Pediatric Application of Coding and Valuation Systems

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The American Academy of Pediatrics provides this technical report as supplemental background to the accompanying coding and valuation system policy statement. The rapid evolution in health care payment modeling requires that clinicians have a current appreciation of the mechanics of service representation and valuation. The accompanying policy statement provides recommendations relevant to this area, and this technical report provides a format to outline important concepts that allow for effective translation of bedside clinical events into physician payment.

STANDARDIZED CODE SETS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Secretary of the Department of Health and Human Services mandates use of standardized code sets in support of electronic health care transactions. These code sets, which address diagnoses, procedures, diagnostic tests, treatments, equipment, and supplies, include International Classification of Diseases, 10th Revision (ICD-10); Healthcare Common Procedure Coding System (HCPCS); Current Procedural Terminology (CPT); National Drug Codes (NDCs); and Current Dental Terminology (Table 1).

The World Health Organization created the ICD-10 with adaptability for expansion and specificity for enhanced measurement, surveillance, research, and reporting across multiple domains. Clinically modified and initiated in the United States on October 1, 2015, the ICD-10 code set encompasses both the clinical modification diagnostic code set in addition to the procedure coding system used for inpatient hospital reporting of procedures. The 4 cooperating parties that oversee and manage the ICD-10 in the United States are the Centers for Medicare and Medicaid Services (CMS), the National Center for Health Statistics of the Centers for Disease Control and Prevention, the American Health Information Management Association, and the American Hospital Association.

abstract

This report represents a collaborative contribution from the members of the Committee on Coding and Nomenclature (COCN) (Chairperson, Dr Molteni). Through multiple meetings, COCN members established the concepts, themes, and structure of the manuscript. Incorporating guidance from COCN members, Dr Kanter (COCN) drafted the manuscript while incorporating additional recommendations from reviewers and the Board of Directors. The authors thank Linda Walsh (Senior Manager, Health Policy and Coding) for guiding the manuscript through production.

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Although the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) remains the HIPAA-mandated code set used in communicating diagnostic selection in electronic health care transactions, additional diagnostic classification systems exist that provide physicians with greater scope and specificity in various clinical areas. For example, classification of mental health disorders is addressed through the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* published by the American Psychiatric Association as well as the *Diagnostic Classification of Mental and Developmental Disorders of Infancy and Early Childhood* (DC: 0–5). The DC: 0–5 classification is especially relevant to pediatrics on the basis of its expanded range and depth of mental health disorders relevant to infants and young children. (See DC: 0–5, available at https://www.zerotothree.org/our-work/dc-0-5.) Although crosswalks exist that relate DC: 0–5 to corresponding ICD-10-CM codes, the relationship between the two is not one-to-one, and DC: 0–5 is not intended to represent a claims-based diagnostic set, as is ICD-10-CM. Instead, DC: 0–5 is intended to complement ICD-10-CM through the inclusion of diagnostic directional and instructive guidance, including application of cultural variables in reaching a diagnosis, which are features not present in ICD-10-CM, a code set bound by an international framework established by the World Health Organization. Because ICD-10-CM expands each year with the inclusion of new codes, opportunities exist to pursue even greater alignment between DC: 0–5 and ICD-10-CM as ICD-10-CM continues to evolve in addressing clinical specificity.

The American Medical Association (AMA) maintains and annually publishes the CPT code set that represents procedures and services performed by physicians and qualified health care professionals. The CPT is otherwise known as level I of the HCPCS. Level II of the HCPCS represents a unique, standardized coding system used to identify products, supplies, medications, and services not otherwise represented in the CPT. HCPCS level II codes include durable medical equipment, prosthetics, orthotics, and supplies and is produced and maintained by the CMS. For example, the CMS often creates G codes as part of the level II HCPCS code set to report Medicare services not otherwise represented in the CPT. The Drug Listing Act of 1972 requires drug firms to list with the US Food and Drug Administration (FDA) drug products prepared for commercial distribution. Drug products are reported by using an NDC, a 10-digit, 3-segment number in which the first segment is assigned by the FDA and the other 2 segments are assigned by drug manufacturers. The first segment of 4 to 5 numbers identifies the labeler (such as manufacturer or distributor). The second set of 3 to 4 numbers identifies the strength and dosing form (such as capsule, liquid) and formulation of the drug by the specific manufacturer. The third 1- to 2-digit number segment identifies the package size and types (see Supplemental Information for example). Medicare, in addition to many other government and commercial payers, requires NDC code reporting when submitting claims for medications, and payers

