

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 12 - A-99

Subject: Non-Medicare Use of the RBRVS
(Resolutions 805 and 836, A-98, Resolution 821, I-98)

Presented by: Kay K. Hanley, MD, Chair

Referred to: Reference Committee H
(B. David Wilson, MD, Chair)

1 At the 1998 Annual Meeting, the House of Delegates referred Resolution 805 (A-98) to the Board
2 of Trustees. Introduced by the American Academy of Pediatrics, this resolution calls for the
3 American Medical Association (AMA) to work “to support the use of Medicare RVU
4 methodology in developing insurance allowables in both the private and public sector,” and
5 further, to “develop educational materials for both patients and insurers regarding this
6 methodology.” The House also referred Resolution 836. Introduced by the Oklahoma Delegation,
7 this resolution calls for the AMA to work to “initiate a congressional effort that would require all
8 state Medicaid programs to use Resource Based Relative Value Scale (RBRVS) for physician
9 reimbursement.” In addition, at the 1998 Interim Meeting, the House referred to the Board of
10 Trustees Resolution 821, which was introduced by the American Academy of Dermatology, the
11 Society for Investigative Dermatology, and the American Society for Dermatologic Surgery. This
12 resolution calls for the AMA to “encourage third-party payors to adhere to Medicare multiple
13 surgery policy,” and to “notify any carriers that fail to follow the multiple surgery policy to advise
14 that such practice is considered inequitable.” The Board referred Resolutions 805 and 836 (A-98)
15 and Resolution 821(I-98) to the Council on Medical Service for a report back to the House of
16 Delegates at the 1999 Annual Meeting.

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18 The following report discusses the current RBRVS methodology, non-Medicare Payors selection
19 of conversion factors, and Medicare’s multiple procedure payment policy; summarizes the results
20 from a recent AMA survey of non-Medicare payors’ use of the RBRVS; and presents several
21 policy recommendations.

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23 RBRVS METHODOLOGY

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25 Resolutions 805 and 836 (A-98) seek to expand the RBRVS methodology in the private and
26 Medicaid sectors. Current AMA policy addresses this issue with a somewhat different approach.
27 For example, Policy H-165.913 (AMA Policy Compendium) favors a pluralistic health care
28 delivery system to include fee-for-service medicine rather than endorsing a specific form of
29 payment as the preferred option. Policy H-385.989 states that the AMA supports a pluralistic
30 approach to third-party payment methodology under fee-for-service, and does not support a
31 preference for usual and customary or reasonable (UCR) or any other specific payment
32 methodology. In addition, Policy
33 H-385.990 reaffirmed the AMA’s support for a neutral public policy and fair market competition
34 among alternative health care delivery and financing systems.

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1 Although the AMA has been a leader in initiating improvements to the RBRVS, the AMA has
2 never formally endorsed the Medicare RBRVS physician payment system. In fact, Policy H-
3 400.971 states specifically that “the AMA opposes application and expansion of the current
4 Medicare RBRVS to private sector payors.” More recently, however, Policy H-400.960, while
5 continuing the AMA position of non-endorsement of the Medicare RBRVS, states the following:

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7 An RBRVS that is annually updated and rigorously validated could be a
8 basis for non-Medicare physician fee and payment schedules. This policy
9 pertains to the RBRVS relative values only. It does not apply to
10 Medicare's conversion factor, balance billing limits, GPCIs, and
11 inappropriate payment policies.

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13 Notwithstanding these policies, adoption of these two resolutions may not achieve the desired
14 outcome since work relative values are based on services provided to a “typical” patient and some
15 specialties do not treat “typical” patients and may receive payments that they may feel are not
16 representative of their work. For example, when the service can be provided to both children and
17 adults, but the typical patient is an adult, the relative value will be valued according to the work
18 required to provide the service to adults, and will not reflect possible additional work required to
19 provide the service to a child. This reality presents an obstacle to achieving the underlying intent
20 of Resolution 836 (A-98), which is to enhance payment levels for pediatric services by
21 encouraging state Medicaid agencies to adopt the RBRVS.

