Overview of a Resource-based Relative Value Scale Fee Schedule for Physician and Other Practitioner Services
Today’s Presentation

• Provide a general overview of the RB-RVS and how Medicare payment is determined

• Provide an overview of the SB 863 provisions
Medicare’s RB-RVS Fee Schedule Has Three Basic Elements

1. Relative value units (RVUs) for each medical service compare the resources required for one service to those required for other services based on:

2. The conversion factor (CF) converts the RVUs into a Medicare payment amount for the procedure.
   - Determines overall fee schedule payment levels.
   - Medicare program uses a single CF for all services except anesthesia.

3. The geographic adjustment factor (GAF) accounts for geographic differences in the costs of maintaining a physician practice.
   - Separate geographic practice cost indices (GPCIs) apply to the RVUs for the three components constituting the service
   - There are nine payment areas (localities) in California.
**RVUs Reflect the Resources Required for a Typical Patient**

- **Work RVUs** reflect the time and intensity of the physician’s effort
  - Take into account pre- and post-procedure time as well as intra-service work
  - Derived through multiple methodologies, but mainly estimates from surveys of practicing physicians

- **Practice expense RVUs** reflect the cost of maintaining an office (clinical and office staff, rent, office supplies and equipment)
  - Separate RVUs for facility-setting vs. non-facility settings
  - Recognizes that some facility costs are covered by the separate facility payment

- **Malpractice RVUs** are based on the insurance premiums of specialties performing the services
Determining the Medicare payment amount involves several steps:

\[
\text{CF} \times \left( \text{RVU}_{\text{work}} + \text{RVU}_{\text{practice expense facility or non-facility}} + \text{RVU}_{\text{malpractice}} \right) \times \left( \text{GPCI}_{\text{work}} + \text{GPCI}_{\text{practice expense}} + \text{GPCI}_{\text{malpractice}} \right)
\]

Unadjusted rate $\times$ policy adjustments = payment

- Modifiers
- Multiple procedure discounting
- Limited license practitioners
- Global fees for surgical procedures
- Health professional shortage area bonus
CMS Adopts Changes in the RB-RVS through an Annual Rulemaking Process

• AMA’s CPT Editorial Panel maintains the CPT coding system used to describe physician services
  – Changes in CPT necessitate annual updates to the RB-RVS for new and revised codes
• AMA’s Relative Value Update Committee (RUC) is a multi-specialty expert panel that makes recommendations to CMS regarding RVUs for work and practice expenses
  – Annual updates for new or revised CPT codes
  – Rolling review of potentially mis-valued services
• CMS reviews RUC recommendations and sets final RVUs
  – Clinical review of time and intensity of each service
  – Proposed rule for public comment around July 1 of each year
  – Multi-specialty refinement panel reviews public comments
  – Final decisions published in a final rule around November 1
SB 863 Requires the AD to Implement and Periodically Revise a RB-RVS Fee Schedule

• Annual updates to reflect changes in procedure codes, relative weights, and inflation

• Maximum reasonable fees in the aggregate not exceed 120 percent of amounts payable by Medicare in 2012 updated for inflation
  – Services not covered by Medicare included at the fee schedule amounts established by the AD

• Four year transition between current OMFS allowances and the RB-RVS allowances

• Ground rules shall differ from Medicare rules as appropriate

• LC § 4600 continues to determine issues of medical necessity, frequency and duration of medical treatment
Default Option Is Effective January 1, 2014 If the AD Has Not Adopted a RB-RVS

- Conversion factors specified for 4-year transition from:
  - Aggregate expenditure levels based on current OMFS to 120 percent of Medicare rates
  - Separate conversion factors for surgery, radiology and all other services to a single conversion factor with anesthesia continuing to have a separate conversion factor

- Medicare ground rules apply
  - Exception: a statewide GAF of 1.078 shall applies in lieu of locality-specific factors
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Current: 100% OMFS</th>
<th>2014: 75/25 Blend</th>
<th>2015: 50/50 Blend</th>
<th>2016: 25/75 Blend</th>
<th>2017: 120% Medicare</th>
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<tbody>
<tr>
<td>Surgery</td>
<td>$52.43</td>
<td>$49.53</td>
<td>$46.63</td>
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<td>Radiology</td>
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<td>51.10</td>
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<td>Anesthesia</td>
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<td>30.06</td>
<td>28.61</td>
<td>27.15</td>
<td>25.69</td>
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<tr>
<td>Other Services</td>
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<td>37.17</td>
<td>38.40</td>
<td>39.62</td>
<td>40.85</td>
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</tbody>
</table>

- Based on overall allowances rather than service-specific allowances
- 100% OMFS is Lewin-estimated “budget neutral” CF prior to GAF
- 120% Medicare is based on July 2012 conversion factor
- Blend is decreasing “budget neutral” CF and increasing RB-RVS CF
- CF will be updated annually for inflation and adjusted by the GAF
Other General OMFS Provisions Apply to the RB-RVS Fee Schedule

• Fees must be adequate to ensure a reasonable standard of services and care for injured employees

• AD has authority to adjust the conversion factors, RVUs and other factors affecting payment amounts within the aggregate 120 percent limit

• Changes to conform with any relevant changes in the Medicare payment system shall be made within 60 days after the effective date of the changes
Center for Health and Safety in the Workplace