### TABLE 1 Coding Concepts

<table>
<thead>
<tr>
<th>Coding or Valuation Concept</th>
<th>Importance</th>
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<tbody>
<tr>
<td>CPT</td>
<td>CPT is the HIPAA-mandated standardized code set by which physicians communicate what was done during the patient encounter.</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>ICD-10-CM is the HIPAA-mandated standardized code set by which physicians communicate why care was rendered during the patient encounter. The reporting of an ICD code(s) linked to their respective CPT code(s) communicates a complete picture of the encounter.</td>
</tr>
<tr>
<td>HIPAA</td>
<td>1996 federal law designed to provide privacy standards to protect patients’ medical records and other health information, including the adoption of specific code sets for diagnoses and procedures used in electronic transmission of health care data, such as in claims for payment.</td>
</tr>
<tr>
<td>CMS</td>
<td>A federal agency within the Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid and CHIP. The CMS annually publishes RVUs for its covered CPT codes in its MPFS (to which many non-Medicare payers reference with regard to payment policy and valuation).</td>
</tr>
<tr>
<td>NDC</td>
<td>10-digit code for reporting drug products, including vaccines (some manufacturers use an 11-digit variation).</td>
</tr>
<tr>
<td>AMA</td>
<td>The AMA owns and manages CPT.</td>
</tr>
<tr>
<td>CPT Editorial Panel</td>
<td>AMA-funded 17-member panel that develops new CPT codes as well as modifies, updates, and revises existing CPT codes as needed.</td>
</tr>
<tr>
<td>RUC</td>
<td>Collaboration between the AMA and CMS that allows specialty society participation in recommending values for new and revised CPT codes.</td>
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<tr>
<td>RBRVS</td>
<td>The Medicare mechanism by which payment for physician services are represented by assessments of resource costs (RVUs) expended to perform the service when compared with other services (relativity); based on values recommended by the RUC and forwarded to the CMS for consideration for publication in its annual MPFS.</td>
</tr>
<tr>
<td>RVUs</td>
<td>Measure of value for the resource costs inherent in a service relative to other services and used in calculation of the Medicare payment formula through application of a conversion factor.</td>
</tr>
<tr>
<td>NCCI edits</td>
<td>CMS-published Medicare and Medicaid guidance that govern reporting of combinations of CPT codes on the same date of service for the same patient. Most payers incorporate NCCI edits into their claims-processing platforms.</td>
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Chip, Children’s Health Insurance Program.
varies in their requirement for NDC coding for vaccines. NDC codes can be found on the FDA Web site, on the drug vial, or in the drug package insert.

NDC configurations may differ among manufacturers depending on when the FDA assigned the code. This lack of standardization has led to variation in the number of digits assigned to each of the 3 segments. To accommodate variation within NDC segments, an 11th digit (a leading 0) may at times be inserted into the labeler, product, or package size segment to act as a place holder to help manufacturers maintain consistency and allow better synchronization across computer systems. Such variation in desired claim formatting can lead to inconsistency in reporting NDC codes to payers. In addition, payers request that administered units be appended to the NDC code on the claim form, and variation in unit measure can jeopardize claim integrity. Proper claim formatting of NDC codes requires confirmation of approach, which may be specific to different payers.

CPT CODE DEVELOPMENT

The AMA 17-member CPT Editorial Panel (see Fig 1) meets 3 times annually to solicit input of physicians, medical device manufacturers, diagnostic test developers, and specialty society advisors in maintaining the CPT code set by adding new codes, deleting outdated codes, or modifying existing codes. The CPT Editorial Panel has created a formal code application process whereby services can be presented for consideration for publication in future CPT code sets. Through its Committee on Coding and Nomenclature, the American Academy of Pediatrics (AAP) assists its members, sections, committees, councils, and chapters in addressing clinical needs by guiding CPT code requests through the application process toward CPT Editorial Panel presentation.

When a new or modified CPT code request is approved, the CPT Editorial Panel refers the code to the American Medical Association and Specialty Society Relative Value Scale Update Committee (RUC) for valuation (see Fig 2). The multispecialty RUC represents a collaboration between the AMA and CMS and makes relative value recommendations for new, revised, and potentially misvalued codes as well as updates relative value units (RVUs) to reflect changes in medical practice. Code valuation requires RUC referral to relevant specialty societies, which distribute surveys to their members to assess typical physician work expended in performing the service under consideration. Relevant specialty societies then present survey results to the RUC along with in-person specialty support for code valuation during the RUC meeting. Once code valuation is confirmed, the RUC forwards its recommendation to the CMS for consideration and publication in the Medicare Physician Fee Schedule (MPFS).

