AHS's Headache Coding Corner

- **A user-friendly guide to CPT and ICD coding**

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Part 5 - CPT Coding and Resource Based Value System (RBRVS): A Review of Reimbursement and Politics

The earlier submissions to the American Headache Society Coding Corner have been focused upon appropriate documentation for Evaluation and Management Services (E&M). The emphasis has been on recognizing that Headache Medicine specialists, for the most part, do a level four or five New Patient Evaluation or Consultation and should be using CPT codes 99214 or 99215 for many of their Established Patient evaluations. By understanding the Documentation Guidelines for the Key Components of E&M (History, Examination, and Medical Decision Making), the written report should pass the scrutiny of a medical audit. The knowledge of proper utilization of the Contributory Components (Nature of the Presenting Problem, Counseling and Coordination of Care and Time) of E&M coding offers another dimension of reimbursement for services which do not necessarily include an extended or comprehensive history and physical examination. The fact that physicians are asked to quantify data using qualitative descriptors for proper E&M documentation makes CPT coding a conceptual challenge. The guidelines for E&M documentation, especially Medical Decision Making, leave so much unstated that it is difficult to tell what documentation may support an E&M claim. The different methodologies to determine the level of CPT coding and different MDM scoring systems have been reviewed in the earlier parts (1 through 3) of the AHS Coding Corner. Part 4 focused on Consultation and Coordination of Care and Time as a determining factor for CPT coding. However, despite efforts for proper documentation of services, there are still other medical economic issues which have the potential to further impact physician reimbursement. To better comprehend the current medical economic climate, an understanding of the Resource Based Relative Value System (RBRVS), which was adopted by Medicare in 1991 and copied by many private insurers is important. This current submission to the AHS Coding Corner will focus on the role the RBRVS plays in determining the monetary value of each CPT code.

Reimbursement policies in Headache Medicine and other "cognitive" specialties are, as indicated above, based upon patient evaluation and management services. In 1989 the U.S. Congress authorized the Omnibus Budged Reconciliation Act which introduced a different Medicare physician payment schedule based on what was called the Resource Based Relative Value System. In 1991, the U.S. Health Care Financing Administration announced its proposed Medicare fee schedule for physician services based upon RBRVS. The RBRVS represented a fundamental departure from Medicare's previous method of payment. This new Medicare reimbursement system was implemented by the Federal Government on January 1992. A controversial feature of the new fee schedule was its proposed monetary conversion factor which translates relative value units into dollars to establish fees. This method of payment was designed to reduce the inequality between fees for office visits and payment for procedures. The intent was to achieve identical payment for identical services across all specialties and achieve uniformity in Medicare payments. The RBRVS was, to a large extent, copied by private insurers and remains the method for determining physician compensation for services provided.

The RBRVS was developed to produce four main outcomes:

1. Uniform policies nationwide
2. A national fee schedule

3. New CPT codes (particularly Evaluation and Management or E/M codes)
4. Establish relative values on the basis of the resources used by physicians to perform a particular service (physician work and practice expense. Malpractice expense was added latter)

Whereas the intent was to reduce the inequality between fees for cognitive services and payment for procedures, there was and remains much discussion as well as published information which challenges the actuality that this goal was not achieved. Controversies continue surrounding the following issues: 1) the conversion factor used to translate resource based relative value units into fees is different for private carriers versus Medicare, 2) there are differences in allocation of practice expenses across services, 3) the volume of diagnostic and imaging procedures has increased far more rapidly than the volume of office visits, which benefits specialists who perform those procedures, 4) the requirements of complying with E&M documentation is much more complex and difficult than coding for a procedure, 5) there is no consistency in the ability of the current complicated reimbursement system to capture differences in work between procedure orientated specialties and physicians in cognitive specialties. Since Headache Medicine is, to a large extent, a cognitive specialty, let us review the Resource Based Relative Value System of reimbursement in more detail.

RBRVS attaches a relative monetary value to each CPT code. Every medical service represented by a CPT code has three components called Relative Value Units (RVU). The RVU's are numeric values that have been developed to represent the relative amount of physician time, resources and expertise needed to provide a medical service for any given patient. The components of RVU are:

1. Physician's Work: This is the physician's time, skill, mental effort, risk and psychological stress of an adverse outcome. The physician's work takes into account the physician's expertise and time spent in preparation and follow-up documentation of each service performed. The physician's work accounts for 52% of the total relative value for a service.
2. Practice Expense: This is the cost to operate a medical practice. Practice Expense includes the staff salaries, the rent, office supplies and office equipment. The physician's practice expense accounts for 44% of the total relative value for a service.
3. Medical Liability Insurance: The professional liability insurance expense is also an estimate of the relative risk of services. The malpractice costs are based on time and specialty specific national averages. This accounts for 4% of the total value for a service.

