

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Coding and Nomenclature

Application of the Resource-Based Relative Value Scale System to Pediatrics

ABSTRACT. In today's rapidly changing health care environment, it is crucial to understand the genesis and principles behind the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule. Many third-party payers, including state Medicaid programs, BlueCross BlueShield, and managed care organizations, use variations of the Medicare RBRVS to determine physician reimbursement and capitation rates. Because the RBRVS fee schedule was created originally for Medicare only, pediatric-specific Current Procedural Terminology (CPT) codes and pediatric practice expense calculations were not included. The American Academy of Pediatrics supports the use of CPT codes and the RBRVS physician fee schedule and continues to work to rectify certain inequities of the RBRVS system as they pertain to pediatrics. *Pediatrics* 2004;113:1437-1440; reimbursement, coding, RBRVS.

ABBREVIATIONS. RBRVS, Resource-Based Relative Value Scale; CF, conversion factor; RVU, relative value unit; AAP, American Academy of Pediatrics; CPT, Current Procedural Terminology; AMA, American Medical Association; CMS, Centers for Medicare and Medicaid Services.

BACKGROUND

The Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule was developed to recognize objective measures of physician work while creating equity in physician reimbursement based on physician work for services across all 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 conversion factor (CF). This CF (dollars per relative value unit [RVU]) is a national dollar value that converts the anticipated total RVUs into legislatively set payment amounts ($RVU \times CF = \text{payment}$) for the purposes of reimbursing physicians for Medicare services provided. The annual assignment by the Centers for Medicare and Medicaid Services (CMS) of the CF is based on variations primarily in adult Medicare utilization and the requirement for CMS to operate within a legislatively determined budget. Changes in the CF should not be assumed to reflect pediatrics

utilization rates or effect a decrease in reimbursement for children's services.

In an effort to deal with the limitations of the RBRVS system as it was designed originally and recognizing that there were only limited pediatric-specific procedures in the Medicare database, the American Academy of Pediatrics (AAP) has continued to propose new Current Procedural Terminology (CPT) codes relevant to pediatrics to the CPT Editorial Panel of the American Medical Association (AMA) over the past years. Some of these CPT codes have been accepted and incorporated into the CPT nomenclature. The AAP Committee on Coding and Nomenclature (previously the Committee on Coding and Reimbursement and the RBRVS Project Advisory Committee) actively works within the CPT Editorial Panel process by submitting CPT codes relevant to pediatrics as well as within the AMA/Specialty Society Relative Value Scale Update Committee process to provide CMS with RVU recommendations that accurately reflect the work involved in providing services to children. Although CMS has assigned physician work values to most CPT codes within the Medicare RBRVS physician fee schedule, the current fee schedule has yet to assign specific reimbursement for several services commonly or uniquely associated with pediatric care (eg, vision screening, case management services, and child abuse services). The present Medicare-based system also has not uniformly recognized many of the aspects of providing care to infants and children, particularly those services for children that require increased physician work compared with similar services for adults.

The RBRVS physician fee schedule was implemented initially by CMS (the Health Care Financing Administration at the time) as a mechanism for the reimbursement of physician services provided to Medicare recipients. CMS neither designed nor planned its system to be a universal reimbursement system for services to all patient populations, such as those commonly covered by state Medicaid programs or commercial insurers. Despite this design limitation, most commercial and public payers have moved rapidly to adopt this method of reimbursement. A recent report by the AMA revealed that 74% of the private plans surveyed in 2002 reported some use of an RBRVS payment system, compared with

63% in 1998.¹ The work estimates driving the RBRVS Medicare physician fee schedule were developed primarily to reflect the services rendered to the typical Medicare patient and, as such, do not always accurately reflect the breadth and scope of work expended in providing care for newborns, infants, and children. A few Medicaid programs that adopted the Medicare RBRVS physician fee schedule to reimburse physicians instituted a separate and higher CF for some pediatric services. Some of these Medicaid programs have maintained a higher pediatric CF or established auxiliary fee schedules or case management fees to augment physician reimbursement for children's care.

Despite these limitations, the AAP advocates the use of the RBRVS physician fee schedule, expanded for pediatric patients, as an appropriate and fundamentally fair system for reimbursing pediatric services. The AAP believes that an RBRVS-based fee schedule, supported by objective assessments of physician work, is more consistent and equitable than the "customary, prevailing, and reasonable" reimbursement system under which physicians historically have been paid for their services. However, if appropriate access to health care is to be ensured for all children, Medicaid programs and other payers must recognize the inequities in reimbursement for some pediatric services within the RBRVS system and work with the AAP, AMA, and CMS to correct these deficiencies. Additionally, all payers (most importantly Medicaid) must recognize the importance of incorporating and reimbursing for all services listed under RBRVS while refining their payment schedules to correspond to the annual updates and revisions of the CMS. State-specific non-RBRVS payment methodologies cannot be endorsed, because they are often arbitrary and do not recognize objective differences in physician work. Payers also must acknowledge and embrace the CMS 5-year review of relative work values and its recent efforts to implement an accurate, resource-based approach to the practice expense portion of total RVUs. The AAP recognizes that the CMS annual budget neutrality adjustments to the RVUs may be necessary to comply with congressional requirements placed on the Medicare budget and 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 CMS has recognized that a Medicare-driven reimbursement tool may underrepresent or undervalue pediatric work. To account for this, Congress mandated that the CMS 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 AAP appreciates the attempts by the CMS to account for pediatric work more equitably, it is still important to remember that pediatricians were severely underrepresented in the original Hsiao et al study² that led to the creation of the original RVUs for physician

