.

For the American College of Surgeons, the General Surgery Coding and Reimbursement Committee finalizes the summary recommendation and submits it to the AMA RUC. Most often the median survey values are selected. In addition to the survey results, compelling evidence is presented to an AMA RUC workgroup, which is then provided to the entire RUC committee for review and approval. Examples of “compelling” evidence are: significant changes in technique or technology supported by peer-reviewed medical literature; changes in the patient population, such as sicker and/or older patients, changes in the number and level of postoperative visits, changes in the global period, or simpler operations being paid at a higher level than more complex procedures requiring

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additional time and physician effort (identified by RUC as rank order anomalies between procedures). Additionally, compelling evidence includes problems with the original Harvard RBRVS data—for example, a misleading vignette, misguided crosswalk assumptions, or flawed methodology. RUC provides recommendations to HCFA, and the agency makes the final decision based on the values. HCFA also has, in the past, conducted a refinement process that includes medical specialty representatives who understand the procedures under review.

Most recently, young surgeon representatives, as well as general surgery representatives to Medicare's Carrier Advisory Committees, have been asked to complete RUC surveys. Members of the College's General Surgery Coding and Reimbursement Committee met with local and regional colleagues to describe the survey process and to ask for help. We have also used data collected independently by the American Society of General Surgeons (ASGS) and the American Society of Colon and Rectal Surgeons (ASCRS).

The College wants to thank all survey respondents publicly for the significant amount of time they spent away from their practices and families to complete surveys. The survey data provided justification for requesting changes to 314 misvalued general surgery services. As CPT codes are added or revised and values assessed, we will need to continue to survey surgeons. So, we encourage you to complete surveys when asked.

**Q. Why does the College only comment on general surgery codes, rather than all surgical codes?**

**A.** The College's principal role in the RUC process is to represent general surgery. Other surgical specialties are represented by their specific societies. College representatives for this process are: John O. Gage, MD, FACS,

RUC representative (one of the few remaining charter members of RUC); Charles D. Mabry, MD, FACS, RUC alternate; Paul E. Collicott, MD, FACS, RUC advisor; and Frank G. Opelka, MD, FACS, representative to the Practice Expense Advisory Committee (PEAC), a subcommittee of the RUC. Other members of the General Surgery Coding and Reimbursement Committee work on these issues as representatives of their specialties. Aaron S. Fink, MD, FACS, has been the RUC Advisor for the Society of American Gastrointestinal Endoscopic Surgeons; Diller B. Groff, MD, FACS, American Pediatric Surgical Association, represents pediatric surgery; and Robert M. Zwolak, MD, FACS, Society of Vascular Surgery and the American Association for Vascular Surgery, is the RUC representative for vascular surgery. During RUC meetings, the College frequently convenes all surgical representatives on RUC and PEAC to discuss issues of mutual interest. There are many important issues on which surgeons can provide their input and represent their specialty interests.

**Q. What are the results of the second five-year review to date?**

**A.** On August 24 and 25, representatives from the College met with Workgroup 2 of the RUC to present survey data and other compelling evidence to support changes in 314 general surgery codes. Six workgroups were developed to review data from general, vascular, thoracic, and pediatric surgery, as well as other specialties that have a smaller number of codes. RUC members were assigned to various groups, and the massive work load for the current five-year review was distributed among these workgroups. The workgroups then reviewed written summaries of traditional survey data, and/or consensus panel recommendations from specialty groups. The RUC general surgery Workgroup 2 was chaired by James Moorefield,

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MD, a radiologist. The other four members of the workgroup were: William Gee, MD, FACS, a urologist; David Hitzeman, DO, an osteopath; William Rich, MD, FACS, an ophthalmologist; and Peter Sawchuk, MD, an emergency medicine physician.

On the first day of the meeting, Workgroup 2 reviewed 32 codes individually with supporting traditional RUC survey data. The remaining 282 codes were presented with minisurvey data. Minisurveys included selected data (time and number and levels of postoperative visits) collected on other codes within the family or grouping of the 32 anchor codes. ASGS participated in data collection for 14 codes, and the ASCRS participated in surveying eight codes. Through the building-block methodology (valuing the component parts—pre-work, intra-service work (skin-to-skin time), and post-service work), changes within the families of codes were justified. To date, the workgroup has recommended increases for many of these codes, but not to the extent proposed by the College. Workgroup recommendations were approved by the full RUC. The RUC's recommendations will be forwarded to HCFA, which is likely to convene its own refinement panels to independently review at least some of the RUC's recommendations. HCFA has the final say on the revised physician work values, and this is the important final step. Payment revision due to the five-year review will become effective in 2002. More information about this process will be provided at a later date.

**Q. I recall reading recent *Bulletin* articles related to this issue. Would you please provide the source information.**

**A.** Dr. Mabry wrote an article entitled "On the cutting edge of reimbursement strategies: The ACS develops new techniques"

for the June 2000 *Bulletin* (85(6):13-21). This article provides a more in-depth analysis of the five-year review. Additionally, the January 2000 *Bulletin* (85(1):36-39) contains the article "In their own words: Practice expenses and the RBRVS revisited" by Dr. Opelka. Related reading, "What surgeons should know about...The 2000 Medicare fee schedule," by Cynthia A. Brown, Associate Director of the College's Health Policy and Advocacy Department, appears in the same issue on pages 8-12. □