RBRVS: Not the Right Payment System for Medical Oncology

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In 1992, the Centers for Medicare & Medicaid Services (CMS) rolled out an innovative way of paying for physicians’ services. This system, which was developed by William Hsiao, MD, from Harvard, changed the way physicians were forever after paid by CMS and by the vast majority of their payors.
From then on, payment would be based on “resource” inputs – physician work, practice expense, and relative malpractice risk – needed to provide the services.

To compute the payment for a service, HCFA (now CMS) would multiply the relative value units (RVUs) for that service for that year by the geographic adjustment factors (GAFs) for each set of RVUs ([work RVUs x work GAFs] + [practice expense RVUs x practice expense GAFs] + [malpractice RVUs x malpractice GAFs]). These adjusted total relative values would then be multiplied by an annual conversion factor or dollar amount to arrive at regionally adjusted payment amounts for all codes paid by the fee schedule.

Seventeen years later, medical oncologists are still confounded by the fact that services performed in the office are not paid fairly in the Medicare system (if you can call it a system) or by commercial payors. Medical oncologists were much less concerned about the viability of this system when “buy and bill” drug margins were quite profitable. But once Medicare and other payors converted to an average sales price, some chemotherapy encounters have become unprofitable, and, as a result, patients are sent to the hospital for drug therapies deemed to be “underwater” (more costly to perform than the reimbursement amount). In 2010, it is currently proposed that Medicare pay providers an average of $23 per hour after the first hour of chemotherapy infusion; our experience is that this is not profitable for any U.S. medical oncology practice.

Besides rewarding drug profits, how did this system go wrong for medical oncology physicians? And what other alternatives do payors have to pay oncologists fairly to avert the hospital setting without huge increases in drug expense?

THE RBRVS PROBLEM LIST
The resource-based relative value scale (RBRVS) is a subjective exercise. The cornerstone of RBRVS is the face-to-face time that a physician spends with the patient, which supports the number of work RVUs a code is assigned. There are relative values for practice expense, but these are not based on cost reports, which is how Medicare pays hospitals for overhead. These practice overhead RVUs are based on surveys, which often are answered without quantitative data. This means that office-based surgeries, infusions, and other procedures without technical and professional components are vastly undervalued by the RBRVS payment system.

David H. Regan, MD, who practices with Northwest Cancer Specialists in Portland, Ore., represented the American Society of Clinical Oncology on the Relative Value Scale Update Committee (RUC) when the American Medical Association (AMA) reviewed the drug administration relative values. During the Congress-mandated restructuring of the drug-infusion coding system, Dr. Regan co-chaired a drug administration work group subcommittee of the RUC, which governs the valuation of work relative values.
Dr. Regan’s involvement in the RUC demonstrates the difficulty of valuing the types of service codes used in medical oncology when they involve determining physician work, as he outlines below. Even if the AMA tried to reevaluate the codes, the data that it collected from physicians was flawed to begin with.

“Considering the nature of the oncologist’s pre-, intra-, and post-treatment patient interaction during chemotherapy encounters, it’s difficult to put a number on supervisory work,” he says. “Also, while physicians may not want to take the time to participate, or they may not thoroughly understand the questions, statistical validity requires a large-enough sample and reliable answers.”

A more diabolical picture of the RUC discriminating against services where cognition is dominant is painted in the *Annals of Internal Medicine*. The authors state that “many RUC members from procedural specialties tend to vote in favor of requested increases. In summary, the RUC process favors increases in procedural and imaging reimbursement for three reasons: specialty society influence in proposing RVU increases, the specialist-heavy RUC membership, and the desire of RUC specialists to avoid increases in evaluation and management RVUs. With their ability to create new codes and influence RVU updates, many procedural specialists can influence fees in a way that can substantially overvalue procedural and imaging services.”

In simple terms, if the GDP goes up, as it did during the 1990s, the conversion factor goes up, too; if it goes down or stays about even, as it has for the past five years, the conversion factor declines and physicians experience cuts. While Congress provided a fix to the SGR for 2009, there will be a 2.1% decline in the conversion factor in 2010 without additional congressional intervention. With the changes in RVUs, many medical oncologists are looking at 23% to 24% fee schedule reductions. This payment may shift cancer care away from community providers into the hospital setting.

**PRIVATE PAYORS AND RBRVS**

Since its debut in 1992, RBRVS has been adopted by private payors as the system of choice for payment. Why not? It is a fee schedule that can be downloaded in EXCEL™ from the Internet. Here are some of the obvious problems with the widespread adoption of this system:

- **Private payors use RVUs without examining what Medicare or the RUC is doing to individual specialties.** This never bothered medical oncologists, particularly when the payment rates were high for drugs, but now it has a material

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Oncologists also believe that practice expense is undervalued. They have a good reason to perceive this. Since 2007, practice expense relative values for almost all the prevalent drug administration codes have gone down, while actual office expenses have stayed level or increased. However, practice expense relative values are calculated using survey data and formulas that are so convoluted, it is hard to prove one way or the other. However, if you look at the practice expense relative values in the Medicare fee schedule for 2008 for the second hour of chemotherapy (CPT 96415), the practice expense payment is 0.67 (or about $24). From a logical perspective, this does not appear adequate for nurse supervision, use of the chemotherapy room, intravenous supplies that are not separately paid, and so forth. This does not even consider capital costs, the administrative costs of processing claims, and the working capital needed to purchase expensive drugs and biologics.

