

MEDICARE PHYSICIAN FEES OVERHAULED

The RBRVS Fee System and Its Implications For Hospitals

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After years of study and about 95,000 comments to proposed regulations, Medicare has begun to implement a new payment system for physician services. Its cornerstone is a resource-based relative value scale (RBRVS) that applies to office- and hospital-based physicians. Fees will be adjusted for geographic cost variations, and the new system will be phased in between 1992 and 1996. Tight limits have been imposed on the amount a physician may charge above the fee schedule amount.

This article first explains major features of the RBRVS fee system, with special attention to provisions that may affect hospitals. Then it identifies financial and operational implications of key concern to hospitals.

THE RELATIVE VALUE SCALE

The foundation of Medicare's new system is a nationally applicable RBRVS crafted primarily by

Summary Medicare has begun to implement a new payment system for physician services; the system's cornerstone is a resource-based relative value scale (RBRVS) that divides physician services into three components—physician work, practice expense, and malpractice insurance—and calculates a relative value for each component. The relative values for the components are adjusted for geographic differences between regional and national resource costs. Then a conversion factor transforms a relative value into a payment amount.

The full RBRVS fee will be paid beginning January 1, 1992, if the fee does not differ by more than 15 percent from the service's adjusted historical payment basis. If the difference generally exceeds 15 percent, the RBRVS fee will be phased

researchers at Harvard University. The total resources needed to produce a physician service have been divided into three components: physician work, practice expense, and malpractice insurance. A relative value has been calculated for each component of each physician service.

Relative values have been established for roughly 7,000 HCPCS/CPT codes. A relative value of 3.10 indicates that the service is 3.1 times more valuable than the standard or reference service, which is a level 3 office visit by an established patient (code 99213, relative value = 1.00). A relative value of 0.80 signifies the service is 20 percent less valuable than the reference service.

Geographic Adjustment The relative values for physician work, practice expense, and malpractice insurance are adjusted for geographic differences between regional and national resource costs. Ignoring these geographic variations could cause substantial losses for physicians practicing in high-cost areas. An inadequate adjustment could

in over four years.

The Medicare RBRVS fee schedule applies to both office- and hospital-based physicians. Several special provisions apply to physicians ordinarily defined as hospital based—radiologists, anesthesiologists, and pathologists. Other provisions of the fee schedule address site-of-service differentials, electrocardiograms, nonphysician practitioners, new physicians or practitioners, and Health Professional Shortage Areas.

Administrators need timely strategies to manage successfully in the new environment and to sidestep lost or delayed reimbursement. RBRVS has financial and operational implications in terms of physician compensation, outpatient hospital reimbursement, new CPT codes, and new outpatient billing procedures.

cause access problems for many Medicare beneficiaries.

For approximately 240 carrier localities, a separate geographic practice cost index (GPCI) has been established for physician work, practice expense, and malpractice insurance. As the law requires, the adjustment for physician work recognizes only 25 percent of the difference between the cost of living in the locality and living elsewhere in the nation (on average); in contrast, the adjustment recognizes 100 percent of the difference for practice expense and malpractice insurance. This phenomenon financially benefits physicians practicing in rural areas and financially hurts urban physicians.

A 10 percent bonus continues to be paid to physicians for services rendered in any designated Healthcare Professional Shortage Area (HPSA). An HPSA may be an urban or rural area. The bonus payment is double the amount paid under prior law.

Conversion Factor A conversion factor transforms a relative value into a payment amount. The conversion factor for all physician services except anesthesiology is \$31.001 in 1992. For a service with an adjusted value of 20.5 units, the payment amount equals \$635.52 ($\31.001×20.5), all

other things being equal.

Table 1 shows the calculation of the RBRVS fee for a repair of a thigh fracture (code 27234) in three geographic locations. Medicare payment is based on the *lower* of the billed charge or fee schedule amount. Medicare pays 80 percent of the amount; the beneficiary is responsible for the other 20 percent.

