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# Reimbursement for Physicians' Cognitive and Procedural Services: A White Paper

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## Overview of the Problem

Putting a price tag on the value of physician services has always been difficult and complex. Before the advent of health insurance on a large scale, fees usually were worked out between the physician and the patient, without governmental or societal intrusion into this relationship.

However, this has changed with the growth of third party payors as the primary financing agents for most people's health care,

Third party payors require predictable payment rates which, when combined with actuarial projections, allow them to maintain adequate premium revenues. The enactment of Medicare and Medicaid intensified interest in how **physician** fees are established. As a result, fee arrangements are no longer considered to be solely the province of the physician and the patient. Reimbursement formulas were established to *standardize* compensation for physician services, through methods such as fee schedules and "usual, customary and reasonable" determinations.

Standardization, unfortunately, has had the effect of locking in historical inequities in compensation for various types of physician services. This is especially true of the value placed on physicians' cognitive and procedural services. Physicians' cognitive services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision-making, and judgment relating to the prevention, diagnosis, and treatment of health problems, and communication of such information to the patient. These "thinking" services historically have been reimbursed at a much lower rate than the technical procedures physicians also provide. This has occurred even though cognitive services are *at least as* important, perhaps *more so, than procedural skills* in the *provision of patient* care. It is self-evident that the correct application of procedures is totally **dependent** upon the initial cognitive *skill* of deciding "what is wrong with the patient." The mind behind the pen, the hammer, the wheel--or the scalpel or catheter--has always been most important. Unfortunately, the historical inequity in reimbursing for cognitive services has resulted in a system *that fails to recognize the importance of physicians' "thinking" functions.*

Part of the reason for this historical inequity *is* explained by the fact that health insurance originally was created to protect patients from the high costs of surgical procedures. Expansion of health insurance benefits led to increased coverage for other procedural services such as laboratory tests and x-rays, but did not include coverage for equally important cognitive services. As a result, physicians began to place greater emphasis on charging for procedures, so that patients could benefit from their insurance. This historical disparity continues today, as is clearly demonstrated by the following:

## I. Income Differentials Between "Procedural" and "Non-procedural" Specialties

Physicians who specialize in surgical/procedural specialties consistently earn more than physicians who derive most of their income from cognitive services. Net income data for 1978, as well as data on average work output by different specialties demonstrate that surgeons and obstetricians/gynecologists earn more than primary care physicians, even after earnings are standardized to an hourly basis.<sup>1</sup> A 1977 study similarly showed that the lowest earnings are shared by general practitioners, family practitioners, pediatricians, and **internists**—specialties that share a dependence on cognitive services.<sup>2</sup> Within the field of internal medicine, those subspecialists that require extensive use of procedural skills earn more than other internists. For example, according to a 1978 Medical *Economics* review the 1977 median income (after expenses) of cardiologists was about \$11,500 more per year than the median for other **internists**.<sup>3</sup>

## 2. Compensation for Specific Services and Procedures

The disparity in reimbursement for cognitive and procedural services can also be seen in average compensation for specific cognitive and procedural services. Physical examination of the patient and history taking, services with which almost all physicians are to some extent involved, are far less remunerative than many of the procedures of surgeons, pathologists, **radiologists**<sup>2</sup> and other procedural specialists.

For example, Medicare-Medicaid reimbursement for a relatively simple office surgical procedure may be several times higher than that for a general medical visit which includes the cognitive services of complete history and physical examination.<sup>4</sup> Yet these cognitive services form the basis of decision making and the application of **appropriate** procedures. Office visits in comparison to surgical procedures are undervalued by a factor of

between two and three, according to a 1979 study sponsored by the Health Care Financing Administration. On the basis of the time, skill, effort, training, and expense required to perform each service, the value of an initial diagnostic office visit to a specialist should be 21 percent of an inguinal hernia repair instead of the 10 percent now reflected in prevailing charges. This is more than a two-fold discrepancy between the comparative value of the office visit and the usual amount at which it is reimbursed.<sup>5</sup>

Primary care physicians are not alone with this problem. Surgical and procedural specialists also suffer from the disparity in compensation for cognitive and procedural services. Surgeons now earn 85 percent of their gross revenue for hospitalized patients from surgery, and only 12 percent from consultation.\* On this basis, it appears likely that consultation—a cognitive service—is being undervalued in relation to the performance of a surgical procedure. Indeed, preoperative evaluation and postoperative evaluation historically have not been separately identifiable services, and generally have been considered of relatively small financial value when considered part of the total service. Similarly, pathologists receive relatively less reimbursement for surgical (anatomical) pathology where critical decision-making is essential than for clinical laboratory procedures that involve fewer cognitive skills.

