American Academy of Pediatrics
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POLICY STATEMENT

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

abstract

FREE

The majority of public and private payers in the United States currently use the Medicare Resource-Based Relative Value Scale as the basis for physician payment. Many large group and academic practices have adopted this objective system of physician work to benchmark physician productivity, including using it, wholly or in part, to determine compensation. The Resource-Based Relative Value Scale survey instrument, used to value physician services, was designed primarily for procedural services, leading to current concerns that American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) surveys may undervalue nonprocedural evaluation and management services. The American Academy of Pediatrics is represented on the RUC, the committee charged with maintaining accurate physician work values across specialties and age groups. The Academy, working closely with other primary care and subspecialty societies, actively pursues a balanced RUC membership and a survey instrument that will ensure appropriate work relative value unit assignments, thereby allowing pediatricians to receive appropriate payment for their services relative to other services. *Pediatrics* 2014;133:1158–1162

BACKGROUND

Creation of Resource-Based Relative Value Scale Payment System

The Medicare Resource-Based Relative Value Scale (RBRVS) was legislated by the Omnibus Budget Reconciliation Act of 1989. The RBRVS-based physician payment system relies on[1] objective measures of physician work, termed work relative value units (wRVUs)[2]; assessments of the practice expense in providing professional services to patients; and[3] the professional liability insurance expense inherent in each specific service. These 3 components are then corrected for geographic variations in salaries and the cost of goods and services. In this way, the RBRVS system has eliminated many of the dramatic disparities that existed when payments were based on the customary, prevailing, and reasonable fees for the service provided.

Conversion Factor

The RBRVS mandate was accompanied by a legislative requirement for annual Medicare budget neutrality. To accomplish this, Congress established the annually updated conversion factor (CF); the dollar

COMMITTEE ON CODING AND NOMENCLATURE

KEY WORDS
Resource-Based Relative Value Scale (RBRVS), medicare payment, RUC, CPT, valuation, physician work, coding

ABBREVIATIONS
AAP—American Academy of Pediatrics
ACA—The Patient Protection and Affordable Care Act
CF—conversion factor
CMS—Centers for Medicare and Medicaid Services
CPT—Current Procedural Terminology
HCPCS—Healthcare Common Procedural Coding System
HIPAA—Health Insurance Portability and Accountability Act of 1996
ICD-9-CM—International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM—International Classification of Diseases, Tenth Revision, Clinical Modification
NCCI—National Correct Coding Initiative
RBRVS—Resource-Based Relative Value Scale
RUC—American Medical Association/Specialty Society Relative Value Scale Update Committee
RVU—relative value unit
SGR—sustainable growth rate
wRVU—work relative value unit

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amount Medicare will pay for each relative value unit (RVU) of service (total RVU × CF = payment). By legislation, annual increases for new technology or treatments were restricted to $20 million annually. Congress provided for an annual update to the CF based on the percentage increase in the Medicare Economic Index. This index is a comparison of the projected increases in use, described as the Medicare Volume Performance Standard, to the actual increase in spending and other Medicare funding factors. Inability to control this growth in physician services led to the Balanced Budget Act of 1997, which replaced the Medicare Volume Performance Standard with the sustainable growth rate (SGR) system now used to control Medicare expenditures.

Sustainable Growth Rate

The SGR is a complex formula used to determine the annual CF on the basis of the projected growth in per capita gross domestic product. Higher-than-projected use of services results in a reduction to the following year's CF. Expected reductions in the Medicare CF over previous years (eg, –20.1% for 2014) have only been avoided by last-minute congressional legislative action. The Patient Protection and Affordable Care Act (ACA) of 2010 replaces the unworkable SGR formula with one that is more closely tied to inflation and the Medicare Economic Index. The ACA also establishes a public/private committee to recommend the level of annual increase in CF. Recent bipartisan Congressional bills would replace the SGR but freeze Medicare payments for 10 years. The AAP strongly endorses this replacement but will also insist that this freeze not delay continued efforts to attain cognitive and non–face-to-face care parity with procedural services.

The American Academy of Pediatrics (AAP) supports the replacement of the SGR formula with one that more closely ties physician payment to inflation and the medical economic index, similar to that proposed in the ACA.