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23 In addition, although the RBRVS establishes the relativity among procedures, it is the conversion
24 factor that also determines the final payment amount. The AMA has been long concerned that
25 private payors would use the conversion factors, limits on balance billing, and associated payment
26 policies to emphasize cost containment to the exclusion of any other goal. Such inappropriate use
27 of the RBRVS could have negative consequences for patient access.

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29 Since the conversion factor determines the dollar value of a service, it may affect physicians and
30 patients perhaps more than any other component. An AMA survey of non-Medicare payors
31 indicated that Blue Cross/Blue Shield (BCBS) and managed care respondents had 1998 conversion
32 factors that exceeded Medicare's, at \$43.99 and \$45.98. As expected, Medicaid has the lowest
33 conversion factor at \$26.31. At the time of the survey, Medicare's conversion factor was \$36.68.
34 These data demonstrate that, even if a payor adopts the RBRVS in an effort to increase payment
35 for physician services provided to children, as Resolution 836 (A-98) advocates, the conversion
36 factor selected by the payor will ultimately determine if overall payment levels actually increase
37 with the adoption of the RBRVS. Some non-Medicare payors ensure increased payments for
38 specific services such as maternity and children's primary care services by using a separate
39 conversion factor or bonus payments.

40 41 MULTIPLE PROCEDURE PAYMENT POLICY

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43 Resolution 821 (I-98) seeks to encourage the adoption of Medicare's multiple procedures payment
44 policy. This payment policy states that, when multiple procedures are performed on the same day,
45 the primary procedure should be paid at the lesser of the actual charge or 100% of the payment
46 schedule for the procedure with the highest payment, while payment for the second through fifth
47 surgical procedures is based on the lesser of the actual charge or 50% of the payment schedule.

1 Surgical procedures beyond the fifth procedure are priced by Medicare carriers “by report” based
2 on documentation of the services furnished. Reducing the value of the work effort when multiple
3 procedures are performed is consistent with the overall RBRVS methodology. The Health Care
4 Financing Administration (HCFA) established this payment policy in 1995 based on a study
5 performed by the research team that developed the RBRVS.

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7 AMA SURVEY OF NON-MEDICARE USE OF RBRVS

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9 The AMA has recently surveyed a variety of non-Medicare payors including Blue Cross and Blue
10 Shield plans, Medicaid, managed care organizations (MCOs) and other private health plans to
11 determine the non-Medicare use of the RBRVS. Analysis of the data, based on responses from
12 222 payors, indicate that there is widespread use of the RBRVS for non-Medicare payment, with
13 63% of respondents using the RBRVS in at least one product line. The survey results indicated
14 that the adoption rate for the RBRVS varies among the four types of payors, with a majority of
15 BCBS, MCOs and Medicaid plans utilizing the RBRVS. Specifically, 87% of the BCBS plans,
16 69% of MCOs, 55% of Medicaid plans, and 44% of other non-Medicare plans use the RBRVS.

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18 Those respondents who indicated that they use the RBRVS were asked to identify those product
19 lines where they have implemented the RBRVS. Historically, the RBRVS has been used primarily
20 by traditional fee-for-service insurers, but the data show that use of RBRVS is now widespread by
21 various types of payors. Part of this effect may be due to the continued dominance of fee-for-
22 service payment mechanisms, even by managed care companies. The data also show that managed
23 care organizations, especially those with an HMO, now use the RBRVS to a greater extent than
24 fee-for-service payors. This finding indicates that the RBRVS is applicable not only to fee-for-
25 service insurers, but to a wide range of product lines.

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27 Also included in the survey were questions regarding the use of various Medicare payment policies
28 such as Medicare’s multiple surgery policy. The acceptance of these policies is an important
29 aspect of correctly implementing the RBRVS system. The data also indicate that all the payor
30 categories showed a high propensity to adopt Medicare payment policies such as the multiple
31 surgery reduction payment policy. In fact, the multiple surgery reduction policy was the most
32 commonly adopted policy, with Medicaid respondents at 96%, MCOs at 84%, BCBS at 80%, and
33 other non-Medicare at 32%. The adoption of global surgical periods was also widespread:
34 Medicaid at 87%, BCBS respondents at 80%, MCOs at 69%, and other non-Medicare at 26%.

