

# REPORT TO THE BOARD OF TRUSTEES

BoT Report - A-99

Subject: Refinement of the Resource-Based Practice Expense Relative Values

Presented by: Randolph D. Smoak, Jr., MD, Chair

---

## 1 BACKGROUND

2  
3 At the 1998 Annual Meeting, the House of Delegates adopted the recommendations in Board of  
4 Trustees Report 7, which called for the American Medical Association (AMA) to continue to  
5 vigorously monitor the development and refinement of the new practice expense values and work  
6 with the Health Care Financing Administration (HCFA) and the specialty societies to address  
7 methodological problems as they arise. The report also reaffirmed Policy H-400.969 (AMA Policy  
8 Compendium) supporting the value of the AMA/Specialty Society RVS Update Committee (RUC)  
9 process for the medical profession. In addition, the House of Delegates was informed by Board of  
10 Trustees Report 44, A-98 of the June 1998 proposed rule on practice expense relative values. The  
11 RUC has established a process to submit recommendations to HCFA to refine and update the  
12 resource-based practice expense relative values that were implemented on January 1, 1999. This  
13 report is submitted for the information of the House of Delegates.

## 14 HCFA'S "TOP-DOWN" METHODOLOGY AND NEEDS FOR REFINEMENT

15  
16  
17 In the Final Rule on the Medicare Physician Payment Schedule, published in the Federal Register  
18 on November 2, 1999, HCFA outlined its plans to implement resource-based practice expense  
19 relative values consistent with the Proposed Rule described in Board of Trustees Report 44, A-98.  
20 This new "top-down" methodology minimized the impacts on individual specialties and services  
21 relative to the "bottom-up" methodology that had originally been proposed. As was the case with  
22 the initial Resource-Based Relative Value Scale (RBRVS) work values released in the early 1990s,  
23 there remain many anomalies in the practice expense relative values that need to be corrected. In  
24 addition, this new methodology also incorporates three sets of data, each which needs refinement to  
25 be appropriately used in this application.

26  
27 First, the AMA's Socioeconomic Monitoring Survey (SMS) data were used to establish a practice  
28 expense per hour of physician hours worked to begin the process of allocation. The AMA has  
29 repeatedly stated that these data were never collected for this purpose. One shortcoming of  
30 HCFA's use of these data is that some specialties with relatively small numbers of practicing  
31 physicians do not have adequate sample sizes to support separate calculation of their expenses per  
32 hour. In addition, corresponding data for non-physician providers were not available because the  
33 SMS surveys only physicians. HCFA has instead cross-walked these specialties and professions to  
34 other specialties included in the SMS sample. Next, physician time data collected for the purposes  
35 of establishing physician work relative values, along with Medicare frequency data, were used to  
36 create pools of practice expense per specialty. Finally, direct practice expense inputs (i.e., clinical  
37 labor, supplies, and equipment) were used, along with physician work relative values, to allocate  
38 the specialty practice expense pools down to the CPT code level. These direct practice expense  
39 inputs, most commonly known as the Clinical Practice Expert Panel (CPEP) data, were highly  
40 criticized when used as the key data element in the previous "bottom-up" methodology. National

1 medical specialty societies submitted comments to HCFA indicating that these data need review for  
2 more than 3,000 CPT codes. The RUC has developed a plan to review and provide  
3 recommendations to HCFA on each of these data sets.

4  
5 Practice Expense Per Hour Data

6  
7 HCFA used the AMA's SMS data on practice expenses and number of physician hours worked as  
8 they were the best data available. (In addition, some have commented that data at the practice level  
9 rather than the individual physician would be desirable for the measurement of practice expenses.)  
10 Specialties that had a smaller number of respondents and non-physician healthcare professionals  
11 not included in the SMS have called on HCFA to either accept external data or to allow for a new  
12 data collection effort. Discussions with HCFA's staff have indicated HCFA is not interested in  
13 individual specialty society surveys, but would prefer one standardized survey with identical data  
14 collection efforts and timing. The AMA will continue to discuss with HCFA the issue of  
15 expanding the SMS sample.

16  
17 In addition, the AMA has begun the development of a new survey that will be administered to  
18 physician practices rather than individual physicians. The AMA will pilot the practice level survey  
19 in 1999 and implement it in 2000 for use every other year; the current SMS survey will be  
20 conducted in odd numbered years. Mathematica Policy Research has been contracted to develop  
21 the new practice level survey. A wide range of committees and staff within the AMA and experts  
22 outside the AMA are being consulted in the development of this survey. AMA staff will share the  
23 draft survey with the RUC in order to seek its input on the practice expense questions. In addition,  
24 to help ensure the accuracy and feasibility of the survey, Mathematica may conduct qualitative  
25 interviews with physicians and staff in their practices. The RUC members have volunteered to  
26 participate in these interviews.

