

147047

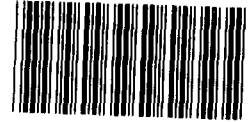


United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-249274

July 13, 1992



147047

The Honorable William E. Dannemeyer
Ranking Minority Member
Subcommittee on Health and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Dannemeyer:

Your letter of February 3, 1992, asked about the costs physicians might incur as a result of Medicare changing from the reasonable charge payment method to use of a resource based relative value scale (RBRVS) for physician services. You attached a copy of an article from the December 23/30, 1991, American Medical News that discussed potential costs to physicians of estimating the effect of the change to RBRVS on their gross revenues from Medicare. You asked us to estimate the total physician and administrative staff hours required for physicians to adjust to the RBRVS system, and the costs associated with such hours.

Information on which to estimate the total staff time and related costs of physicians changing to RBRVS is not available. However, implementation of RBRVS will involve some administrative costs for physicians. Some of these costs, such as those related to learning how to use new procedure codes, are routine costs associated with any fee-for-service billing system. Other costs, such as estimating the effect on gross revenues, should be one-time costs and these will vary substantially among physicians.

BACKGROUND ON MEDICARE AND RBRVS

Medicare, authorized by title XVIII of the Social Security Act, is a health insurance program that covers most Americans age 65 or older and some disabled people. About 35.5 million people are expected to be covered by Medicare during 1992. Medicare consists of two parts. Part A covers inpatient hospital, skilled nursing, home health, and hospice services. Part B covers physician services and a broad range of other noninstitutional services, such as diagnostic laboratory

GAO/HRD-92-38R, RBRVS and Administrative Costs

054874/147047

tests and x-rays. Until 1992, Medicare paid physician services using the reasonable charge method.¹

Because of perceived disparities in payment rates for various kinds of physician services, the Congress changed the physician payment method to RBRVS. Under RBRVS, each physician service is assigned a value relative to other services considering the physician work and other resources needed to provide it. The service's relative value is multiplied by a dollar conversion factor to arrive at the amount Medicare will recognize for payment.² For example, a service with a relative value of 2 is expected to require twice as many resources and would be paid twice as much as a service with a relative value of 1.

Implementation of RBRVS is designed so that the total amount of Medicare payments to physicians is the same as it would have been if the reasonable charge method had continued. However, the amount paid for particular services can change significantly. Generally, payments for evaluation and management services, such as office visits, increase, while payments for procedural services, such as surgeries, decrease.

RBRVS is being phased in over a 5-year period. During the phase-in, payment rates that are higher under RBRVS are increasing at a faster rate than rates that are lower under RBRVS are decreasing.

DIRECT ADMINISTRATIVE EFFECTS OF RBRVS ON PHYSICIANS

Implementation of RBRVS necessitated two administrative changes for physicians. First, the procedure codes and descriptions for physician visits changed when RBRVS went into effect on January 1, 1992. This probably required physicians to spend some time becoming familiar with the new codes so that they can properly code visits. Also those

¹Medicare paid 80 percent of the reasonable charge, which was defined as the lowest of the physician's actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (set at the 75th percentile of all physicians' customary charges).

²Relative values are adjusted for geographic variations in professional earnings level, physician practice costs, and malpractice insurance.

physicians who use automated bill generation systems will need to adapt these systems for the new codes. Although we could not make precise estimates, neither of these adaptations should involve a major expenditure of time or resources. The situation is similar to that which occurs whenever new procedures are developed or the description/coding of existing procedures changes--a relatively common occurrence.

Second, when RBRVS went into effect, the limit on the amount physicians can charge patients above the amount Medicare allows for payment also changed. When physicians accept assignment on claims, they agree to accept Medicare's allowed amount as payment in full--Medicare pays 80 percent and the beneficiary is responsible for 20 percent coinsurance. When physicians do not accept assignment they can bill the beneficiary for more than the 20 percent coinsurance, up to a maximum limit specified by Medicare statute.

In 1991, the maximum limit was 140 percent of the allowed amount for patient evaluation and management services and 125 percent of the allowed amount for procedural services. For example, if the Medicare allowed amount for an office visit was \$40 in 1991, the maximum permissible charge would have been \$56 ($\$40 \times 1.40 = \56). Similarly, if the Medicare allowed amount was \$1,000 for a particular surgery, the maximum charge would have been \$1,250 ($\$1,000 \times 1.25 = \$1,250$). In 1992, the maximum is set at 120 percent of the Medicare allowed amount for all services.

To comply with this legal requirement, physicians who do not accept assignment on all Medicare claims would have to ensure their billing systems do not generate bills higher than the limit on unassigned claims. Modifying billing systems could involve some cost. To assist physicians in this regard, Medicare furnished them with lists of Medicare allowed amounts and maximum charge limits for the procedures they have billed Medicare in the past.

POTENTIAL INDIRECT ADMINISTRATIVE COST EFFECTS

The American Medical News article discussed a potential indirect cost to physicians of implementing RBRVS--determining the likely effect of RBRVS on physician gross revenues. This article cited potential costs of \$2,500 to \$4,500 if a small physician practice hired a consultant to perform such an analysis for them. Although Medicare's adoption of RBRVS does not require physicians to assess

effects on gross revenues, from a business standpoint many physicians might want to do so. This would be particularly true for physicians with a heavy concentration of Medicare patients; for example, ophthalmologists specializing in cataract surgery and gerontologists.

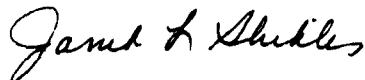
Medicare provided physicians with a substantial portion of the information necessary to estimate the effects of RBRVS implementation on gross revenues. Every physician that had billed Medicare was sent information on all the new visit and consultation codes as well as procedure codes the particular physician and/or other physician in the same specialty billed Medicare. The information consisted of the procedure codes along with the participating physician fee schedule amounts, the nonparticipating physician fee schedule amounts, and the limiting charges. Physicians were also provided information on how to obtain these fee schedule amounts and limiting charges for procedure codes not included in their physician-specific reports.

Using the Medicare-supplied data and estimates of the number of procedures that would be furnished during 1992, a physician could compute expected Medicare revenues. The difficulty of making such computations would be related to the difficulty of obtaining procedure volume estimates. If a physician's billing system permitted easy extraction of procedure volumes from a previous period, estimating would be relatively straightforward. On the other hand, if estimating volume involved manual extraction from hard copy records, it could be relatively expensive. Because the cost of estimating RBRVS' effect on physician gross revenues is dependent on the internal data sources available in the physician's office and information on that is not readily available, we were not able to estimate the overall cost.

- - - -

I trust that this response addresses your concerns. If you have any questions, please contact me on (202) 512-7119.

Sincerely yours,



Janet L. Shikles
Director, Health Financing
and Policy Issues