For anesthesia services rendered by an anesthesiologist, the conversion factor before any geographic adjustment is \$13.94 for 1992, down 29 percent from 1991. The comparable unadjusted conversion factor for anesthesia services provided by medically directed certified registered nurse anesthetists (CRNAs) is \$10.75; for nonmedically directed CRNAs, it is \$15.75. However, the fee paid to a nonmedically directed CRNA may not exceed the fee that an anesthesiologist would be paid.

TRANSITION PERIOD

The full RBRVS fee will be paid beginning January 1, 1992, if the fee does not differ by more than 15 percent from the service's "adjusted historical payment basis" (AHPB), which essentially is the average adjusted prevailing charge in 1991, updated for inflation and reduced 5.5 percent to

TABLE 1: RBRVS FEE FOR REPAIR OF THIGH FRACTURE (CODE 27234) IN THREE LOCATIONS

Item	Colorado	New Orleans	Manhattan, NY
Relative value units			
Physician work	12.48	12.48	12.48
Geographic adjustment	$\times 0.999$	$\times 0.994$	$\times 1.059$
Adjusted value	12.468	12.405	13.216
Practice expense	16.36	16.36	16.36
Geographic adjustment	$\times 0.988$	$\times 1.003$	$\times 1.255$
Adjusted value	16.164	16.409	20.532
Malpractice insurance	2.66	2.66	2.66
Geographic adjustment	$\times 0.683$	$\times 1.185$	$\times 1.647$
Adjusted value	1.817	3.152	4.381
Total adjusted value	30.449	31.966	38.129
Conversion factor	$\times \$31.001$	$\times \$31.001$	$\times \$31.001$
RBRVS fee*	<u>\$943.95</u>	<u>\$990.98</u>	<u>\$1,182.04</u>

*Fee before any other adjustments.

ensure budget neutrality. If the difference exceeds 15 percent, the RBRVS fee will be phased in over four years. For these services, the fee schedule amount will be a "blended fee" during the transition period (see **Table 2**).

For 1992 the blended fee for a service with an AHPB exceeding 115 percent of the RBRVS fee (109 percent for radiology) will equal the AHPB minus 15 percent of the RBRVS fee. For services with an AHPB below 85 percent of the RBRVS fee, the blend will equal the AHPB plus 15 percent of the RBRVS fee.

The blended fee for 1992 will be used to calculate the blended fee for 1993, when the blend will equal 75 percent of the updated 1992 blended fee plus 25 percent of the RBRVS fee for 1993. For 1993 through 1996, a similar process is used except that the weights change, as **Table 2** indicates.

BALANCE BILLING

The RBRVS fee schedule amount paid to a physician who does not participate in Medicare—that is, one who does not accept Medicare as full payment for services rendered—is 95 percent of the amount paid to a participating physician. The nonparticipating physician, however, may charge an extra amount for services rendered to Medicare patients.

The RBRVS fee system tightens the limit on the amount a nonparticipating physician may charge above the Medicare payment level. The "limiting charge" for 1992 is a maximum of 120 percent of the fee schedule amount for nonparticipating physicians, and the 1992 level may be below the 1991 limit. For 1993, the limit is 115

percent of the fee schedule amount for nonparticipating physicians.

HOSPITAL-BASED PHYSICIANS

The RBRVS fee schedule applies to both office-based and hospital-based physicians. The final regulations contain several special provisions that apply to physicians ordinarily defined as hospital based—radiologists, anesthesiologists, and pathologists. The Health Care Financing Administration (HCFA) estimates that the average Medicare fee for these hospital-based services will dip about 10 percent in 1992.

Radiologists The relative values that Medicare used in 1991 for radiologists have been rescaled to be consistent with the relative values for services rendered by other physician specialists.

Medicare payment policy for interventional radiological services has been standardized nationally under the RBRVS fee system. CPT codes for complete procedures are no longer recognized for Medicare billing. Instead, the radiological portion of the service (supervision and interpretation) and the primary nonradiological aspect of the service are billed separately. In general, any other nonradiological procedure is paid on a sliding scale, depending on the number of nonradiological procedures performed.

Separate RBRVS payment is available for low osmolar contrast media (LOCM) administered to hospital patients in conjunction with intravenous, intraarterial, and intrathecal injections. Payment is based on the lower of acquisition costs or the national average wholesale price less 8 percent.