RESOURCE-BASED RELATIVE VALUE SCALE

RUC valuation of CPT services is based on resource cost allocation represented by the 3 elements of physician work, practice expense, and professional liability. RVUs are assigned to each of these elements in representing each element’s contribution to resource costs relative to other types of services. Although initial physician work RVUs were based on the results of the nonsurveyed 1988 Hsiao Harvard study, subsequent and current physician work RVUs are based on specialty society survey of its members with focus on the time it takes to perform the service, the
technical skill and physical effort, the required mental effort and judgment, and stress due to the potential risk to the patient. In assessing physician work RVUs, allocation of time inputs is also conceptually addressed from the perspective of intraservice time (time spent in actually performing the service) as well as pre- and postservice time (time spent preparing to perform the service and final concluding elements after performing the service). As opposed to practice expenses, physician work RVUs do not differ whether the service is performed in the physician’s office or a facility setting.

Practice expense RVUs address direct expenses related to performing the service (such as clinical labor activities, medical supplies, and equipment that are directly expensed to the physician) as well as indirect expenses (such as administrative staff, building space, and office supplies incurred by the physician to manage and operate the office). Practice expense RVUs differ depending on whether the service is performed in the physician’s office versus a facility (where the costs of clinical personnel, equipment, and supplies are incurred by the facility). Because CPT codes address professional (and not facility) procedures and services, the physician incurs lower CPT practice expense RVUs for a service performed in a facility place of service as opposed to the physician’s office. The RUC relies on its Practice Expense Subcommittee as well as the professional specialty societies and CMS to evaluate expense inputs for CPT services. In addition to physician work and practice expense RVUs, total service RVUs also include professional liability insurance RVUs to account for the cost of malpractice insurance premiums. Average RVU allocation of these 3 categories across all physician specialties is 50.9% (physician work), 44.8% (practice expense), and 4.3% (liability expense), respectively.

THE CMS AND THE MPFS
When RVUs are designated for the target CPT service, the RUC reports its RVU recommendations to the CMS, which then has final authority to either accept, reject, or modify the RUC recommendations (with the CMS historically accepting the overwhelming majority of RUC recommendations). The CMS announces its final valuation assignments through its annually published MPFS. The MPFS not only lists all CMS-accepted RVU values but also provides other useful details about the target service, including whether Medicare designates the CPT code as an active (covered) service, its procedural global package, and the applicability of other types of descriptive modifiers. Although the CMS explicitly publishes its MPFS for Medicare, many other payers, including Medicaid programs and commercial plans, use information contained in the MPFS in modeling their own respective fee schedules and payment policies. Thus, specialty societies, such as the AAP, carefully focus on this CMS publication and provide comments to the CMS when necessary in support of pediatric or other specialty care. For example, in its 2018 MPFS, the CMS expressed interest in eventually modifying its evaluation and management (E/M) documentation guidelines to reduce regulatory burden and place greater emphasis on medical decision-making. In response, the AAP provided extensive comments to the CMS highlighting the uniqueness of pediatric care in documenting E/M visits and confirming the commitment of the AAP to represent pediatric interests by collaborating with the CMS through what will likely be a lengthy process of E/M modification. Along with MPFS publication of RVUs for its covered services, the CMS publishes an annual conversion factor by which the Medicare

FIGURE 2
RUC.
payment rate can be calculated for the respective service by using the following formula:

\[
\text{Medicare Payment} = \text{Annual Medicare Conversion Factor} \times \left[ (\text{Work RVU} \times \text{Work Geographic Practice Cost Index (GPCI)}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) \right]
\]

In addition to assignment of RVUs for new services, the MPFS also addresses valuation for modified and misvalued codes. Through collaboration with the RUC, the CMS undertook sequential 5-year reviews of all code valuations from 1997 to 2012. Subsequent to that, the CMS continues to work with the RUC to reassess code valuation on the basis of request by the CMS, the public, or the RUC. For example, the RUC Relativity Assessment Workgroup selects services for valuation review on the basis of multiple factors, including newer technology impacting either work or practice expense, evolutionary shift from inpatient to outpatient site of service, high or rapid volume growth, and previously Harvard-valued with high use. Through collaboration with the CPT Editorial Panel, the CMS addresses pairings of services frequently performed together that merit bundling. In its annual MPFS, the CMS typically announces services that merit RUC revaluation (potentially misvalued codes) on the basis of any of the above factors as well as services that have experienced substantial changes in practice expense or that have experienced a substantial change in hospital length of stay or procedure time.9

