Demystifying RVUs

Part of CAPC Billing Series

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Center to Advance Palliative Care™

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Billing Series: CAPC Events and Resources

- **Upcoming Virtual Office Hours:**
  - **Billing and RVUs in Hospital-Based Palliative Care** with Julie Pipke, CPC

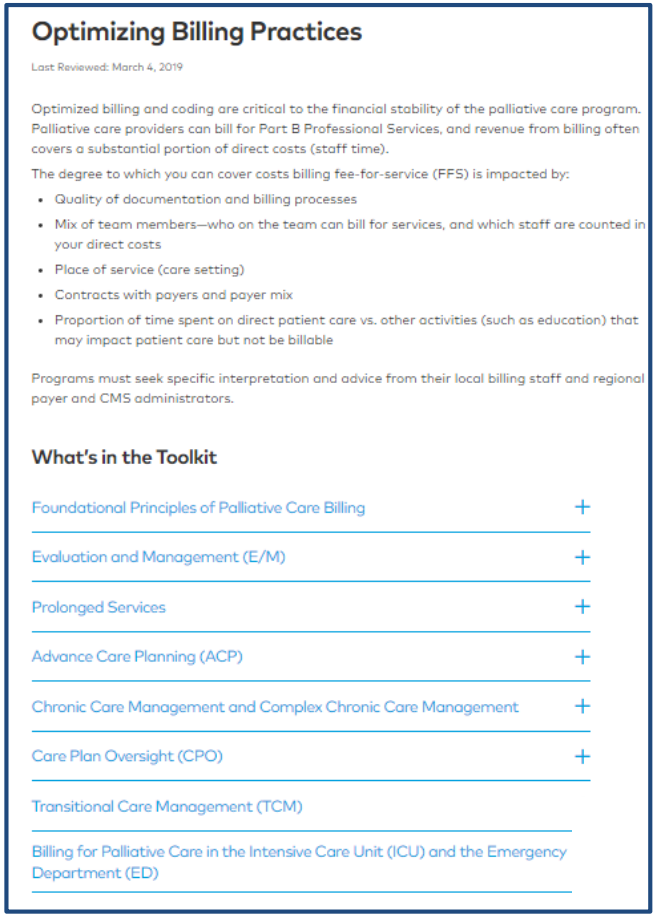
    Fri, September 13 at 12:00pm ET
  - ***NEW*** **Inpatient Billing and Coding** with Philip Santa-Emma, MD, FAAHPM

    Tues, September 17 at 2:00pm ET
  - **Billing for Community Palliative Care** with Anne Monroe, MHA

    Mon, September 23 at 12:30pm ET
- **Webinar Recordings:**
  - **Inpatient Palliative Care Billing: 3 Case Studies**
  - **Billing and Coding for Advance Care Planning: How to Document Services Correctly to Reflect Productivity**
  - *Use the ***NEW*** Topic filter 'Billing, Finance, and Payment' to see additional relevant webinars!*

- **Resources:**
  - **Optimizing Billing Practices**

    https://www.capc.org/toolkits/optimizing-billing-practices/



Optimizing Billing Practices

Last Reviewed: March 4, 2019

Optimized billing and coding are critical to the financial stability of the palliative care program. Palliative care providers can bill for Part B Professional Services, and revenue from billing often covers a substantial portion of direct costs (staff time).

The degree to which you can cover costs billing fee-for-service (FFS) is impacted by:

- Quality of documentation and billing processes
- Mix of team members—who on the team can bill for services, and which staff are counted in your direct costs
- Place of service (care setting)
- Contracts with payers and payer mix
- Proportion of time spent on direct patient care vs. other activities (such as education) that may impact patient care but not be billable

Programs must seek specific interpretation and advice from their local billing staff and regional payer and CMS administrators.

