AMERICAN ACADEMY OF PEDIATRICS

Resource-Based Relative Value Scale Project Advisory Committee

Issues in the Application of the Resource-Based Relative Value Scale System to Pediatrics: A Subject Review

ABSTRACT. In today's rapidly changing health care environment, it is crucial to understand the genesis and concepts of the Medicare Resource-based Relative Value Scale (RBRVS) physician fee schedule. Many third-party payers, including state Medicaid programs, Blue Cross–Blue Shield agencies, and managed care organizations are using variations of the Medicare RBRVS to determine physician reimbursement and capitation rates. Because the RBRVS fee schedule was originally created for Medicare only, pediatric-specific Current Procedural Terminology codes and pediatric practice expense issues were not included. The American Academy of Pediatrics agrees with the use of the Current Procedural Terminology codes and the RBRVS physician fee schedule and continues to work to rectify the inequities of the RBRVS system as they pertain to pediatrics.

ABBREVIATIONS. MedPac, Medicare Payment Advisory Committee; HCFA, Health Care Financing Administration; RBRVS, Resource-based Relative Value Scale; CF, conversion factor; RVU, relative value unit; AMA, American Medical Association; CPT, Current Procedural Terminology; RUC, AMA/Specialty Society Relative Value Scale Update Committee; E/M, evaluation and management; BMAD, Part B Medicare Data Files.

The American Academy of Pediatrics recognizes the efforts of the Physician Payment Review Commission (as of 1998, the Physician Payment Review Commission is the Medicare Payment Advisory Committee, or MedPac), organized medicine, and the Health Care Financing Administration (HCFA) to reduce health care spending in the United States, while ensuring access to health care services for Medicare recipients. The Medicare Resource-based Relative Value Scale (RBRVS) physician fee schedule was established to recognize objective measures of physician work, while creating equity in reimbursement for all physician services across specialties. The RBRVS system, which is based on uniform definitions of physician work, has eliminated many of the more dramatic reimbursement irregularities within the Medicare physician fee schedule. Each year, Congress establishes a budget for Medicare by setting a single, so-called conversion factor (CF; in previous years, there were three separate CFs). This CF is a national dollar value that converts the total relative value units (RVUs) into payment amounts (RVU × CF dollar amount = payment) for the purposes of reimbursing physicians for services provided.

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Over the past few years, the Academy has initiated many pediatric-specific Current Procedural Terminology (CPT) code proposals, some of which have been accepted by the American Medical Association's (AMA) CPT editorial panel and have been incorporated into the CPT manual. The Academy has worked actively within the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process to provide the HCFA with RVU recommendations that reflect accurately the work involved in providing services to children for these pediatric-specific CPT codes. Although the HCFA has assigned values to these pediatric-specific CPT codes within the Medicare RBRVS physician fee schedule, the current Medicare RBRVS physician fee schedule has yet to assign specific reimbursement for a number of services commonly or uniquely associated with pediatric care (eg, vision screening, child abuse services). The present Medicare-based system also has not recognized completely many of the unique aspects of providing care to infants and children; some services for children require increased physician work compared with similar services for adults.

The RBRVS physician fee schedule was implemented initially by the HCFA as a mechanism for the reimbursement of physician services provided to Medicare recipients. It was not designed as a universal system of reimbursement for the provision of services to all patient populations, including those commonly covered by state Medicaid agencies and private payers. Despite these design limitations, private payers have moved rapidly to adopt this method of reimbursement. A recent report by MedPac revealed that nearly half of the private plans surveyed in 1995 reported some use of a RBRVS payment system.[1] The work estimates within the RBRVS Medicare physician fee schedule were developed primarily to reflect the services rendered to the typical Medicare patient and, as such, they often do not reflect accurately the breadth and scope of work expended in the provision of care for newborns, infants, and children. In fact, many Medicaid programs determined that the HCFA's original valuation of pediatric services was low and, if left uncorrected, would ultimately impede beneficiary access to care. Consequently, a few Medicaid programs that adopted the Medicare RBRVS physician fee schedule to reimburse physicians instituted a separate CF for some pediatric services. A few of these Medicaid programs have maintained higher CFs or established auxiliary fee schedules or case management fees to augment physician reimbursement for children's care.