Five-Year Review Process

At RBRVS's inception, Congress also mandated a 5-year review of work values to review changes in medical practice that might increase or decrease the cost of providing specific services or to revisit perceived inequities in RBRVS values. For example, as part of the 2010 5-year review, preventive medicine services codes were resurveyed on the basis of updated *Bright Futures* care recommendations, resulting in increased wRVUs for those services.

Pediatric Current Procedural Terminology Codes

The AAP Committee on Coding and Nomenclature has sought and continues to seek input from AAP sections, councils, and committees regarding the development of new/revised *Current Procedural Terminology* (*CPT*) codes that reflect changes in the provision of services to children. New *CPT* codes or revisions to existing *CPT* codes can be proposed by any individual or entity, but those sponsored by medical specialty societies are considered more representative of current medical practice. Once a new/revised *CPT* code is accepted by the *CPT* Editorial Panel, the AAP Committee on Coding and Nomenclature then works within the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process to provide the Centers for Medicare and Medicaid Services (CMS) with wRVU and direct practice expense recommendations that accurately reflect the resources expended in providing those services to children. Each November, the CMS publishes (in the *Federal Register*) the upcoming year's RBRVS fee schedule for public comment. In some cases, the CMS accepts the RUC recommended values. However, in other cases, the CMS has published values that have differed from those recommended by the RUC and, as such, the AAP has been very active in its advocacy efforts to reverse those CMS decisions when they have adversely affected payment for services that are critically important to children or recommended by established guidelines, such as those contained in *Bright Futures*.

Non-Medicare Use of RBRVS

Payers are required to use *CPT* as the procedural code set, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The majority of non-Medicare payers, including state Medicaid programs and commercial insurers, use the Medicare RBRVS payment system to set payment for *CPT* codes. According to an American Medical Association (AMA) survey of 127 different public and private payers, 77% of respondents use the Medicare RBRVS.[1] However, non-Medicare payers are not legally bound to use the Medicare RBRVS (or its CF) and can establish their own payment methodologies. The AAP private payer advocacy initiative is constantly working with insurers to make certain that payment policies are RBRVS-based and meet the needs of children and their health care providers.

The Medical Home

Both the Medicare program and the enacted ACA are focused on enhancing the quality of services provided to enrollees while controlling non–value-added use of services through an increased emphasis on prevention and chronic disease management. Patient education, medication management, preventive screening, chronic disease case management, and telephone/

electronic patient communication are critical to the success of the medical home model. The AAP is working with other primary care specialties to develop codes and obtain RBRVS valuation for non–face-to-face services while developing evaluation and management codes to permit appropriate payment for disease management, education, and preventive services, all of which are crucial to chronic care management.

APPLICABILITY TO PEDIATRICS

Although coding and payment policies are primarily driven by the adult Medicare component of the CMS, recently both *CPT* and the RUC have been much more responsive to the needs of pediatric patients. However, if access to efficient and effective health care for all children is to be ensured, Medicaid and other payers must recognize and pay for all of the *CPT* codes, including those for immunization administration, non–face-to-face services, and children's screening services. The AAP believes that it is essential that the CMS publish values for all codes valued by the RUC, including those that may not be applicable to the adult Medicare population, but are still essential for comprehensive pediatric care.

National Correct Coding Initiative

Under provisions outlined in the ACA, Medicaid agencies must use Medicare's National Correct Coding Initiative (NCCI) edits to determine payment policy. The CMS developed the NCCI to promote national correct coding and to control improper coding, which had been resulting in inappropriate payments for Medicare Part B claims. NCCI policies are based on coding conventions defined in *CPT* guidelines, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and review of current coding practices. The AAP is provided an opportunity to review and comment on these edits before their publication, giving the pediatric community 1 more opportunity to advocate that children's access to needed services not be compromised by exclusively adult-oriented payment decisions.

Pediatric National Payment Representation

The AAP has representation on the *CPT* Editorial Panel, the RUC, the *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) Editorial Advisory Board, and the *International Classification of Diseases, Eleventh Revision* (*ICD-11*), Pediatric Topic Advisory Group. This representation provides the AAP with a consistent voice, respected by adult specialty society colleagues and national payers. State- and payer-specific payment decisions that conflict with national rules or policies and that disadvantage children are being addressed through the active involvement of AAP members, state AAP chapters, and AAP chapter pediatric councils.