What's in the Toolkit

Foundational Principles of Palliative Care Billing +

Evaluation and Management (E/M) +

Prolonged Services +

Advance Care Planning (ACP) +

Chronic Care Management and Complex Chronic Care Management +

Care Plan Oversight (CPO) +

Transitional Care Management (TCM)

Billing for Palliative Care in the Intensive Care Unit (ICU) and the Emergency Department (ED)

The Center to Advance Palliative Care

NATIONAL SEMINAR

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Learning Objectives

Understand what makes up RVUs:

- ➔ Describe the relationship between RVUs and Billing
- ➔ Explore the complicated relationship between RVUs and productivity in palliative care

Value of RVUs

- RVUs are important **BECAUSE**
  - They are assigned to each CPT code
  - They are a proxy measure of productivity
  - They are widely used
  - They are directly tied to reimbursement

Understand what makes up RVUs

- An **RVU (Resource-Based Relative Unit)** is a numeric value assigned to each CPT code that reflects the practitioner resources required to deliver that service
- Medicare updates its Physician Fee Schedule each year, which assigns RVU totals to each of the 10,000+ CPT codes
- The amount paid for each service is based on the RVU assigned, the annual RVU payment, a 'conversion factor' to maintain budget neutrality, and geographic adjustments
  - Most other insurers follow Medicare's RVU updates

Understand what makes up RVUs:

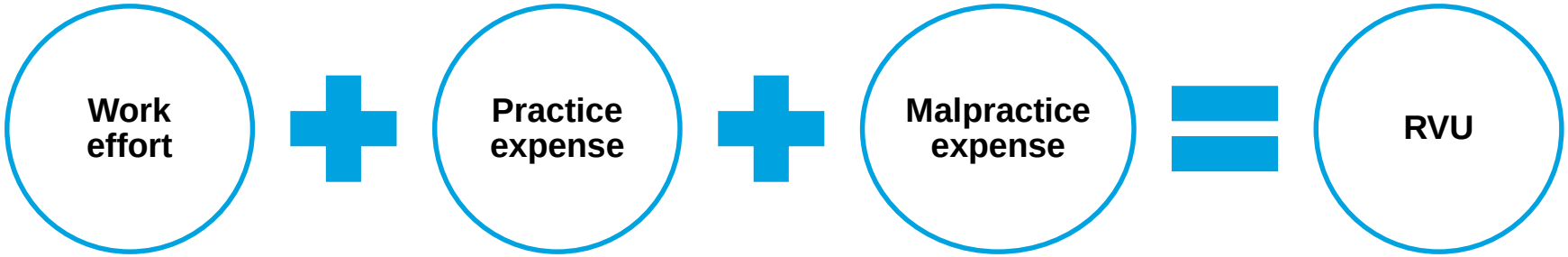
- For each service provided, Medicare determines the RVUs of reimbursement based on:
  1. **Clinician work RVUs (wRVUs)**
  2. **Practice expense RVUs**
  3. **Professional liability insurance RVUs**

Total RVUs = 1 + 2 + 3

Reference: The Basics: Relative Value Units (RVUs). https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf. Accessed May 14, 2019.

Factors included in RVUs

For any given clinical activity there is an RVU that is created by combining 3 factors:



- Time
- Skill
- Expertise
- Intensity

- Rent
- Supplies
- Staff
- Equipment

- Professional liability insurance

Reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093517/

Who can report CPT codes for reimbursement?

- Physicians (MD/DO) and qualified ‘Non-Physician Practitioners” (NPPs), including advanced practice nurses and physicians assistants, who are working under appropriate supervision can bill for their services

- Non-advanced practice nurses, social workers (except those delivering psychotherapy services), and other interdisciplinary team members cannot bill for their services

Clinician Work - wRVU

- Is based on the **time** and **intensity** of each CPT-described
  - 'Intensity' includes technical skill and effort, mental effort and judgement, stress and risk to the patient
- Clinician work is the variable most likely to impact your reimbursement – this will depend on clinician effort, billing and coding expertise, and documentation

Why Your Administrators are Interested in Your wRVUs

- Equity and consistency – “we do it for everyone else”
- Need for comparative metrics to evaluate resource requests
- **Direct correlation to revenue (higher RVU is higher reimbursement)**
- They are a proxy for “accountability” and “productivity”

