IN RECENT years, the medical community, government officials, and the general public have focused increasing concern on physician reimbursement. The immediate cause for the heightened concern is that the growth rate in expenditures for physicians' services has far outpaced the growth rate of the general economy. As a result, we spend a larger share of income each year for physicians' services...

A related concern is that these expenditures are not necessarily spent effectively. Greenspan et al, for example, concluded that 20% of implantation of permanent pacemakers was not indicated and that 36% was only possibly indicated. Similarly, Chassin et al judged unnecessary 17% of coronary angiograms and upper gastrointestinal endoscopies and 32% of carotid endarterectomies...
Societies differ in how they pay for physicians' services. Under a market exchange system, government has an interest in containing cost inflation and ensuring access to high-quality and cost-effective health care. Price, along with other policy instruments, may be an effective means of achieving these objectives. Method and rates of payment constitute economic incentives under which physicians make clinical decisions, choose specialties, and determine practice locations, although the exact degree of influence remains largely unknown owing to lack of adequate empirical evidence.


### Resource-Based Relative Value Scale (RBRVS)

- Prior to 1992 Medicare payments based upon charges – “Reasonable and customary”
- In 1992 Medicare established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS).
  - Payments for services are determined by the resource costs needed to provide them.
  - Three components: physician work, practice expense and professional liability insurance.

### Resource-Based Relative Value Scale (RBRVS)

- December 1985 - The Harvard National RBRVS Study is initiated.
- December 1989 - Omnibus Budget Reconciliation Act of 1989 enacting a physician payment schedule based on an RBRVS.
- November 1991 - Initial Meeting of the AMA/Specialty Society RVS Update Committee (RUC)
- January 1992 - The Medicare RBRVS is implemented.
- May 1992 - The RUC considers the first relative value recommendation from a specialty society. HCFA accepts this recommendation.
<table>
<thead>
<tr>
<th>Resource-Based Relative Value Scale (RBRVS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AMA provides expert assistance to CMS</td>
</tr>
<tr>
<td>• Built around two basic ideas:</td>
</tr>
<tr>
<td>– CPT</td>
</tr>
<tr>
<td>– RVU</td>
</tr>
<tr>
<td>• AMA manages the process by which both CPT and RVU recommendations are made to CMS.</td>
</tr>
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<tr>
<td>• “listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians”</td>
</tr>
<tr>
<td>• “provide a uniform language that will accurately describe medical, surgical and diagnostic services, and will thereby provide an effective means for reliable communication”</td>
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<tbody>
<tr>
<td>• Established 1966 by the AMA</td>
</tr>
<tr>
<td>• Spans every conceivable procedure, operation, test, patient encounter</td>
</tr>
<tr>
<td>– Supplemented by 5 digit alphanumeric HCPCS (Healthcare Common Procedure Coding System) codes</td>
</tr>
<tr>
<td>• Updated annually by AMA CPT Editorial Panel</td>
</tr>
<tr>
<td>• 5-digit codes necessary, but may not be sufficient for payment</td>
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<table>
<thead>
<tr>
<th>AMA CPT Editorial Panel</th>
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<tbody>
<tr>
<td>• CPT is maintained by the AMA CPT Editorial Panel.</td>
</tr>
<tr>
<td>– 17 member panel is authorized to revise, update, or modify CPT.</td>
</tr>
<tr>
<td>– 13 of the seats are nominated by the AMA</td>
</tr>
<tr>
<td>• Includes a member with expertise in performance measurement and two members of the CPT HCPAC.</td>
</tr>
<tr>
<td>– Remaining seats are nominated by the Blue Cross and Blue Shield Association, America’s Health Insurance Plans, the Centers for Medicare and Medicaid Services and the American Hospital Association.</td>
</tr>
<tr>
<td>– Advisory Committee to the CPT Editorial Panel</td>
</tr>
<tr>
<td>– 1 representative from each of the 122 specialty societies seated in the AMA House of Delegates.</td>
</tr>
</tbody>
</table>
AMA CPT Editorial Panel

- Codes updated annually to reflect current medical practice.
  - Addition/deletion of codes and revisions in procedure description

The CPT/RUC Health Care Professionals Advisory Committee (HCPAC)

- HCPAC allows participation of limited license practitioners and allied health professionals in the CPT/RUC process.
  - 11 organizations seated on HCPAC
  - Represent physician assistants, chiropractors, nurses, occupational therapists, optometrists, physical therapists, podiatrists, psychologists, audiologists, speech pathologists, social workers and registered dieticians.
- Responsible for developing codes and relative value recommendations for codes reported by non-MD/DO professionals.