The biggest wrinkle in Medicare payment is the update to the conversion factor known as the sustainable growth rate, or SGR (an oxymoron – it is not sustainable and rarely grows). The SGR ties the annual conversion factor to growth in the gross domestic product (GDP), the measure of the nation’s output of goods and services.
multiplier effect throughout the specialty. These are not negotiated cuts that passively cut reimbursements across the specialty regardless of payor source.

- **Some experts insist that procedural specialties are able to negotiate a different, higher conversion factor for their procedures than that paid to cognitive specialties.**
  Oncologists sometimes try to negotiate on drug reimbursement without paying as much attention to service codes. However, there is evidence from electronic remittance advice data that some payors are using a higher conversion factor for drug administration than for evaluation and management codes.

- **Some commercial payors use a multiple of the total Medicare allowable as their basis of payment for service codes.** This means that all the political ebbs and flows of the RBRVS system and congressional budget mandates are incorporated in private payment.

  Private payors want to compensate enough to maintain a community presence and prevent hospital treatment – but what to do?

**ALTERNATIVE PAYMENT METHODS**

Here are some payment methods that are being tested or implemented in the market today. We will comment on the opportunities and problems inherent in each one:

- **Supplement Medicare payment.** There are areas where payors supplement RBRVS by paying a per-day or per-hour facility fee using a miscellaneous code. This is a negotiated rate that affords medical oncologists a level of comfort that their underpayments and overhead expenses are recognized and reimbursed.

- **Pay for reporting.** As you may know, Medicare in 2009 and 2010 will pay 2% more for reporting certain quality indicators to physicians in the Physician Quality Reporting Initiative. This effort can be implemented on a claims, registry, or electronic medical record generation basis. But for oncologists, the only option is really claims-based. All my market research in this area indicates that at this point in time fewer than 50% of oncologists have participated in this effort. One reason for nonparticipation is that in 2007 the total remuneration averaged about $600 per physician. So this certainly has not been a roaring success in the community cancer care segment.

- **Pay for technology.** CMS will pay an incentive from 2009 until 2013 for physicians to e-prescribe. In 2012 and thereafter, there will be a discount from Medicare professional services for nonadopters of e-prescribing technology. In addition, CMS has given grants to ensure that e-prescribing technology is affordable. The problem is that providers have to want to adopt new technology – old habits die hard in this market. In the end, if this initiative works (and that is a big if), it will be a win-win – less iatrogenic events, more prescribing data for payors, and more efficient prescribing with better benefit investigation and patient adherence information for providers. Patient adherence to expensive oral cancer agents is a major issue for both patients and providers. E-prescribing really supports a better feedback loop to those managing care.

- **Pay for performance.** The big buzzword is P4P. In oncology, this generally means adherence to clinically relevant guidelines for chemotherapy and/or supportive care drugs. By using these pathways, costs are more predictable, and proven regimens assure a certain amount of patient safety. The problem with this approach is that it is not elegantly simple. Most chemotherapy regimens are based on the stage of cancer and/or whether the patient has failed other regimens. This information cannot be transmitted on a claim as neither the ICD-9-CM or the future ICD-10-CM diagnosis system conveys it. So the information must be faxed in or telephoned to someone and verified. Also, the perceived reduction in cost, which has never been conclusively proven, would stagnate after a few years if everyone goes on the same set of guidelines.

- **Case rates.** This idea has been used for radiation therapy. Based on the Medicare Diagnosis-Related Group (DRG) concept, the payor would pay one contracted rate for a single diagnosis throughout 90 to 120 days
of care. Again, this payment system has to be manually transmitted by fax or telephone as the costs for different stages and cell types of cancers vary widely. Case rates would also vary as to whether the patient was operated on or not, whether care was curative or palliative, and the types of involved providers (medical oncology, radiation, surgery, and so forth). This system might work after years of experience perfects a system that works well for all major cancers. But DRGs to date still do not have the flexibility to accommodate new technologies. This could be quite problematic in cancer.

- **Pay for savings.** Plans can look at their total spend for medical oncology in terms of the specialty number and/or groups of codes billed. If that number is reduced through the use of approved regimens, the payor and the providers share the savings. There must be approved protocols so that quality of care does not suffer. This is an elegant solution in terms of simplicity, but it is definitely risky in terms of patient quality of care and is yet unproven.

In summary, there is no perfect payment system for office-based medical oncology. But with the demise of profitability from "buy and bill" coupled with RBRVS, it is my belief that community oncology will not survive without more innovative payment systems. Right now, my consulting practice is seeing many physician cancer clinics in the death spiral. This means practices cannot bring enough money in to pay their drug bills, and yet, if they do not bill drugs, they cannot pay their drug debts or meet their overhead. It is a dire situation.

If they want to do away with "buy and bill" profitability, payors need to think proactively as to the best payment system to maintain community cancer care. Otherwise, the only financially viable alternative may be the hospital outpatient department.

**References**

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