The ACA has also recognized the importance of services to children by mandating that, by 2014, all Medicaid programs use the Medicare CF as the floor for a large percentage of services provided in the office by primary care physicians. Although the AAP supports this attempt to equalize payments for services provided to adults and children, it continues to advocate for inclusion of all evaluation and management and procedural services provided to children and for a base Medicaid CF for pediatric services that exceeds Medicare's base to ensure that all children have access to care in a medical home. In addition, the AAP supports the development of a value-based reimbursement system that will additionally reward practices and providers that demonstrate high quality and superior health outcomes in the patients they serve.

National Pediatric Database

The Medicare system uses a single national database (Medicare Part B Database) to track use of services to adults, allowing the CMS to identify policy and payment changes that negatively affect access to services or identify overuse of new or high-cost services. The absence of a single national database for Medicaid makes similar analyses for pediatric care challenging or impossible and limits important research tracking relationships between pediatric access to care, use of services, and quality outcomes. The AAP continues to actively lobby for a single national Medicaid database.

COMPONENTS OF THE RBRVS PAYMENT SYSTEM

The RBRVS system assigns a numeric value to each of 3 RBRVS components:

- Physician work
- Practice expense
- Professional liability insurance expense

Physician Work

The work a physician expends in directly providing a service or performing a procedure is called "intra-service work." In the office setting, the intra-service period is defined as face-to-face patient encounter time. In the hospital setting, it is the time spent on the patient's unit or floor, and for surgical procedures, it is the period from initial incision to the closure of the incision. Work performed before and after provision of a service is referred to as "pre-service work" and "post-service work," respectively. When pre-service, intra-service, and post-service works are combined, they create the

"total work" involved in the provision of that service.

Practice Expense

The practice expense component of the RBRVS includes the cost of clinical staff time, medical supplies, and medical equipment. In aggregate, practice expense accounts for an average of 44.8% of a code's total RVU. Increased paperwork, reporting regulations (eg, immunization registries and reportable quality indicators), and expenses involved in transitioning to electronic health records are common to all pediatric practitioners. The practice expense values for an office (nonfacility) service will be higher than those for services provided in a hospital or other facility not owned by the provider, because much of the facility practice expense is covered under Medicare Part A, and physician services are covered under Medicare Part B; hence, some procedures have differing RVUs depending on whether they are performed in a "facility" as opposed to the practitioner's office.

Since 1998, the CMS has used a formula for calculating practice expense that allocates the costs of providing a specific service uniformly across all specialties by using expert panels to decide each of 6 categories of costs involved in each type of patient encounter: clinical labor, medical supplies, medical equipment, office expense, administrative labor, and all other expenses.

Professional Liability Insurance Expense

RBRVS assigns RVUs to cover the professional liability insurance expense incurred by physicians in providing each service. Similar to practice expense, these costs are normalized for all specialties providing that service.

Geographic Practice Cost Indices

The Omnibus Budget Reconciliation Act of 1989 also introduced the concept of geographic practice cost indices to address the disparity in the cost of living in urban (37% higher) versus rural practices. Each component of the total RVU (physician work, practice expense, and professional liability insurance) is subjected to different correction values with states varying in the number of regions that are assigned different geographic practice cost indices.

RBRVS CONVERSION

Conversion from RVUs to payment amounts is a multistep process that is covered in detail in the RBRVS Brochure and RBRVS Conversion Spreadsheet from the AAP.

HIPAA CODE SETS AND DISEASE CLASSIFICATION

HIPAA established standard transaction codes for medical claims submission. The primary codes for reporting physician encounters include the Healthcare Common Procedure Coding System (HCPCS) Level I and Level II codes for procedural reporting and the *ICD-9-CM*[1] codes for diagnosis reporting.