Despite the limitations of the RBRVS fee schedule

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used currently, the Academy does advocate the use of an RBRVS physician fee schedule expanded for pediatric patients as the optimal mechanism of reimbursement for pediatric services. The Academy believes that this fee schedule, based on an objective estimate of physician work, is more consistent and equitable than the customary, prevailing, and reasonable system under which physicians historically have been reimbursed for the provision of each service. If ease of access to health care is to be ensured for children, Medicaid programs and other payers must be educated on the current disparity in reimbursement for some pediatric services within this system and work with the Academy, the AMA, and the HCFA to correct these deficiencies. Additionally, all payers (most importantly, Medicaid) must recognize the importance of incorporating and reimbursing all services listed under RBRVS, while refining their payment schedules to correspond to the HCFA's annual updates and revisions. State-specific payment methodologies are not adequate because they are often arbitrary and do not recognize objective measures of work across specialties. Payers also must acknowledge and embrace the HCFA's 5-year review of the relative work values and the HCFA's recent efforts to implement an accurate resource-based approach to the practice expense portion of total RVUs. The Academy recognizes that the HCFA's yearly budget neutrality adjustments to the RVUs are necessary to comply with Congressional requirements placed on the Medicare fee schedule; however, private payers and state Medicaid programs must recognize that these adjustments are merely attributable to budgetary constraints imposed by Congress (budget neutrality) and do not reflect changes in the provision of care or the amount of work expended in providing a specific physician service.

The HCFA does recognize that a Medicare-driven reimbursement tool may underrepresent or undervalue pediatric work. To account for this, Congress mandated that the HCFA revisit this pediatric work issue as part of a normal 5-year review process, specifically to evaluate whether codes for pediatric services are valued correctly. Although the Academy appreciates the attempts by the HCFA to account for pediatric work more equitably, it is still important to note that pediatricians were severely underrepresented in the original Hsiao study[2] that led to the creation of the original RVUs for physician work. Despite this fact, the overall fairness of the system that was created led rapidly to its incorporation into reimbursement formulas for children's health care services by many third-party payers as well as by state Medicaid agencies. Although these surveyed work values may be comparable with those required in evaluation and management (E/M) services provided to children, this hypothesis has not yet been studied adequately. In some pediatric subspecialties (eg, pediatric cardiology, pediatric nephrology), in which valid survey data have been collected, there is quantifiable proof of underestimation of total physician work, particularly in situations in which major physiologic and developmental differences exist.[3,4]

The Academy believes that the unique characteristics of children's health care services have not yet been incorporated fully into the universe of medical and surgical procedural codes and services to children despite Congress' admonition to the HCFA. The Academy supports the continued efforts of the AMA CPT and the HCFA, through the CPT and RUC processes, to address this payment anomaly. The Academy also appreciates their commitment to represent more effectively, through the CPT process, the diversity of CPT codes specific to children and to assign appropriate work values to these procedures and services.

It is essential that the RBRVS process use adequate sample size and valid survey questions. The Academy must ensure survey completion by physicians who deliver health care services to children and are knowledgeable about the RBRVS system. It is inappropriate and not in the best interest of pediatrics simply to extrapolate work values assigned for services to children from those values determined by surveying physicians who primarily provide adult services. Some of the differences between adult and pediatric services can be demonstrated in each of the following components of the RBRVS system.

PRESERVICE TIME, INTRASERVICE TIME, AND POSTSERVICE TIME

The average child demonstrates anxiety and fear with any separation from a parent and may be unable to respond to the preparation for the physical examination and for procedures that follow. These differences uniformly add more time and stress to this preservice period compared with the time required by the average adult patient. Most children subsequently will require constant adaptations of the physical examination, applied technology, or necessary procedures in response to their constantly changing behavior and level of cooperation. Small physical size and poor cooperation also may extend intraservice time. The need to communicate to parents, a child care facility, the school, or extended family (eg, grandparents) requires increased postservice times. This situation has been accentuated as reporting requirements by managed care organizations expand and the complexity of patient care required in standard ambulatory/outpatient environments increases.