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9 The Geographic Practice Cost Index (GPCI) is a legislatively mandated RBRVS adjustment factor that accommodates geographic variation in health care expenses. GPCIs impact work, practice expense, and malpractice expense and apply to various state- or metropolitan-based localities. The AAP provides additional detail regarding the GPCI and RBRVS calculations at https://downloads.aap.org/DOPCSP/RBRVS.pdf.

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THE CMS AND THE MEDICARE ACCESS AND CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015

Through the legislative mandate of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), Congress has standardized and stabilized its approach to the setting of the annual Medicare conversion factor (which establishes Medicare payment for RVU-based fee-for-service visits and procedures) while also introducing value-based elements into the fee schedule. Through MACRA legislation and subsequent Department of Health and Human Services rule writing, Medicare has instituted the following elements into the fee-for-service platform under the banner of its MACRA-legislated Quality Payment Program:10

- An annual 0.5% increase in the Medicare conversion factor during years 2016–2018, with a 0.25% increase in 2019;
- No annual change in the Medicare conversion factor during years 2020–2025;
- Annual conversion factor increases of either 0.25% or 0.75% beginning 2026 and thereafter (with the higher level dependent on physician threshold participation in advanced alternative payment models); and

- Clinician participation in value-based quality programs and alternative payment models that can either positively or negatively impact overall Medicare payment (with more favorable programmed increases applying to those participating in advanced alternative payment models).

The last point, referencing value-based participation, is instrumental in the CMS effort to transition Medicare from solely fee-for-service toward a payment structure in which quality and value parameters also influence payment.11 MACRA legislation included 2 options by which Medicare physicians could pursue these value-based activities: the Merit-Based Incentive Payment System (MIPS) or the advanced alternative payment model. Under MIPS, Medicare physicians report an annual inventory of quality measures, improvement activities, promoting interoperability via electronic health record technology, and cost of care parameters, all of which can either positively or negatively impact subsequent Part B Medicare payments on the basis of a benchmarked composite score. Alternatively, Medicare physicians who participate at a given threshold volume in advanced alternative payment models (models that include not only potential upside but also downside financial risk) may bypass MIPS reporting in meeting their Quality Payment Program reporting requirements. Thus, in addition to the stabilization of the annual Medicare conversion factor; the MACRA adds a supplemental layer of Medicare Part B payment adjustment on the basis of performance in quality- and value-based clinical activities reported to the CMS via annual submission.

THE CMS AND THE NATIONAL CORRECT CODING INITIATIVE

Coding edits represent rules that address payment policy or coding guidance when reporting certain types of services together. Such edits may impact payment by either preventing the 2 services from being reported together or requiring a specific coding modifier to indicate that the 2 services sufficiently meet payer or coding guidance. Established by the CMS, the National Correct Coding Initiative (NCCI) is a widely accepted set of coding edits used by Medicare, Medicaid, and many commercial payers in addressing reporting of many combinations of code pairs. The NCCI edits are
categorized by procedure-to-procedure edits (which address improper reporting of code combinations), medically unlikely edits (which address the number of units any 1 service can be reported on a given patient on the same day), and add-on edits (which require an appropriate parent code when an add-on code is also reported). The CMS updates these NCCI edits quarterly, and in addition, the CMS annually publishes an NCCI Policy Manual, which provides extensive narrative background on the edits. Although the CMS explicitly publishes its NCCI guidance to apply to Medicare and Medicaid claims, the widespread adoption of the NCCI by many other payers and the incorporation of NCCI edits into revenue cycle billing platforms establishes the NCCI as a de facto national coding edit policy that impacts both government and commercial claims.

With Medicare accounting for 20% of national health care spending, Medicare regulatory and valuation guidance significantly influences other health care systems, including Medicaid and commercial payers. Not only do most Medicaid and commercial payers model their coding edits after the CMS NCCI, many payers use the Resource-Based Relative Value Scale (RBRVS)—influenced MPFS to generate their own internal fee schedules. Because of the influence that these national Medicare payment and AMA coding programs have on pediatric health care, the AAP, through its various sections, committees, councils, and chapters, engages and monitors these CMS programs in addressing the needs of pediatric physicians and their patients. Through collaboration with the CMS as well as through participation in CPT, RUC, and *International Classification of Diseases* (ICD) processes, the AAP applies its experience and knowledge of these processes by integrating the unique aspects of pediatric care into the platforms and framework that form the foundation for reporting of diagnoses, procedures, visits, and other types of patient encounters.