One of the reasons that cognitive services often are not adequately reimbursed is the lack of descriptors in most insurance plans for "health counseling," "preventive services," and other cognitive services. Furthermore, even though Current Procedural Terminology (CPT) allows separate coding for different "levels of care," a technique that would permit primary care physicians to achieve appropriate payment for cognitive services, CPT still is not accepted by many insurers. Universal acceptance of CPT and proper use of the "levels of care" concept is clearly needed if cognitive services are to be **adequately** reimbursed. However, acceptance of CPT by insurers will not in itself solve the problem.

## Benefits Of Reducing the Reimbursement Disparity

Although the inequity in compensation for cognitive and procedural services has been condoned, in varying degrees, by both insurers and physicians, ASIM believes that the time has come for a critical evaluation of whether or not this reimbursement disparity is in the best interest of patients. *A reduction in the disparity between reimbursement for cognitive and procedural services may help alleviate some of the major problems facing medicine, such as the high cost of health care, the maldistribution of physicians by specialty, and the growing perception that medical care has become "too impersonal."*

### 1. Costs of Health Care

It is generally recognized that one of the reasons for the high costs of health care has been the trend toward increased physician utilization of expensive tests, procedures, ancillary services, and hospital services. Although little is known about the effects of financial incentives on the ordering of tests and procedures, the use of these procedures may be increased because of the financial incentives that favor procedural over cognitive services. A recent paper suggests that the financial reward given technological services, as opposed to cognitive services, may be a factor in "over-utilization" of expensive procedural care.<sup>6</sup> The National Council on Health Planning and Resource Development, in its 1980 report "Productivity and Health," has advocated, as one means of increasing health-care productivity, that the disparity between payment for technology-intensive, ancillary procedures and payment for consultative

services be reduced.<sup>7</sup>

We expect that this would result in an *increase in the appropriate use of cognitive services with a potential decrease in procedural services*. Although it is not possible to project accurately that total health care expenditures **would be reduced** by this shift, there does seem to be a reasonable likelihood that a moderating effect on costs would result from encouraging and rewarding the application of thought rather than techniques.

### 2. Specialty Mix of Physicians

Even if a reduction in the reimbursement disparity for these services does not have a direct effect on the quantity of **procedures** ordered by individual physicians, there is little question that it will help bring about a more appropriate mix of primary care physicians and procedure-oriented specialties-which in itself would have a beneficial effect on costs, since procedure-oriented specialists utilize more expensive procedure: than primary care physicians. A physician's choice of specialty cannot be explained by differences in expected lifetime **earnings** among specialties alone. However, one recent report concluded that the economic incentives that favor **specialized** over primary care practice tend to induce physicians to enter the more **procedural** oriented specialties.\* An earlier study similarly concluded that high fees for some procedures common to a given specialty tend to encourage an over-supply of such specialties.<sup>2</sup> The reduction of the disparity in reimbursement for cognitive and procedural skills should *encourage more physicians to enter cost-effective primary care specialties, such as internal medicine, family practice and pediatrics, and fewer physicians to opt for the cost-generating procedural specialties.*

### 3. Physician-Patient Relationship

As specialized training in technical procedures has become more **financially valuable** in comparison to cognitive skills, there has been growing concern that the traditional caring, personal aspects of health care are not receiving the emphasis they deserve. Physicians are asked to spend more time and effort on preventive health counseling, patient education, and direct communication with patients, yet all of these activities-despite their importance for both patient health and the maintenance of a constructive physician-patient relationship-are grossly undercompensated. Indeed, the physician who spends a significant amount of time counseling a patient on the hazards of smoking or other destructive health habits is likely to find that his patient will not be reimbursed for this service.

Since inadequate reimbursement for cognitive services may act as an economic barrier to the provision of personal, caring services, it can have detrimental effects on the doctor-patient relationship. A recent paper has suggested that the current reimbursement disparity has led to an "adversarial" relationship between physicians and patients that is reflected in the numbers of malpractice actions initiated against physicians.<sup>1</sup> To the extent that better reimbursement for cognitive services improves the relationship between physicians and their patients, a moderating effect on the number of malpractice suits filed, and the cost of malpractice premiums, can be expected to result.

A restructuring of patient reimbursement methods to allow adequate compensation for important cognitive services, such as counseling and preventive education, would promote the kind of caring, personalized approach to health care desired by most patients and physicians alike.

### Conclusion

ASIM recognizes that reducing the disparity in compensation for cognitive and procedural services will not be easy. History and tradition favor the continued existence of this inequity. The difficulty in quantifying cognitive services and the natural resistance to change also creates obstacles to reform.

However, ASIM believes that all of these obstacles can

be overcome if physicians and third party payors are committed to solving the problem. If we are to bring about a health care system that is more cost-effective, more caring, and more oriented towards "thinking," rather than just "doing," a reduction in the disparity in patient reimbursement for cognitive and procedural services is an important and essential step in achieving this goal.

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