Work Relative Value Units (wRVU) Table (2019) - Palliative Care and Hospice

Inpatient (Hospital)		Office		Home		SNF		ALF	
Initial (minutes)	wRVU	*New*	wRVU	*New*	wRVU	*Initial*	wRVU	*New*	wRVU
99221 (30 m)	1.92	99201 (10m)	0.48	99341 (20m)	1.01	99304 (25m)	1.64	99324 (20m)	1.01
99222 (50)	2.61	99202 (20)	0.93	99342 (30)	1.51	99305 (35)	2.35	99325 (30)	1.52
99223 (70)	3.86	99203 (30)	1.42	99343 (45)	2.53	99306 (45)	3.06	99326 (45)	2.63
Subsequent		99204 (45)	2.43	99344 (60)	3.38	*Subsequent*		99327 (60)	3.46
99231 (15)	0.76	99205 (60)	3.17	99345 (75)	4.09	99307 (10)	0.76	99328 (75)	4.09
99232 (25)	1.39	*Established*		*Established*		99308 (15)	1.16	*Established*	
99233 (35)	2.00	99211 (5)	0.18	99347 (15)	1.00	99309 (25)	1.55	99334 (15)	1.07
		99212 (10)	0.48	99348 (25)	1.56	99310 (35)	2.35	99335 (25)	1.72
		99213 (15)	0.97	99349 (40)	2.33	*Annual*		99336 (40)	2.46
		99214 (25)	1.50	99350 (60)	3.28	99318 (30)	1.71	99337 (60)	3.58
		99215 (40)	2.11						

Prolonged Services *Face to Face (add-on)*		*Non-F2F (Not for hospice)*		Advance Care Planning		Complex Care Management (Not for hospice)		
Outpatient (face-to-face)	wRVU	Any setting	wRVU	Any setting	wRVU	*CM Initiation*	wRVU	
99354 (30-74 extra)	2.33	99358 (31-75)	2.10	99497 (16-45)	1.5	G0506	0.87	
99355 (76-105 extra)	1.77	99359 (76-105)	1.00	99498 (46-75)	1.4	*CCCM*		
Inpatient (unit/floor)						99487 (first 60m/month)	1.00	
99356 (30-74 extra)	1.71					Add-On		
99357 (76-105 extra)	1.71					99487 (each add'l 30m)	0.50	

Notes:

 # Though Medicare will not, if your insurer pays consult codes (Outpt 99241-5; Inpt 99251-5), consult codes have higher wRVUs than above.

 # All of these codes are billable for hospice patients except Non-F2F Prolonged Codes and Care Management Codes.

 # These are work RVUs only. Total RVUs include practice expense and malpractice expense RVUs as well.

 # RVU information comes from the Medicare Fee Schedule Lookup, shortened at https://go.cms.gov/1QdW07Z .

Graphic credit to Christopher Jones, MD

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Practice Expense RVU

- When a physician provides a service in a facility, such as a hospital or outpatient clinic, the costs of the clinical personnel, equipment, and supplies are incurred by the facility, not the physician practice.
- For services provided in a facility, physicians are paid a “facility-based” practice expense RVU which excludes the practice expenses provided by the facility.
- The “facility-based” practice expense RVU is typically lower than the office-based practice expense RVU for the same service.

Practice Expense RVU: Case

- A diagnostic colonoscopy is provided in the physician's office
  - Physician's payment would be based on a practice expense RVU of 6.78

- A diagnostic colonoscopy is provided in a facility
  - The payment would be based on a practice expense RVU of 1.94