For Medicare beneficiaries who are neither hospital inpatients nor hospital outpatients, separate payment for LOCM is made for all intrathecal injections, as well as intravenous and intraarterial injections, if used for patients with a history of asthma or allergy, generalized severe debilitation, sickle cell disease, or certain other conditions.

For portable x-ray suppliers, the RBRVS payment includes an amount to cover the expected additional costs associated with setting up equipment and positioning patients in nursing homes and patients' homes. Each patient setup is billable separately during both single-patient and multiple-patient trips. The setup payment varies geographically. Furthermore, the transportation costs are paid based on local prices, as determined by Medicare carriers. Payment for these costs is prorated over the number of patients served during a trip.

Anesthesiologists For anesthesiologists, the relative value guide used in 1991 and the fee reductions applicable to concurrently directed procedures carry over under RBRVS. And, as in 1991, actual

TABLE 2: FEE BLENDS DURING THE TRANSITION PERIOD (1992-96)

Year	Adjusted Historical Payment	RBRVS Fee
1992*	AHPB ± 0.15 × (RBRVS fee)	
1993	75%	25%
1994	67%	33%
1995	50%	50%
1996	0%	100%

*Applies to all physician specialties except radiology.

time will be used to calculate time units, rather than average time, as HCFA proposed.

HCFA will apply a new definition to measure anesthesia time. Specifically, anesthesia time involves the *continuous actual presence* of the anesthesiologist (or a qualified medically directed person). It starts when the patient is prepared for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance. Medicare

carriers will monitor high-volume procedures, particularly codes indicating surgery with widely varying anesthesia times.

Separate payment is available under RBRVS for specialized procedures (e.g., insertion of a Swan-Ganz catheter) that an anesthesiologist or a non-medically directed anesthetist provides. These procedures must be reasonable, necessary, and not covered in a global surgery fee. Separate payment also is available for monitored anesthesia care when furnished by an anesthesiologist or nonmedically directed CRNA. Under justifiable circumstances, it also may be available for medically directed CRNAs.

Through December 1993, the RBRVS fee paid to a teaching anesthesiologist will not be reduced when two concurrent procedures involve interns and residents. Beginning in 1994, however, the fee will not be reduced only when one intern or resident is involved.

Pathologists Relative values have been established for 59 of the approximately 1,100 services listed in the pathology section of CPT. The remainder are considered to be clinical diagnostic laboratory services and are statutorily excluded from the RBRVS fee system. Some of the pathology codes have relative values for both the professional and technical components. Other pathology codes have a relative value for the professional or technical component only.

A new category of service—clinical laboratory interpretation services—has been established for 15 clinical laboratory codes. Under RBRVS, payment is available for these services when the interpretation is requested by the patient's attending

The outpatient payment limit does not apply to ambulatory surgical centers.

physician, results in a written narrative report, and requires the pathologist to exercise medical judgment. A standing order for an interpretation by the consulting physician can meet the definition of a request for this purpose.

SITE-OF-SERVICE DIFFERENTIAL

Services that are primarily performed in an office setting are subject to an "outpatient payment limit" when rendered in an outpatient hospital setting. Under RBRVS, the

limit applies to a national list of 400 CPT codes. And, except when a physician uses a special emergency visit code, emergency services are no longer exempt from the "outpatient payment limit."

The limit does not apply to office-based procedures performed in an ambulatory surgical center, nor to anesthesiology services, diagnostic and therapeutic radiology services, covered surgical services performed in an ambulatory surgical center, and rural health clinic services. Furthermore, the limit may be waived when an independent practitioner is merely leasing space but is not utilizing hospital staff or other hospital resources.

ELECTROCARDIOGRAMS

Beginning January 1, 1992, Medicare no longer pays separately for electrocardiogram (EKG) interpretations when performed or ordered as part of or in conjunction with a visit or consultation associated with certain CPT codes: 93000, 93010, 93040, 93042. Payments for EKG interpretations have been bundled into visit codes in proportion to the sites of service (e.g., inpatient and outpatient) where they traditionally have been performed. A physician who provides the visit will be paid for an EKG interpretation, regardless of whether one is actually done. Consequently, physicians who do a large number of interpretations are likely to be underpaid, and no separate payment is allowed for physicians providing interpretations on referral.