**ROLE OF CODE SETS AND THE RBRVS IN ALTERNATIVE PAYMENT MODELS**

Medicare’s establishment of the Quality Payment Program under MACRA legislation represents a watershed achievement in the evolution from sole reliance on fee-for-service toward value-based alternative payment models. Alternative payment models are designed to reduce the rate of growth in health care expenditures by reducing wasteful care and encouraging efficiencies in the care of populations and episodes. Although standardized code sets such as CPT and ICD have been the historical foundation for fee-for-service payment structure, such code sets will continue to play an instrumental role in the design of alternative payment models. ICD-10 especially was created to provide enhanced clinical detail, which is essential to accurately defining the populations and appropriately assigning clinical risk inherent in structuring payment bundles. Various models of hierarchical condition categories (HCCs) demonstrate the role that accurate diagnosis assignment plays in allocating risk-based payment, and diagnostic specificity has been an important long-standing feature of facility-based bundled payment diagnostic-related group models. Although the HCC models published as CMS-HCC (for Medicare Advantage) and as Health and Human Services–HCC (for non-Medicare use) provide structural detail, including stratification of infant and child, health care organizations may modify HCC models in proprietary ways that are not transparently disclosed to providers. Childhood-relevant, resource-intensive conditions often represent complex associations of chronic abnormalities (especially behavioral) exacerbated by unfavorable social health determinants, all of which may be underrepresented in proprietary risk adjustment models. Many of the quality measures that represent a required reporting feature of alternative payment models include ICD-based identification of patient eligibility. The AAP monitors and participates in pediatric-relevant quality metrics through its membership with the National Quality Forum, the endorsing organization for many pediatric quality measures, including numerous Healthcare Effectiveness Data and Information Set measures. Similar to the value that clinical diagnostic specificity plays in defining populations, CPT will continue to play a role in specifying the various services allocated to particular populations and episodes. Many alternative payment models represent core fee-for-service, CPT-based payment processes layered on financial risk-based performance benchmarks, which then impact subsequent, downstream payment. CPT assignment to rendering clinicians allows for identification of the physician’s role in care within the model as needed for assessment of clinical contribution and patient attribution. Through leveraging of CPT valuation, understanding the relative value of services as illuminated by the RBRVS allows for strategic contracting in developing the administrative and clinical contractual framework within alternative payment models. The RBRVS and its RVU-based elements remain an effective means to track the reduction in volume and the achievement of efficiencies, which
represent the goals of alternative payment models.

**ADDITIONAL RESOURCES**

- CMS MPFS Look-Up Tool: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/;
- CMS NCCI edits: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html; redirect= /NationalCorrectCodInitEd/;
- CMS Quality Payment Program: https://qpp.cms.gov/;
- Coding at the AAP: https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/default.aspx;
- AAP coding hotline: https://www.aap.org/en-us/Pages/cu/Coding-Hotline-Request.aspx; and
- AMA RUC survey training video: https://www.youtube.com/watch?v=nu5unDX8VIs.

**LEAD AUTHORS**

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**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>DC</td>
<td>Diagnostic Classification of Mental and Developmental Disorders of Infancy and Early Childhood</td>
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<tr>
<td>E/M</td>
<td>evaluation and management</td>
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<td>FDA</td>
<td>US Food and Drug Administration</td>
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<td>GPCI</td>
<td>Geographic Practice Cost Index</td>
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<tr>
<td>HCC</td>
<td>hierarchical condition category</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>ICD-10</td>
<td>International Classification of Diseases, 10th Revision</td>
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<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases, 10th Revision, Clinical Modification</td>
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<tr>
<td>MACRA</td>
<td>Medicare Access and Children’s Health Insurance Program Reauthorization Act</td>
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<td>MIPS</td>
<td>Merit-Based Incentive Payment System</td>
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<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
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<td>NCCI</td>
<td>National Correct Coding Initiative</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<td>RBRVS</td>
<td>Resource-Based Relative Value Scale</td>
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<td>RUC</td>
<td>American Medical Association and Specialty Society Relative Value Scale Update Committee</td>
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<td>relative value unit</td>
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