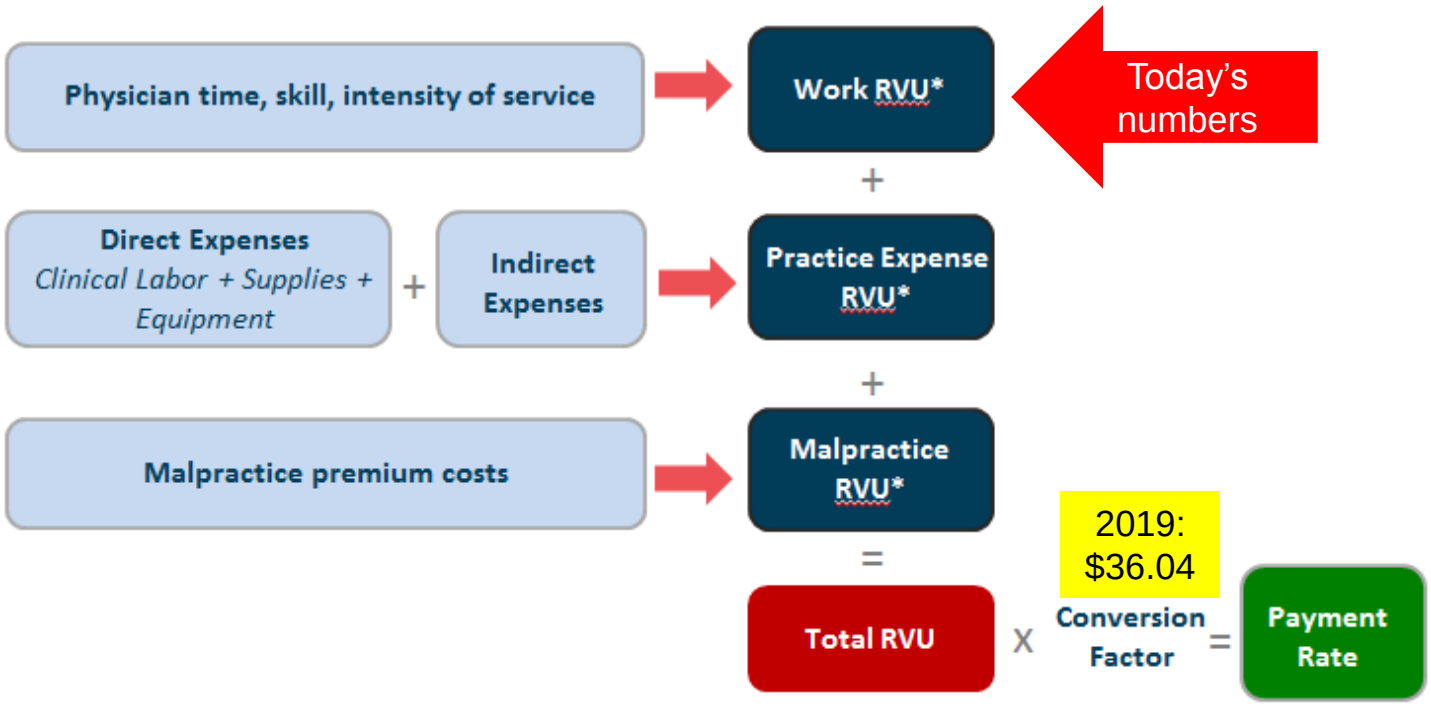
Reference: Overview. CMS.gov Centers for Medicare & Medicaid Services. https://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Accessed May 14, 2019.

Resources for looking up RVUs

- https://www.cms.gov/apps/physician-fee-schedule/overview.aspxww
- https://www.aapc.com/practice-management/rvu-calculator.aspx

RELATIONSHIP BETWEEN RVUs AND BILLING

RVU (Relative Value Unit)



RVU = relative value unit
*All RVU components subject to a geographic adjustment at http://www.e-mds.com/gpci

Reference: https://bit.ly/2F7qeN1
Additional: https://go.cms.gov/2GBI8t4

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RVUs: Case Comparison

- Initial palliative care visit vs total hip arthroscopy
- Both done in a hospital
- Look Up RVUs, multiply by conversion factor (38.02)

CPT Code	Clinician Work RVU	Facility-Based Practice Expense RVU	Professional Liability RVU	Total RVU	Reimburse-ment (Approx)
Initial Hospital Care - Palliative **(99223)**	3.86	1.41	.10	5.37	$204.27
Hip Replacement **(27130)**	20.72	14.32	3.90	38.94	$1,481.28

Reference: AAPC. AAPC. https://www.aapc.com/practice-management/rvu-calculator.aspx. Accessed May 14, 2019.