A Geographical Practice Cost Index (GPCI) adjusts the RVU for regional differences. The GPCI is therefore based on practice location. The components of the GPCI include the disparity in the cost of living, the disparity in rent and wages and the disparity in malpractice premiums. Using the three components of RVU (RVU work + RVU practice expense + RVU liability), one can calculate the total adjusted RVU as follows: Total adjusted RVU = RVUw x GPCIw = RVUpe x GPCIpe + RVUmp + GPCImp.

As indicated above, under RBRVS the reimbursement for any given CPT code is based on the RVU's assigned to the CPT code multiplied by what is defined as a Conversion Factor. The Conversion Factor is what translates the RVU's into a dollar amount or actual payment for the service provided. Therefore, the calculation for physician reimbursement for any CPT code assigned to a service provided is: Payment = RVU x Conversion Factor. The Medicare

Conversion Factor for all CPT codes in 2007 was $37.89. That means that Medicare would pay $37. 89 for a code worth 1 RVU or $75.78 for a code worth 2 RVU's, etc. etc... Therefore, under the RBRVS system, the 2007 Medicare fee for the CPT code 99214 (a 25 to 30 minute office visit for a headache patient established visit) in Dallas was approximately $90.09. The Conversion Factor, however, is a multiple of four components which all affect reimbursement. The four components are:

1. Estimated Medical Economic Index
2. Estimated Updated Adjustment Factor which is tied to the Sustainable Growth Rate (SGR)
3. Legislation change
4. Budget Neutrality: Any increase (>$20 million) must be accompanied by an equivalent reduction

The total amount of money that Medicare pays physicians each year is based upon the second component listed above, the Sustainable Growth Rate or SGR. In addition, any discussion of reimbursement for Evaluation and Management (E&M) CPT Codes is directly linked to the SGR formula. The Sustainable Growth Rate is determined by different components and calculations. Based on the SGR, the total amount that Medicare pays physicians each year is limited by a formula built around medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in the fee for service Medicare pool, and changes in law or regulation. Decreases in the Conversion Factor, and subsequent decrease in physician reimbursement may occur if total expenses exceed an SGR defined target because of such events as service volume increases. In the simplest terms, the SGR is an expenditure target. For example, it the volume of Medicare physician services goes up faster than the SGR, then the Conversion Factor is reduced the following year. This obviously affects physician reimbursement for services rendered. Therefore, physician payment under SGR is like a pie: If one specialty receives a larger slice of the pie, others must accept smaller portions.

The fact that legislation change can affect the Conversion Factor and subsequent reimbursements is evident at the time of submission of this review. In 2008 Medicare physician payment rates were scheduled to be cut by 10.1%. There was legislation to reduce Medicare payments even more with the goal to cut payments over 30% between 2008 and 2015. On 18 Dec 07, the Senate passed the Medicare, Medicaid and SCHIP Extension ACT of 2007 (S.2499) that would replace the 10.1% reduction in Medicare Part B payments in 2008 with a 0.5% increase for six months. That means that physicians will face a payment reduction in Part B payments in July 2008 unless Congress once again intervenes. If the intended cut in reimbursements had occurred, the Conversion Factor would have been lowered to $34.06 from the $37.89 rate. To exemplify how a 10.1% decrease in reimbursements would affect physicians treating headache patients, the following compares the rate of reimbursements for the most commonly used E&M codes in 2007 versus 2008. The first three CPT codes are a New Patient Evaluation, the next three CPT codes are for the Established Patient Evaluation and the last three CPT codes are the New Patient Consultation.

CPT	RUV	2007 ($37.89)	2008 ($34.06)
99203	2.55	$99.91	$81.42
99204	3.91	$139.79	$128.85
99205	4.93	$175.40	$155.75
99213	1.67	$59.40	$53.15
99214	2.53	$90.09	$80.42
99215	3.43	$121.98	$108.72

99243	3.43	$122.44	$109.21
99244	5.06	$179.49	$160.10
99245	6.25	$222.87	$231.66

Although we have been talking primarily about Medicare reimbursements, it is important to emphasize that private insurers usually follow the Medicare lead. Since Medicare represents a smaller fraction of the total patient population in most Headache Medicine practices, it is critical to understand the relationship between the Medicare RBRVS and CPT reimbursements as they apply to third party payers. Compared to the complexities of Medicare's physician payment system, the situation for private insurance contracts is often even more problematic. Although most private insurers use a fee schedule modeled on RBRVS, many insurance carriers offer specialty specific contracts. In addition, private insurers also usually use different Conversion Factors than Medicare.