Relative Value Unit (RVU)

- A unit of measure to compare physician work
- Based on elements of time, intensity, technical skill/physical effort, mental effort/judgment and stress
- Comparison relative to other patient care activities
- Theoretically equalizes physician work independent of payment

Medicare Fee-For-Service Reimbursement

\[ \$ = \text{Total Relative Value Unit (RVU)} \times \text{Conversion Factor (Constant, Adjusted Yearly For Budget Neutrality)} \]

\[ \downarrow \]

\[ \text{Physician Work RVU x GPCI} + \text{Practice Expense RVU x GPCI} + \text{Malpractice RVU x GPCI} \]

*Geographic Practice Cost Index
**AMA RVS Update Committee (RUC)**

- A 31 member committee recommends RVU values for CPT Codes to CMS.
  - 21 members appointed by medical specialty societies
    - Includes those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for high percentages of Medicare expenditures.
  - 4 seats rotate on a 2-year basis
    - 1 seat reserved for a primary care representative, 2 reserved for an internal medicine subspecialty and the remaining seat is open to any other specialty society not already a member
  - 6 seats - RUC Chair, Co-Chair of the RUC HCPAC Review Board, representatives of AMA and AOA, Chair of the Practice Expense Subcommittee and CPT Editorial Panel.

**Changing/Adding/Valuing A CPT Code:**

**The Process**

<table>
<thead>
<tr>
<th>CPT Editorial Panel (17)</th>
<th>RVU Update Committee (RUC) (31)</th>
<th>RVU Recommendations</th>
<th>CMS</th>
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<tbody>
<tr>
<td>Code Approval</td>
<td>Established Reimbursement</td>
<td>Reimbursement</td>
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<tr>
<td></td>
<td>Practice Expense Subcommittee (PE Subcmte)</td>
<td>Contracting</td>
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<td>Third Party Fee Schedules</td>
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<tr>
<td>122 Medical Specialty Societies</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11 Health Care Professional Societies</td>
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</tbody>
</table>

**Changing/Adding/Valuing A CPT Code:**

**The Timing for 2014 Medicare Payment Schedule**

<table>
<thead>
<tr>
<th>The CPT Process</th>
<th>The RUC Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline for Submission of CPT Proposals</td>
<td>CPT Meeting</td>
</tr>
<tr>
<td>LOI Sent to Specialty Societies Due to AMA</td>
<td>Society Survey Recommendations Due to AMA RUC</td>
</tr>
<tr>
<td>RUC Meeting</td>
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</tr>
</tbody>
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|---------------|-----------------|--------------|-------------------|-------------------|

**AMA RVS Update Committee (RUC)**

- Advisory Committee to the RUC
  - Consists of 1 representative from each of the 122 specialty societies seated in the AMA House of Delegates
Proposing a CPT code? Questions and Paperwork

• Performed by large numbers of physicians? Who
• New service? Clinical efficacy well established?
  • 5 articles in US, peer-reviewed journals
• How currently reported? Why inadequate?
• Bundled with anything? An E/M same day?
• Representative vignette
  • Describes the typical patient who would receive the procedure(s)/service(s).
• What diagnoses? Volume estimates (total and Medicare)
• What Category?

CPT Categories

• Category I CPT Codes
  – Describe procedures and services with 5-digit code and descriptors, intended for common practice by many physicians nationally
• Category II CPT Codes – Performance Measurement
  – Optional performance measurement tracking codes intended to reduce the need for chart abstraction
• Category III CPT Codes – Emerging Technology
  – Temporary set of tracking codes for new and for emerging technology, intended to facilitate data collection

The RUC Process

Steps 1 - 3

• Step 1: The CPT Editorial Panel’s decisions transmitted to the RUC
• Step 2: Specialty society indicates level of interest in developing a relative value recommendation.
• Step 3: AMA distributes survey instruments for specialty societies.
  – Required to survey at least 30 practicing physicians.
  – 10 to 20 services act as reference points.
  – Surveyed physicians asked to evaluate the work involved in the new/revised code relative to these reference points.