Case Discussion

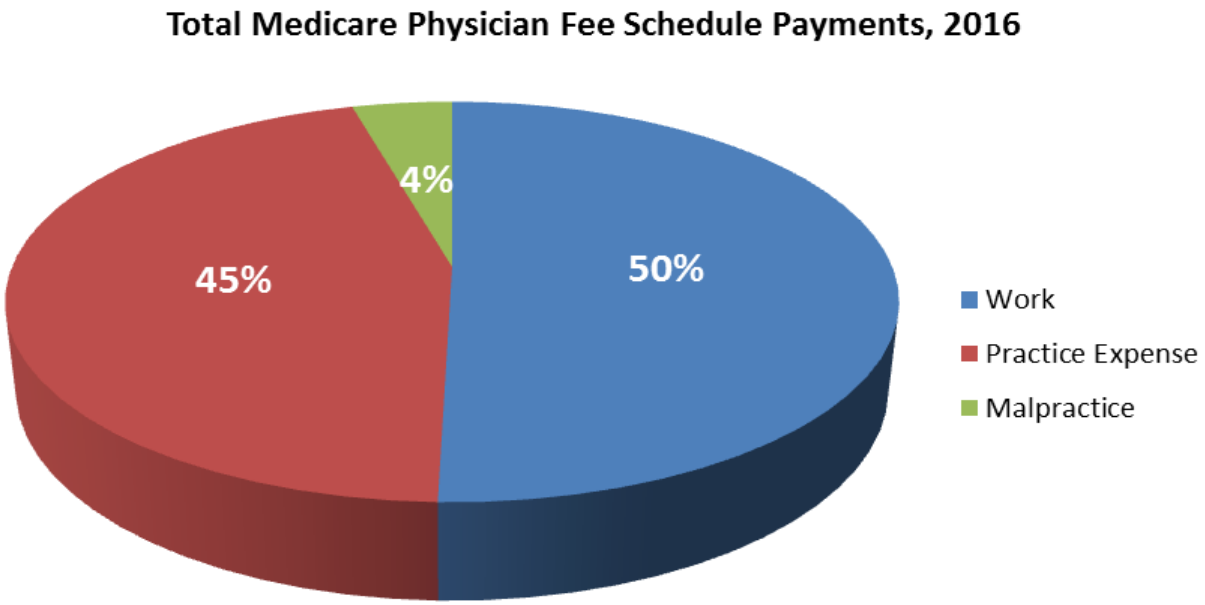
- Per CMS, the arthroscopy requires more physician time and effort than the initial palliative care visit
- The time actually performing the arthroscopy (the intra-service time) is about the same as an initial palliative care visit: 60 min. However, there is more pre- and post-procedure clinician time required for for the surgery.
  - Prepping
  - Scrubbing
  - Closing
- The intra-service time for the arthroscopy is weighted more heavily than the intra-service time for the palliative care visit to reflect Medicare's assessment of the higher skill and effort and associated stress of providing the arthroscopy.
- Pre- and post-op visits are included in the arthroscopy (bundle)
- Orthopedic surgery malpractice is more expensive that that for HPM

RVU Summary

- **Physician work RVUs** account for the time, technical skill and effort, mental effort and judgment, and stress to provide a service.
- **Practice expense RVUs** account for the non-physician clinical and non-clinical labor of the practice, as well as expenses for building space, equipment, and office supplies.
- **Professional liability insurance RVUs** account for the cost of malpractice insurance premiums.

NOTE: Physician work and practice expenses comprise roughly 95% of total Medicare expenditures on physician services.

RVU (Relative Value Unit)



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RVUs AND PRODUCTIVITY

Case: Mr. Z

- Mr. Z has Lung Cancer with hemoptysis, respiratory failure, and COPD. He was admitted to the ICU and put on mechanical ventilation. He has been intubated for 2 weeks and weaning attempts have been unsuccessful. ICU team is considering feeding tube placement, and tracheostomy but his prognosis is poor, and he is agitated. Palliative care team is asked to consult. PC team does a comprehensive history and physical exam and addresses his pain, delirium, secretions in the initial visit and then meets with family in the patients room for 60 min to discuss prognosis and goals of care.

- How would you bill and code this case?

Billing and Coding for Mr. Z

- Option 1
  - Initial inpatient hospital visit Comprehensive History and Physical 99223
- Option 2
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - Prolonged Face to Face meeting – Code 99356
- Option 3
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - ACP discussions first 30 min – Code 99497
  - ACP discussion additional 30 min – Code 99498
- Option 4
  - Bill Critical Care Codes for 90 min of care
    - 99291 for first 74 min
    - 99292 for each additional 30 min beyond the first 74

Comparative RVUs

Code	RVU	Revenue
99223	3.86	$206
99356	1.71	$93
99497	1.50	$80
99498	1.40	$75
99291	4.50	$205
99292	2.25	$103

Answer

- I don't know- BUT there are RVU implications, and RVUs approximate productivity and directly influence revenue.