The *International Classification of Diseases* (ICD),[2] published by the World Health Organization, is used to code for a diagnosis, symptom, condition, or event linked to a provided service. The current clinical modification in the United States (ie, *ICD-9-CM*)[1] has been in use since 1979. Conversion to *ICD-10-CM*, in use internationally since 1994, is expected in the United States on October 1, 2015. The 7-digit alphanumeric system of *ICD-10-CM* allows for greater specificity for tracking illnesses, injuries, and disease-management programs. The AAP supports this transition to *ICD-10-CM* and is well positioned within the World Health Organization topical advisory groups to ensure that the Eleventh Revision of the ICD contains accurate, current, and comprehensive pediatric diagnoses and nomenclature.

HCPCS Level I Codes: *CPT*

HCPCS Level I codes are also called *CPT* codes. *CPT* is a listing of descriptive terms and identifying codes for reporting medical services and procedures developed and maintained by the American Medical Association. The *CPT* nomenclature comprises 3 categories of codes.

Category I CPT Codes

Category I *CPT* codes describe a procedure or service identified with a 5-digit *CPT* code and descriptor nomenclature. Category I *CPT* codes must represent services or procedures that are approved by the Food and Drug Administration, widely used in practice, and evidence based.

Category II CPT Codes

Category II *CPT* codes are supplemental tracking codes, without assigned RVUs, that are used to report adherence to quality indicators, adherence to clinical guidelines, and suggested best practices. Their use is encouraged, although not required. When reported, they facilitate quality data collection that support nationally established performance measures.

Category III CPT Codes

Category III *CPT* codes are temporary tracking codes, also without assigned RVUs, that allow for tracking new and emerging technologies while further studies determine whether they have sufficient use and more convincing literature support to qualify as Category I *CPT* codes.

HCPCS Level II Codes

HCPCS Level II codes, commonly referred to as HCPCS ("hick-picks") codes, are used to identify services not included in the *CPT* nomenclature (eg, ambulance services, durable medical equipment, prosthetics, orthotics, and supplies)

that are developed and assigned by the CMS without direct input from the specialty societies. HCPCS Level II codes are alphanumeric codes, consisting of a single alphabetical letter followed by 4 numeric digits and are used to report office supplies such as injectable drugs and inhalation solutions as well as some orally administered drugs.

RECOMMENDATIONS

1. In the absence of more global reimbursement systems, the principles embodied by the fully implemented RBRVS system should continue to be the preferred process to establish physician payment, while recognizing a need to strive toward more parity between cognitive and procedural services, including complex chronic care, behavioral/mental health, and non–face-to-face services.
2. RBRVS values for *CPT* codes should accurately reflect the complexity of both cognitive and procedural physician work, comprehensive practice expense, and professional liability insurance expense in providing services to infants, children, adolescents, and young adults.
3. The CMS should publish all RUC-recommended values, not just those that are applicable to the Medicare population.
4. The RUC process should accurately assess the nonprocedural physician work, practice expense, and professional liability insurance expense included in the provision of health care services to infants, children, adolescents, and young adults. To accomplish this, the RUC survey instrument, which is used to obtain estimates of the time and complexity required in performing a procedure to estimate a recommended professional work value, should be revised to allow for the accurate valuation of nonprocedural cognitive services.
5. Nationally, the education of pediatricians and pediatric subspecialists within AAP entities should be pursued to better understand the RUC survey instrument and the elements of physician work toward encouraging robust RUC survey participation among AAP members.
6. All payers, including Medicaid, should pay for the full spectrum of *CPT* codes and recognize *CPT* guidelines.

LEAD AUTHORS

Robert S. Gerstle, MD
Richard A. Molteni, MD

COMMITTEE ON CODING AND NOMENCLATURE, 2013–2014

Margie C. Andreae, MD, Chairperson
Joel F. Bradley, MD
Eileen D. Brewer, MD
Jamie Calabrese, MD
Steven E. Krug, MD
Edward A. Liechty, MD
Jeffrey F. Linzer, Sr, MD
Julia M. Pillsbury, DO
Sanjeev Y. Tuli, MD

FORMER COMMITTEE MEMBERS

Robert S. Gerstle, MD
Richard A. Molteni, MD
Lynn M. Wegner, MD

LIAISON

Samuel D. Smith, MD – *American Pediatric Surgical Association*

STAFF

Becky Dolan, MPH, CPC
Teri Salus, MPA, CPC
Linda Walsh, MAB

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