work. Despite this deficiency, the overall fairness of the system that was created rapidly led to its incorporation into reimbursement formulas for children's health care services by many third-party payers as well as by state Medicaid programs. The assumption that there is equivalency of work between pediatricians and pediatric subspecialists to that of internists and adult subspecialists has not been rigorously studied. In some pediatric subspecialties (eg, pediatric cardiology and 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 AAP believes that the unique characteristics of children's health care services have not yet been incorporated sufficiently into the corpus of medical and surgical procedural codes for services provided to children despite Congress' admonition to the CMS. The AAP supports the continued efforts of CPT and the CMS through the CPT and AMA/Specialty Society Relative Value Scale Update Committee processes to address this problem. The AAP also appreciates their commitment, through the CPT process, to represent more effectively 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 survey process include an adequate pediatric sample size and valid survey questions. To that end, the AAP must ensure accurate survey completion by physicians who deliver health care services to children and are knowledgeable about the RBRVS system and the survey process. It is inappropriate and not in the best interest of pediatricians to simply extrapolate work values assigned for services to children from those values determined by surveying physicians who primarily provide adult services. The RBRVS system assigns value to each procedure based on physician work (including preservice, intraservice, and post-service time and effort), office practice expense, and procedure-based malpractice expense. Differences between adult and pediatric services can be demonstrated in each of those RBRVS system components.

Physician Work: Preservice, Intraservice, and Postservice Time

Children typically exhibit anxiety and fear when examined or during procedures resulting in the need for additional time and effort by the physician to respond to and prepare the child for the examination or procedures. This uniformly adds more time and stress to the preservice and intraservice periods compared with that required by the average adult patient. Children require constant adaptations to the physical examination, applied technology, or procedures in response to their constantly changing behavior and level of cooperation. Small physical size and limited ability to cooperate may also extend intraservice time. Follow-up communication with child care facilities, schools, absent parents, or extended family (eg, grandparents) requires increased postservice times.

Practice Expense

The practice expense component of the RBRVS includes clinical staff time, medical supplies, and medical equipment, accounting for, on average, 42% of the total RVU for a code. The costs of supplies and equipment are not proportional to a child's size. Therefore, arbitrary reductions of medical supplies and equipment based on patient size are inappropriate. Major factors affecting pediatric practice expense as compared with many other specialties are the high volume of lower-intensity office visits, the large volume of telephone management services, and the case management and administrative work required. As an example, high patient turnover requires more examination rooms per provider to maintain physician efficiency, as compared with specialties that see 1 to 3 patients per hour. High volume requires more clerical staff to deal with larger patient-flow volume and resulting phone calls; recognizing that 40% to 50% of most pediatric office volume is booked within 24 hours of the encounter, staff members are forced to do insurance verification at the time of patient arrival, which affects their ability to process patients efficiently. Providing care to young children also requires more direct hands-on staff time, results in less efficient room use because of difficulties dressing and undressing patients, and is marked by increased complexity and time in collecting laboratory specimens. These factors need to be accounted for in any resource-based practice expense study and in the resulting practice expense calculations for services for children.

Professional Liability RVUs

The RBRVS system assigns RVUs to cover the malpractice expenses incurred by physicians. These malpractice RVUs, originally calculated for office-based pediatricians, may systematically undervalue the practice liability costs for some pediatric specialties. The prolonged statutes of limitation on child-related legal actions, as compared with adult care, result in increased malpractice risk exposure for physicians providing services for children, compared with adults. In many states, that risk is measured in decades rather than years. As such, physicians treating minors are required to purchase an "extended reporting endorsement" to cover the risk until the patient achieves the age of majority, which imposes additional practice expenses in retaining medical records and the attendant security protections for that protracted period. This difference in exposure is not calculated into the RBRVS system and was not included in the initial Hsiao et al study.² Pediatric-specific survey data for malpractice expense should be used for this component when assigning final RVU valuations. Without pediatric-specific CPT codes, however, there is no way to do this without having different CFs for pediatric patients.

OTHER REIMBURSEMENT FACTORS

CPT Code Set

The AAP recognizes that the CPT code set is the accepted standard for coding physician services and

communicating with third-party payers and is required for electronic data exchange under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Third-party payers, however, do not necessarily recognize nor reimburse for the full spectrum of health care services represented by the complete CPT code set, nor does HIPAA require insurers to reimburse for all CPT codes, merely to accept transactions electronically that include CPT procedure codes. The AAP strongly advocates for the acceptance and reimbursement for the complete CPT code set by all payers and encourages members to work to that end in negotiating contracts with individual payers.

National Pediatric Database

To better understand the spectrum, frequency, and regional variations in health care services for children, the AAP urges the creation of a national database for services to children analogous to Medicare's Part B Medicare Data Files, which contain Part B Medicare claims information. A national database for health care services for children is critical for making the Office of the Inspector General (OIG) Medicare and Medicaid compliance program applicable to pediatricians. The current use of Medicare-based utilization patterns inappropriately labels pediatricians as "outliers" and potential targets for health care fraud investigations. Finally, only by understanding the frequency with which codes for pediatric services are reported will the AAP be able to analyze utilization patterns and the effects of new codes on total health care costs. A pediatric database analogous to the Part B Medicare Data Files database should be encouraged or legislated and published annually.

RECOMMENDATIONS

1. The principles of the Medicare RBRVS system should be supported as an intrinsically more reasoned and equitable reimbursement methodology than alternative systems.
2. Work should continue within the RBRVS system to remove implementation inequities and ensure that the RBRVS system appropriately accounts for the work and expense in caring for neonates, infants, and children.
3. All payers should recognize the full spectrum of CPT codes and their guidelines.
4. Movement to an alternative to RBRVS should be supported only if the alternative system represents a significant enhancement and is responsive to the needs of children.

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2003–2004

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