Identifying and Correcting Mis-Valued Services Paid Under the Medicare Physician Fee Schedule

Congress requires that the Centers for Medicare and Medicaid Services (CMS) use the Resource-Based Relative Value Scale (RBRVS) to determine Medicare fee-for-service payments to physicians. The RBRVS measures the resource costs required to provide each physician service, ranking each service relative to all other services. These resource costs are expressed in the form of relative value units (RVUs). The total relative value assigned to each service is divided into three components:

- Physician work—consists of factors recognizing the time it takes to perform the service, the technical skill and physical effort, the mental effort and judgment, and the potential risk to the patient. On average, physician work accounts for slightly over 50 percent of the total RVU of a service.
- Practice expense—consists of factors recognizing the direct costs, such as for equipment, supplies, and administrative and clinical staff, and the indirect costs, such as office rent and utilities that the physician incurs in providing the service. On average, practice expense accounts for just over 45 percent of the total RVU of a service.
- Professional liability insurance—reflects the cost of professional liability insurance associated with performing the service. On average, professional liability insurance accounts for roughly 5 percent of the total RVU of a service.

Medicare adjusts the RVUs for each of the three components to reflect cost differences by geographic area, known as Geographic Practice Cost Indices (GPCI). It converts the geographically adjusted total RVU for each service into a payment amount by multiplying it by a dollar multiplier, called a conversion factor.

The Medicare payment formula is:

> Payment Amount = [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (PLI RVU × PLI GPCI)] × Conversion Factor

The great majority of non-Medicare payers, including private health plans, use the RBRVS as the basis for determining payments.

How does CMS maintain the values it assigns to physician services on an on-going basis?

CMS maintains the RBRVS through annual and periodic updates to RVUs assigned to each service and changes to the underlying methodology. The annual changes are limited to CMS value assignments to services for which a new procedure code is established (or an existing procedure code is significantly altered). Generally, all services for which a procedure code already exists are considered to be appropriately valued. The former periodic review, which took place every five years and was known as the "Five-Year Review," provided an opportunity to re-assess the accuracy of the values assigned to existing services. In 2012, CMS replaced the "Five Year Review" with more frequent, year-round reviews. CMS relies to a large extent on recommendations from the American Medical Association/Specialty Society Relative Value System Update Committee (RUC), which is comprised of representatives appointed by major physician specialty organizations and supported by an advisory group representing a broader group of specialties. While CMS makes the final decision on the relative value assigned to each service, in recent years the agency has accepted approximately 88 percent of the recommendations it has received from the RUC since Medicare began using the RBRVS as the basis for physician payments in 1992.

What does the health care reform law do to promote more accurate assignment of relative values assigned to physician services paid under the Medicare fee schedule?

The Patient Protection and Affordable Care Act (ACA) contains a provision that promotes identification and correction of mis-valued physician fee schedule services. Congress included the provision on the belief that too little attention is devoted to monitoring whether services have become overvalued. The provision contains two main parts: providing direction to the Secretary of the Department of Health and Human Services (HHS), largely carried out through CMS, for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services. Details regarding the two main parts are below.

Identifying and Correcting Potentially Mis-valued Services

The Secretary shall periodically identify services as being potentially mis-valued using the following criteria:

- Codes (and families of codes as appropriate) for which there has been the fastest growth.
- Codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses.
- Codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes.
- Multiple codes that are frequently billed in conjunction with furnishing a single service.
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
- Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes).
- Such other codes determined to be appropriate by the Secretary of HHS.

The Secretary of HHS shall review the relative values for services identified as being potentially mis-valued using the above criteria and make appropriate adjustments.

To execute the requirement to review relative values and make appropriate adjustment, the Secretary of HHS may use:

- Existing processes to receive recommendations on the review and appropriate adjustment of potentially mis-valued services.
- Conduct surveys, other data collection activities, studies, or other analyses as the Secretary of HHS determines to be appropriate to facilitate the review and appropriate adjustment.
- Use analytic contractors to: identify and analyze potentially mis-valued services; conduct surveys or collect data; and relative value adjustment recommendations.
- Make appropriate coding revisions, which can be done using existing processes, e.g. the Current Procedural Terminology (CPT) code maintenance process that may include consolidation of individual services into bundled codes (that would then receive bundled payment). The language in the law notes that this approach may be especially relevant to codes with low relative value units.

The Secretary of HHS shall make adjustments to relative values in a budget neutral manner, which means that any reductions in payments for any services found to be mis-valued must go into payments for all other services.

The Secretary of HHS may coordinate the required review/appropriate adjustment with the periodic review.

Validating Relative Value Units

Under the law, the Secretary of HHS shall establish a process to validate relative value units for physician fee schedule services. This validation process:

- May include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.
- Shall include a sampling of codes for services that are identified using the above criteria listed under the "Potentially Mis-valued Codes" heading.
- May use methods described above as options for executing the requirement that the Secretary of HHS review and adjust relative values of potentially mis-valued codes, i.e.: using existing processes, including RUC and CPT; conducting surveys; collecting/analyzing data; and using analytic contractors.
- Shall include appropriate adjustments that are made in a budget neutral manner.

When does the provision take effect? Does CMS have to take action?

The provision became effective on the date that the ACA became law, March 23, 2010. It requires that CMS assess the accuracy of the RVU assigned to essentially all services on an on-going basis (while the provision identifies certain categories of service, e.g. fastest growing, for worthy of focus, CMS has complete discretion as the last category is "such other codes as determined appropriate by the Secretary"). It requires CMS to correct any service determined to be mis-valued. While determining which services are overvalued—and determining the correct value for those that are overvalued—may take time, the provision signifies the congressional intent that CMS act diligently.

Why is this provision important?

Ensuring that physician service value assignments are accurate is important as the RBRVS drives approximately $100 billion in annual Medicare payments for physician services and substantial amount in payments made by other payers. Recent reports from the Medicare Payment Advisory Commission (MedPAC), a non-partisan research arm of the Congress, and the Center for Studying Health System Change, a well-respected think tank, have highlighted the adverse effect of improperly valued services, or mis-valued services, on our health care system. Mis-valued services distort incentives and may result in the overuse or underuse of specific services on the basis of financial, as opposed to clinical, reasons. Inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. These effects are magnified because of the "budget neutral" system by which Medicare pays for physician services. Congress requires that aggregate Medicare expenditures for payments for physician services remain relatively constant from one year to the next. As a result, when payment for a physician service increases, payment for all other services decreases to account for the increased expenditures from paying the single physician service for which the relative value has risen.

Although there is significant interest in moving away from a system that pays for discrete physician services in an overarching system that provides incentives to increase volume, refining the RBRVS remains crucial until new payment models are designed and implemented on a widespread basis. Innovative payment models are likely to be tested, and even models that dramatically change incentives may still, at least in part, be based on current fee-for-service payment rates that are built by RVUs. In addition, Medicare can make payment policy changes within the context of the RBRVS to facilitate a transition to models of care that focus more explicitly on improving care coordination.