When one looks at the various contracts from different private insurance plans, it is not unusual for private insurers to pay about 104% of Medicare fees for office visits and up to about 135% for procedures and imaging studies. These values are obviously estimates and vary according to location and the time the contract was initiated. However, whatever the actual numbers, the fact that private insurers have adopted the Medicare RBRVS principal but have different payment systems and use different Conversion Factors defeats the initial purpose for developing RBRVS. Obviously, the goal to achieve identical payment for identical services across all specialties and achieve uniformity in physician reimbursement has not been achieved. In addition, remember that the Medicare Conversion Factor **for all CPT codes** is one value; currently $37.89 per RVU. In addition, most physicians whose primary practice is based on direct patient care using E&M CPT codes (as is often the case in Headache Medicine), often find that private insurers pay significantly more than Medicare for procedures versus an office visit. This creates an income disparity between cognitive physicians who bill with E&M codes versus physicians involved in procedural specialties.

This brings us back to some of the issues regarding the formula used for determining the value of the Conversion Factor used by both Medicare and private insurers. If for no other reason other than to emphasize the ongoing discussions concerning reimbursements, at this point it seems appropriate to introduce some of our readers to the current debate taking place regarding replacing the Sustainable Growth Rate formula. There are a number of physicians and physician advocates who believe that the SGR formula does not keep pace with the cost of providing patient care or practice cost increases. Many physician medical associations, including the American Academy of Neurology, are currently suggesting replacing the SGR formula with a long term plan which includes redefining a funding scheme that advocates believe may be more efficient in keeping pace with the current cost of providing medical care. There is a movement to replace the SGR system with a payment mechanism based on the Medical Economic Index or MEI. The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wages. It measures input prices for resources needed to provide physician services. The MEI is designed to estimate the increase in the total cost for the average physician to operate a medical practice. This may include the physician's own time, non physician employees, compensation, rent, medical equipment and other expenses. The MEI also measures year to year changes in prices for these various inputs. Thus, as it is today, calculations for MEI may be adjusted up or down depending on how actual expenditures compare to the target rate or SGR.

The task with updating the relative values of more than 7,000 CPT codes as well as recommending values for new CPT codes is assigned to the Relative Value Scale Update

Committee or RUC. The RUC is a committee of the AMA and was created about the same time as the RBRVS was initiated. Medicare mandates that RVU's be updated every five years. The Centers for Medicare & Medicaid Services (CMS) had delegated the update process to the RUC. The RUC recommends RVU changes to the CMS, which must ultimately approve them. Therefore, each year the RUC meets to recommend RVU's for new CPT codes plus every five years, the RUC considers potential revisions to RVU's for all existing CPT codes.

Evaluation and Management services make up more than 50% of total Medicare physician payments but, in most headache practices, constitute the majority of patient care. As can be determined from the above review of RBRVS, the direct role that complex policies of reimbursement have for consultancy and the ongoing care for headache patients produce additional economic obstacles for the specialty of Headache Medicine. Understanding how to document the Key Components and Contributory Components of CPT evaluation and management coding is crucial if the headache specialist is to be properly reimbursed for services rendered. Although much of the preceding discussion is more specific for Medicare reimbursement, the headache specialist must recognize that those same principals are used when private insurers define reimbursements and offer contracts for patient care. Those same principles are employed when private insurers down code physicians because documentation does not support a specific CPT code. Physicians must recognize that large bureaucracies have evolved within the private insurer's network that greatly influences physician reimbursements. Time consuming negotiations with these bureaucracies as a patient advocate are also common encounters for physicians practicing within a cognitive medical specialty such as Headache Medicine.

As physicians, we spend increased time and expense in managing unfunded government legal mandates such as HIPAA confidentiality regulations. For many health care providers the cost of rent and the general office overhead including staff salaries continues to escalate. These increases in expenses are often associated with decreases in the compensation of physicians treating headache patients relative to cost of living increases. Decreased reimbursement from government health programs such as Medicare often serve as a template for decreased reimbursement from private insurers who, as indicated above, almost universally use Medicare prices as a framework to negotiate physician payments, generally setting payments as a percentage of the Medicare fee structure. If these expenses are further complicated by inadequate CPT documentation and improper CPT coding, and physicians are not paid properly for their services rendered, this could eventually produce physician economic burdens which could affect patient access to headache physicians. In some places this has probably already happened.

This section of the AHS Coding Corner was meant to be an introduction to a very complex program which defines the different levels of our current CPT reimbursement process. The basic principle is that we get paid for what we do by better understanding the system in which we work. In the long run, we physicians must better understand the complexities of RBRVS which produced the current CPT payment system and introduced the new Evaluation and Management CPT codes.