	Codes	wRVUs	Total wRVUs	Revenue
Option 1 Comprehensive	99223	3.86	**3.86**	**$206**
Option 2 Prolonged Visit	99223 + 99356	3.86+1.71	**5.57**	206+93 **= $299**
Option 3 ACP	99223 + 99497 + 99498	3.86 +1.50+1.40	**6.76**	206+80+75 **= $361**
Option 4 Critical Care	99291 + 99292	4.5+2.25	**6.75**	205 + 103 **= $308**

Many teams only bill for the initial visit and do not take advantage of prolonged, ACP and Critical care services. Meaning only 3.86 RVU. **Did they do less work?**

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Same Visit, Different RVUs

- Billing is influenced by many factors
  - Local culture
  - Regional MAC preferences
- We are not encouraging one way of billing a case like this, just pointing out that HOW you are **billing and coding will impact** measures of productivity using RVUs and **YOUR BOTTOM LINE**

Take Home Points

- Become an EXPERT biller and coder
- Work regularly with your coders to continually improve and problem solve
- Make billing and coding excellence part of your culture

Case 2: Hospital A and Hospital B

Hospital A

- Mostly goals of care and MOLST conversations
  - Uses RN's and MSW's for the majority of the work
  - Physician oversight but limited "hands on" clinical
  - See 2200 new consults per year with an average of 3 follow up visits for a total of 6600 visits/year
  - Bills 500 initial visits and follow ups under MD NPI per year

Hospital B

- Predominantly pain and symptom management
  - Exclusively APRN and MD service
  - No MSW or chaplain
  - Sees 1800 new consults per year with an average of 2 follow up visits for a total of 5400 visits per year
  - Bills 5400 visits under MD and NP NPIs

Case 2: Hospital A and Hospital B

- Which team is more productive?
- Which team generates more revenue?
- Which team is more effective?

Hospital A and Hospital B Palliative Care Teams

- Which team is more efficient in terms of RVUs as a measure of productivity?
  - Team B – is generating more RVUs and more revenue because every visit can generate RVUs
- Which team is more effective?
  - This is why RVUs are complicated in Palliative Care
  - Both teams, neither team, or one of the teams may be meeting the needs of the patients, referring providers and administration
    - RVUs cannot answer this question

Take Home Points

- RVUs are almost universally used in healthcare
- Billing, coding and RVUs do not tell the whole story with regard to effectiveness and productivity in palliative care
  - **BUT** in FFS reimbursement, RVUs = $ so it is important to understand that relationship

RVUs: What's Next?

- New codes available for HPM teams
  - ACP, Prolonged Non-Face-to-Face Services, Complex Chronic Care Management Services, others
- 2020 MPFS may see increases in office-based E/M RVUs, with other E/M services likely to follow
- Value-based payment will not diminish importance of RVUs, as they will remain a fundamental measure of billing clinician work and resources

Questions?

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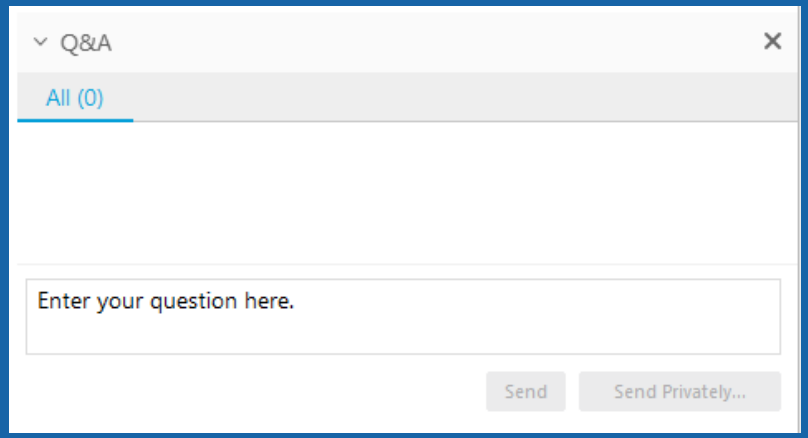

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