An exception arises in the unnamed situation when an EKG interpretation is unrelated to the visit. Separate payments are also available for specialized EKG interpretations (e.g., 93201, 93210).

NONPHYSICIAN PRACTITIONERS

The RBRVS fee system changes the amount Medicare pays for covered services performed by nonphysician practitioners (NPPs) who were reimbursed on a fee or charge basis in 1991, but not on a cost basis. Physician assistants, CRNAs, clinical nurse specialists, nurse practitioners, nurse midwives, physical and occupational therapists in independent practice, clinical psychologists, and clinical social workers are covered. In general, NPP fees or payment limits will change because they are based on or limited by the amount Medicare would pay if a physician rendered the service.

NEW PHYSICIANS OR PRACTITIONERS

The new payment system continues to pay a reduced fee to "new" physicians for the first four years of practice. This reduction also applies to new physical and occupational therapists in independent practice. Contrary to pre-1992 policy, the reduction also applies to a new physician practicing in a group setting. The reduction does not apply to primary care services that physicians provide, nor to services furnished by physicians, physical therapists, or occupational therapists practicing in rural areas that are designated as HPSAs.

For the first year of practice, the payment to the new physician or practitioner is 80 percent of the fee schedule amount. In the next three years, the factor rises to 85, 90, and 95 percent, respectively. In the fifth year, the fee reduction ends and the full fee is paid.

STRATEGIC PLANS

The RBRVS fee schedule has financial and operational implications for hospitals. Administrators need timely strategies to manage successfully in the new environment and to sidestep lost or delayed reimbursement.

Physician Compensation The RBRVS fee system generally increases fees for evaluation and management services (such as visits and consultations) and decreases them for surgical and other procedures. Unless the volume and intensity increase sufficiently or other counterbalancing changes occur, a hospital may not recover the compensation paid to hospital-salaried physicians for direct medical care rendered to Medicare beneficiaries.

Outpatient Reimbursement Medicare reimbursement of hospital outpatient radiology, physician pathology, and certain diagnostic tests may decrease under RBRVS. Financial administrators need to carefully examine the adequacy of the new payment amounts. The costs of rendering

certain services may far exceed the new payment levels.

Outpatient Payment Limit The revised, nationally uniform outpatient payment limit may cause some services to shift from a hospital to a physician's office, or vice versa. The shift may be confined to certain specific services. The financial consequences may be large or small depending on the circumstances.

New Codes Many HCPCS/CPT codes have been revised or introduced for the RBRVS system. The most important changes pertain to evaluation and management services and major/minor global surgery. Furthermore, a national list of procedures subject to the outpatient limit has been introduced, and coding for interventional radiology has been changed. Complete and accurate coding (and billing) is essential to avoid erroneous payments.

Charge Levels The amount charged for various hospital or physician services may have to be adjusted in response to the RBRVS fee schedule. For physician services, Medicare pays based on the lower of the billed charge or fee schedule amount.

Teaching Hospitals Teaching physicians are paid under RBRVS on the same basis as other physicians. However, with its physicians' concurrence, a qualifying teaching hospital may still elect to be paid on a cost basis for the direct medical and surgical services its physicians provide. Cost reimbursement may be financially preferable to RBRVS payment, depending on the circumstances.

Provider Services Physicians who expect their Medicare income from direct care to decrease may ask hospital administration for additional compensation for provider-related or administrative services. A central issue for hospital administrators is whether the additional costs can be recovered.

Nonphysician Practitioners The RBRVS system may increase or decrease the amount a hospital collects from Medicare for the services of different groups of NPP employees, depending on the circumstances. In addition, higher NPP fees may make independent practice a more attractive career option, thereby causing a temporary staffing problem for certain hospitals.

Electrocardiograms The general elimination of separate Medicare payments for EKG interpretations raises questions about how payments will be made to physicians doing the interpretations. Administrators may wish to investigate the possibility and legality of the ordering physician paying for the interpretation out of the Medicare fee for the corresponding visit. □