Survey Request

Thank you for agreeing to participate in the survey. The American College of Chest Physicians (ACCP) represented by Burt Lesnick, MD, FCCP and the American Thoracic Society (ATS) represented by Kathrin Nicolacakis, MD, FCCP are advisors representing Pulmonology in the American Medical Association (AMA) Specialty Society Relative Value Update Committee (RUC).

ACCP and ATS are asking you to complete a separate RUC survey on 94060 Bronchodilator Responsiveness and a separate survey that includes four new PFT codes for lung volumes, airway resistance and diffusing capacity, 940X1-940X4. Note that we have deleted 10 PFT codes and replaced with four new codes for PFTs performed by plethysmography, gas dilution and oscillometry and an add-on code for diffusing capacity. These bundles of PFT codes resulted from the analysis of pulmonologists reporting to Medicare four or five codes to measure lung volumes, airway resistance and diffusing capacity. With advances in technology, there are economies that will be evident upon completion of the surveys. Completing these surveys for the five codes should take under one hour.

The surveys need to be completed by March 15, 2011. Your individual response to the 6 questions is needed. Click on the links below to go to the two surveys. I suggest that you start with 94060 since all the questions are basically the same. It will make the survey with the four new codes, 940X1-940X4 easier for you to complete.

94060 https://www.surveymonkey.com/s/NG3TMT6
940X1-940X4 https://www.surveymonkey.com/s/WQGGHDX

If clicking on the links doesn’t work, please copy the links above to access the SurveyMonkey survey through your browser. If you have any questions while completing the survey, do not hesitate to call Diane Krier-Morrow, MBA, MPH, CCS-P, ACCP and ATS consultant staff at 847-677-9464 or email me at dkriermorr@aol.com and she can talk you through the survey questions in 5-10 minutes.
No mention of reimbursement

COI exclusions

Survey

The American Medical Association/ Specialty Society RVU Update Committee

PHYSICIAN WORK RVU Update Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey

Survey
Survey

State your time...

...and your perception of complexity

Survey

Mental Effort/Judgment

Technical Skills/Physical Effort

Stress

Practice Expense Component of the RBRVS

• PE accounts for an average of 44.8% of the total relative value for each service.
• Data used to calculate:
  – Indirect practice costs
    • Non-clinical staff
    • Overhead
  – Direct practice expenses
    • Clinical labor
    • Supplies
    • Equipment
    • Malpractice

Survey

How many RVUs do you think it’s worth?

...and your perception of complexity

**Survey**

1. Have you ever been involved in a suit that involved a malpractice claim? If so, what was the outcome? [Yes][No]

2. How many RVUs do you think it’s worth? [RVUs]

**Survey**

Survey

Mental Effort/Judgment

Technical Skills/Physical Effort

Stress

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Survey

State your time...

Survey

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    • Malpractice
RUC Process
Steps 4-8

• Step 4: The specialty RVS committees review the results, and prepare recommendations to the RUC.
• Step 5: Recommendations presented to the RUC by the The Specialty Advisors.
• Step 6: The RUC evaluates specialty society’s recommendation and accepts it (by 2/3 majority), refer it back to the specialty society, or modify it before submitting it to CMS.
• Step 7: The RUC’s recommendations are forwarded to CMS in May and reviewed by CMS Medical Officers and Contractor Medical Directors.
• Step 8: The Medicare Physician Payment Schedule, including CMS’s review of the RUC recommendations, is published late Fall.

Controversies

Noerr-Pennington Doctrine

• Allows all persons to exercise their right to petition the government free from potential antitrust liability.
  – Allows competitors to engage in joint petitions to the government and to ask the government to mandate or authorize activities that would ordinarily violate federal antitrust laws.
• Based on 3 United States Supreme Court decisions
  • Eastern Railroad Presidents Conference v. Noerr Motor Freight Inc.
  • United Mine Workers v. Pennington
  • California Motor Transport Co. v. Trucking Unlimited
• RUC activities are a request for government action therefore not price fixing.

Washington Post: “How a Secretive Panel Uses Data that Distorts Doctors’ Pay” (7/21/13)

• Real life times inconsistent with RVU service times
  – “the AMA’s estimates of the time involved in many procedures are exaggerated, sometimes by as much as 100 percent”
  – More likely to raise estimates of work despite productivity/technology advances
• AMA and specialty societies have too much influence over physician pay.
  – The AMA/medical societies, not government, develop the raw data for analysis
  – Estimated costs - $7 million in time and expense annually.
  – Raw data comes from doctors providing the procedure
• CMS ill equipped to oversee process – insufficient manpower
  – AMA not considered advisory committee - not subject to the Federal Advisory Committee Act
• Meetings are secret and confidential
• Skews toward specialists and away from primary care

How You Can Get Involved?