PRACTICE EXPENSE

Practice expense accounts for an average of 41% of the total RVU for a code. The greatest factor in pediatric practice expense is related to the high volume of lower level office visits, high rate of participation in managed care, and the large number of telephone triage services in pediatrics for which there is no reimbursement. Providing care to young children also requires more direct hands-on staff time, less efficient room use because of difficulties dressing and undressing patients, and increased complexity and time in collecting laboratory specimens. It is essential that all of these factors be accounted for in any resource-based practice expense study and in the final practice expense calculations for E/M services for children.

PROFESSIONAL LIABILITY RVUS

The RBRVS system assigns RVUs to cover the malpractice expense of physician practices. The assigned RVUs, which were assigned for office-based pedia-

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tricians, may undervalue the total practice costs for some pediatric specialties. In neonatology, for example, prolonged statutes of limitations and the inability of the public sector to provide for comprehensive services for children with congenital or acquired neurologic and developmental defects have led to an increasing risk management exposure for those pediatricians providing critical care services for children. These situations are not accounted for under the RBRVS system and were not included in the initial Hsiao study.[2] Pediatric and pediatric specialty survey data for malpractice expense must be obtained and used so that this component of total physician work will not be underestimated.

OTHER REIMBURSEMENT FACTORS

Other important factors that relate to reimbursement include the following:

CF

The CF is a national monetary value that converts the total RVUs into payment amounts for the purpose of reimbursing physicians for services provided. Historically, there were three separate CFs: one for surgical services, one for nonsurgical services, and one for primary care services. This separation provided higher reimbursement rates to surgical disciplines than to office-based physicians, cognitive specialists, or hospital-based medical physicians.

In 1998, the system was changed so that there would be only one CF. To ensure equity, the Academy strongly supports a single CF for all categories of physician services.

Budget Neutrality Adjustment

To maintain budget neutrality in the past, the HCFA has used Medicare Volume Performance Standards and either decreased the CF or decreased physician work values for certain services and/or procedures, despite the fact that these work values were obtained by careful surveys. Pediatric services should not be subjected to a Medicare-driven volume performance standard. The budget neutrality adjustments used in the Medicare system should not be used by private payers, especially because private payers do not need to remain budget neutral. The Academy supports a fee schedule for pediatric services that is based on the RBRVS fee schedule, not a fee schedule based on the Medicare fee schedule.

Protection of E/M Services

When budget neutrality is applied in the Medicare system, only the CF should be affected. New technology is expected to increase the number of surgical codes far beyond the small number of E/M service codes. New surgical codes or procedures that are added to the RVU pool should only require a reevaluation of the family of codes in which the new code will reside. If this is not done, the limited E/M codes will continue to undergo a process of constant devaluation.

CPT

The Academy recognizes the CPT as the language accepted for communicating physician services to third-party payers. Third-party payers, however, do not recognize and reimburse for the full spectrum of health care services represented by the complete CPT. In an effort to resolve this discrepancy, the Academy promotes the acceptance and reimbursement by all payers of the complete set of CPT-4 codes as defined by the AMA.

National Pediatric Database

To better understand the spectrum, frequency, and regional variations in health care services for children, the Academy urges the creation of a national database for services for children similar to Medicare's Part B Medicare Data Files (BMAD), a database containing Part B Medicare data that includes claims information. Only by understanding the frequency with which codes are reported will the Academy be able to understand utilization patterns and the effect of new codes on total health care costs. Both private payers and state Medicaid agencies should be encouraged or legislated to participate in this project.

SUMMARY

The Academy supports the concept and use of the RBRVS system as the basis for physician reimbursement. As conceptualized, it represents a reasoned and equitable system for physician reimbursement. The present implementation of the system addresses many of the inequities of previous reimbursement systems. However, the Academy also recognizes that the current and proposed implementations still contain inequities that will need to be addressed and that a process to modify the RBRVS system for neonates, infants, and children should be initiated. In particular, a system for the ongoing evaluation of practice overhead expenses, including those specific to pediatrics, needs to be implemented and universal adoption of a single CF by payers is mandatory.

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