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36 Respondents who use the RBRVS also indicated which of the following six CPT modifiers they
37 accept. Fifty-six percent of the respondents indicated they accepted all six of the modifiers.

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- 39 • 22—Unusual procedural services 81%
- 40 • 25—Significant, Separately identifiable
41 E&M service by the same physician
42 on the same day of the procedure 75%
- 43 • 26—Professional component 92%
- 44 • 51—Multiple procedures 89%

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- 1 • 57—Decision for surgery 64%
- 2 • 59—Distinct procedural service 63%

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4 The acceptance of the various Medicare and CPT policies including the multiple surgery reduction
5 is an important aspect of correctly implementing the RBRVS system. It is not sufficient to only
6 use the Medicare established relative value units (RVUs) if the CPT modifiers and global surgical
7 periods are not recognized. A payment system that does not utilize these payment policies would
8 not resemble Medicare's RBRVS, since the actual implementation of the system would be quite
9 different. Therefore, if a payor is to adopt the RBRVS, it is important to utilize the various
10 appropriate payment policies that are an integral part of the RBRVS.

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12 This issue of correctly using CPT modifiers is of great importance to the AMA. In November
13 1998, the AMA wrote to nearly 1,000 medical directors expressing the concern that some health
14 insurance companies and managed care plans were using claims editing practices that are
15 inconsistent with AMA CPT and Medicare policies. If it is determined that third-party payors and
16 other public programs redefine HCFA's Medicare multiple surgery reduction policy by reducing
17 payment for additional surgical procedures after the first procedure by more than 50%, the AMA
18 could undertake a similar campaign to educate payors on the inappropriateness of such reductions.

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20 DISCUSSION

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22 As noted earlier in this report, current AMA policy does not endorse a specific payment
23 mechanism such as the RBRVS, but instead, states that use of RBRVS relative values is one option
24 that could provide the basis for both public and private physician payment systems – independent
25 of Medicare's conversion factor and inappropriate payment policies. The Council believes that
26 current policy which supports the RVU methodology as one option in a pluralistic payment
27 system, remains the best position for the AMA.

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29 The Council also believes that recognition of key payment policies is critical to successfully
30 implementing the RBRVS. In particular, the Council believes that the 50% reduction chosen by
31 HCFA under its multiple surgery rule be endorsed as the maximum amount of a reduction that
32 third party payors should apply to multiple procedures.

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34 In addition to recognizing appropriate payment policies, the Council believes it is imperative that
35 payors update their fee schedule on an annual basis to reflect coding changes and revisions to
36 relative values. Each year, new services are assigned relative values and existing codes receive
37 revised relative values. Therefore, payors must continually update their fee schedule so physicians
38 and other health care providers are reimbursed according to the most recent relative values and
39 payment policies. The Council is pleased, therefore, that a 1997 AMA survey of non-Medicare
40 payors showed that 97% of respondents who used the RBRVS updated their RVU schedule
41 annually.

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43 RECOMMENDATIONS

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45 The Council on Medical Service recommends that the following be adopted in lieu of Resolutions
46 805 and 836 (A-98) and Resolution 821 (I-98), and that the remainder of the report be filed:

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- 1 1. That the American Medical Association (AMA) reaffirm Policy H-400.960 which advocates
2 that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS)
3 relative values could provide a basis for non-Medicare physician payment schedules, and that
4 the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most
5 current and accurate data and implementation methods.
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- 7 2. That the AMA reaffirm Policy H-400.969 which supports the use of the AMA/Specialty
8 Society process as the principal method of refining and maintaining the Medicare relative
9 value scale.
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- 11 3. That the AMA continue to identify the extent to which third-party payors and other public
12 programs modify, adopt, and implement Medicare RBRVS payment policies.
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- 14 4. That the AMA strongly oppose and protest any efforts by third-party payors and other public
15 programs to redefine the Health Care Financing Administration's Medicare multiple surgery
16 reduction policy by reducing payment for additional surgical procedures after the first
17 procedure by more than 50%.
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- 19 5. That the AMA encourage third-party payors and other public programs to utilize the most
20 current CPT codes updated by the first quarter of the calendar year, modifiers, and relative
21 values to ensure an accurate implementation of the RBRVS.