

Resource Based Relative Value Scale (RBRVS)

September 2, 2009

History

The development of relative value scales dates to the early 1950s. The prototype was first used by the California Medical Association in 1956 and was known as the California Relative Value Scale (CRVS). The original models were based strictly off billed charges when determining the value of one procedure to another. Over the next 30 years many third party payers across the country utilized the CRVS to determine their reimbursement to providers.

In 1985, Congress established the Physician Payment Review Commission (PPRC) to help formulate changes in the system that Medicare used to pay physician services. In December 1985, Harvard conducted a national Resource Based Relative Value Scale (RBRVS) Study at the request of the Health Care Financing Administration (HCFA) whose name was changed later to the Centers for Medicare & Medicaid Services (CMS). In September 1988, Harvard submitted Phase I of the RBRVS Final Report to HCFA/CMS. Based on the study, the recommendation of the PPRC and subsequent legislative action reform was in the making.

Congress passed the Omnibus Budget Reconciliation Act of 1989 which enacted a physician payment schedule based on a RBRVS. The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) was formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised codes in Physicians' *Current Procedural Terminology* (CPT®). In November 1991, the initial meeting of the AMA/Specialty Society RUC took place: RUC charter documents were created; RUC approved for the formation of the Research Subcommittee, and a RUC Advisory Committee and a Health Care Professionals Advisory Committee were established. The annual updates to the physician work relative values are based on recommendations from a committee involving the AMA and national medical specialty societies. In January 1992, Medicare implemented RBRVS as their methodology for developing reimbursement. Since that time a significant number of recommendations from the RUC have been accepted and utilized in the RBRVS system. In 1998 the Practice Expense Advisory Committee (PEAC) was created to provide additional input.

There have been continual changes and improvements in RBRVS Methodology since its beginning in 1992. Many of the changes and improvements are a result of involvement by the AMA and other specialty societies giving physicians a voice in shaping the relative values established in RBRVS Methodology.

RBRVS Methodology

RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services. RBRVS Methodology ranks services according to the relative cost required to provide that service and compares that service in relation to other services. Some procedures are more complex and time consuming than others and some require more resources than others. In determining that value, each procedure has been given a Relative Value Unit (RVU). An RVU has three components and those components may vary based on the nature of the procedure or service as mentioned above.

The RVU for each procedure is based on the components below:

Physician Work reflects the physician's time, skill and intensity required for the services.

Practice Expense reflects the physician's direct expenses which include: office rent, staff, supplies, equipment and other overhead that may be required to provide the service. The practice expense can vary based on the site of service, i.e., whether the procedure was performed in the physician's office or in a hospital setting.

Practice Liability Expense reflects the professional liability or malpractice expense to the physician to provide a service.

This methodology is nationally recognized and widely used by 70 percent of the commercial payers in addition to CMS, TRICARE and other government programs. The RVU determination is maintained and adjusted based on recommendations of committees involving AMA and specialty societies to ensure that the entire medical profession is represented in this process.

The RVU for each CPT code is publically available and can be found at cms.hhs.gov.

Reimbursement Calculation

With RVUs, the value of a procedure relative to another procedure is set based on a number. Government programs and commercial insurers use that relative value to determine reimbursement for a particular procedure or service. A scaling factor known as a "conversion factor" is used to convert the RVU into a fee for reimbursement. The conversion factor(s) used may be a single conversion factor or many based on the carrier or payer's pricing methodology. The conversion factor is at the discretion of the payer. Other factors may be added in to compare services performed in different geographical areas if that is considered necessary for the payer.

Blue Cross and Blue Shield of Alabama is phasing in our relative based pricing methodology using the Resource Based Relative Value Scale (RBRVS). In order to accomplish that transition, we will utilize many conversion factors during the current phase.

Facility and Non-Facility Fees

Many of the physician services can be performed in either an office setting or a facility setting, which may include hospital inpatient, outpatient, ASC, etc. As mentioned above, one of the components of the RVU calculation is that of **Practice Expense**. When physician services can be performed in either a facility or a non-facility setting, the following values account for the practice expense:

Non-Facility Practice Expenses represent the physician's direct and indirect cost related to providing that service in the physician's office, patient home or other non-hospital setting. Those expenses could include rent for office space, employees, supplies, equipment, etc.

Facility Practice Expenses represent the physician's direct and indirect cost of providing a service in a facility setting. The expenses of rent, supplies, labor and equipment are part of the cost of the facility where the service is being rendered.

Site-of-Service

The RVU specific to the site-of-service provides the ability to establish a physician fee that is appropriate to compensate for the physician's costs associated with performing a given procedure in a particular setting. In most cases, the physician practice expense in the office setting is higher than it would be in a hospital. The result of the difference is a higher RVU in the office resulting in a higher fee. On the resulting fee schedule, you will see a reimbursement for a facility setting and non-facility setting when appropriate. The implementation of RBRVS and the site-of-service component allows the incentive office surgery procedures listed in Exhibit F of the PMD Agreement to be properly priced so they will be deleted from the agreement.