- Understand the process
- Suggest new CPT codes
- Respond to e-mail queries
- Participate in surveys
- Participate in your professional societies

Outpatient New Visit (99203)

- Work RVU: 1.42
- Expense RVU: 0.60
- Malpractice RVU: 0.13
- Total RVU: 2.15
- Conversion factor = $35.82
- Medicare reimbursement = $77

The RVU system and physician specialty choice

Revenue Discussion

Richard Sobieray
Associate Executive Director
Faculty Group Practice Administration
The Ohio State University Wexner Medical Center
Categories of Revenue

- Patient Service Revenue
  - Gross Patient Service Revenue (GPSR) vs. Net Patient Service Revenue (NPSR)
  - Patient Service Revenue Payment Methodologies
  - Other Patient Service Revenue
- Other Revenue
- Academic Revenue
  - Research
  - Teaching

Patient Service Revenue

- Today, patient service revenue is mostly about price and volume versus negotiated contract rates.
- Tomorrow, patient service revenue will become more value based (price and outcomes).
- Gross Patient Service Revenue (GPSR)
  - The total amount of charges that result from the provision of health care services to patients.
  - Your charge per service times # of services provided.
  - “Sticker Price”

Patient Service Revenue

- Net Patient Service Revenue (NPSR)
  - The amount of patient revenue that is collectable as cash after reducing charges to contractual rates and other deductions such as bad debt, charity care and insurer denials.
  - GPSR times write-off %
  - “Actual Payments” or “Cash Inflows”

Patient Service Revenue

- Today, it’s essentially Price X Volume.
- When analyzing this you must understand volume at the macro and micro-levels:
  - What is happening to my overall volume?
  - CPT mix, including potential shifts in services or coding patterns
  - Provider capacity, including effect of ramp ups and shifts in provider schedules
  - Provider productivity expectations
- For payment rates (Price) you must understand:
  - Who is paying you and what they will pay you?
Payment Methodologies

- **Medicare**
  - Funded through tax and premium dollars.
  - Physician fee schedule determined annually based upon RVU assignments to CPT codes and conversion factor.
  - Traditional versus Managed Care
  - Non-negotiable.
  - Some pay for performance beginning to take shape (i.e. Medical Homes).

- **Medicaid**
  - Funded with state and federal dollars.
  - For low income people.
  - Fee schedule determined similarly to Medicare except the ultimate payment rates are determined by state budget constraints.
  - Traditional versus Managed Care
  - Non-negotiable

- **Commercial**
  - Funded through premium dollars.
  - Generally employer-based, however exchanges are beginning to change the landscape.
  - Fee schedule typically negotiated as a % of Medicare.
  - It is important to be as diligent on contract language as you are on rates.
  - Negotiable
  - Some pay for performance beginning to take shape (i.e. Medical Homes).

- **High Savings Co-Management and Shared Bundled Payment Capitation**

- **Low Payer Pay for Performance Medical Home Fee for Service**

- **High Provider Financial Risk**
Expense Discussion

Categories of Expenses

- Expenses = “Cash Outflows”
- Expenses fall into two categories:
  - Provider expenses
    - Salaries and Benefits
    - Malpractice
    - Travel and CME
  - Overhead expenses
    - Staff salaries and benefits
    - Supplies and pharmaceuticals
    - Space and Utilities
    - Purchased Services
    - Corporate Allocations
    - Amortization and Depreciation
    - Interest
    - Other

How are Provider Resources Spent?

Provider Expenses:
- 40% - 80%
- Benchmark using MGMA Cost Survey or RVU split as determined by CMS (wRVU and malRVU)

Overhead Expenses:
- 20% - 60%
- Benchmark using MGMA Cost Survey or RVU split as determined by CMS (peRVU)

Improving Financial Performance

Margins are generally very small
## Improving Financial Performance

To improve the operating results, one can either increase revenues, decrease expenses, or both.

- One can increase revenue either by growing volume or increasing revenue per unit (payment rate)
  - Difficult to increase volume in the short run
  - Under the new payer landscape, opportunities are also limited with increasing revenue per unit unless it's found in the provider coding patterns
- Expense control has become the new norm for improving profitability in the short run