27  
28 Physician Time Data

29  
30 HCFA used multiple sources to collect its physician time data, including the original Harvard  
31 RBRVS studies, RUC surveys, and other HCFA estimates. A number of manipulations were  
32 performed to these data and many have expressed concern over the validity of this important  
33 element of the entire "top down" methodology. HCFA has expressed a desire to expand its use of  
34 these data by allocating indirect expense to CPT codes using physician time. The RUC is very  
35 interested in refining these data over the next year.

36  
37 One manipulation that HCFA conducted was to scale Harvard data to RUC data by increasing the  
38 Harvard data, on average, by 25%. HCFA's rationale for this adjustment was a comparison of  
39 Harvard and RUC time data for identical codes. HCFA conclude that since the RUC time  
40 estimates increased on average by 25% for these codes, that all codes not yet reviewed by the RUC  
41 should also be increased by 25%. It may be possible that physicians have become more  
42 sophisticated in completing questionnaires on time since the initial Harvard studies. For example,  
43 the instructions for estimating pre-, intra-, and post-service time in the Harvard surveys were not  
44 detailed. On the other hand, this increase in time could be due to the fact that the codes surveyed  
45 by both Harvard and the RUC were included in the five-year review. It is possible that, for these  
46 services, there was an actual change in time required to perform the services. The RUC will  
47 attempt to validate these scaling factors by comparing RUC time data collected on specialty  
48 reference services over the past few years to Harvard data for the same code.

1 In addition to refining time data for existing codes, the RUC will review the time data provided for  
2 new and revised codes to determine if the data appear valid. Finally, for the small number of codes  
3 specifically identified for refinement of time data, specialty societies will bring these issues to the  
4 RUC for review.

5

6 Direct Practice Expense Data

7

8 The RUC has implemented a Practice Expense Advisory Committee (PEAC) to review the direct  
9 expense inputs (i.e., clinical time, supplies, and equipment) for individual CPT codes. Most  
10 observers would agree that the CPEP process was ineffective in collecting accurate direct expense  
11 data. With thousands of CPT codes needing review, this new committee faces a daunting task. Its  
12 initial organizational and methodological efforts will be designed to facilitate this process.

13

14 The PEAC mirrors the RUC in composition with additional experience added for nursing and  
15 practice management. Eugene Ogrod, MD is Chair of the PEAC and Ann Cea, MD is the  
16 representative for the AMA. Doctor Cea will also serve as Vice-Chair. The PEAC is comprised of  
17 the following organizations:

18

- 19 Chair (Appointed by Chair of the RUC)
- 20 American Medical Association
- 21 CPT Editorial Panel
- 22 Health Care Professionals Advisory Committee
- 23 American Academy of Dermatology
- 24 American Academy of Family Physicians
- 25 American Academy of Neurology
- 26 American Academy of Ophthalmology
- 27 American Academy of Orthopaedic Surgeons
- 28 American Academy of Pediatrics
- 29 American Academy of Physician Assistants
- 30 American Academy of Otolaryngology - Head and Neck Surgery
- 31 American Association of Neurological Surgeons
- 32 American College of Cardiology
- 33 American College of Emergency Physicians
- 34 American College of Obstetricians and Gynecologists
- 35 American College of Physicians/American Society of Internal Medicine
- 36 American College of Radiology
- 37 American College of Rheumatology (Internal Medicine Rotating Seat)
- 38 American College of Surgeons
- 39 American Nurses Association
- 40 American Osteopathic Association
- 41 American Psychiatric Association
- 42 American Society of Anesthesiologists
- 43 American Society of Cytopathology (Other Rotating Seat)
- 44 American Society of Plastic and Reconstructive Surgeons
- 45 American Urological Association
- 46 College of American Pathologists
- 47 Medical Group Management Association
- 48 Society of Thoracic Surgeons
- 49 To be Elected (Internal Medicine Rotating Seat)

1 At the time this report was written, plans are underway to convene a meeting of the PEAC on April  
2 15-18, 1999 to review the highest priority codes. These recommendations will be submitted to  
3 HCFA in May and, if accepted, will be implemented into the 2000 Medicare Physician Payment  
4 Schedule.

5

6 RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUES FOR NEW AND REVISED  
7 CODES

8

9 In addition to refinement of existing codes, direct expense inputs will be required for all new CPT  
10 codes from this point forward. The RUC will review these data when presented with work relative  
11 value recommendations for new and revised CPT codes. The RUC is currently developing a  
12 practice expense survey to collect this information simultaneously with the survey for work relative  
13 values and physician time.

14

15 CONCLUSION

16

17 The RUC has made significant progress in both its plans to play a major role in the refining and  
18 updating the newly implemented resource-based relative value recommendations. Over the course  
19 of the next year, the RUC will work to improve the process that it has just initiated. The AMA  
20 Board of Trustees will continue to update the House of Delegates on the RUC's activities.