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Essentials of Physician Reimbursement

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Physician reimbursement has been central to the extensive debate over health care reform. Understanding the essentials of physician reimbursement is fundamental to understanding healthcare finance, the recently approved changes to our health care system, and how to respond as those changes take effect.

Any examination of physician reimbursement should begin with a discussion of Medicare.

When it was initiated in 1966, Medicare paid physicians based on physicians' usual and customary charges. The program was originally intended to cover only acute illnesses. The federal government worked with physicians to develop the Current Procedural Terminology (CPT) coding system, which became the standard for submitting physician billing to Medicare.

After two decades, the government realized that the charge-based system it developed was performing a poor job of cost control. In 1989, Congress abandoned the usual and customary charge Medicare payment format, and instead started paying physicians according to variation in the services performed, the costs of providing services and the potential liability expense related to services provided. In essence, the federal government shifted from paying physicians based on what they charged per service to the actual and expected resources expended in the delivery of services. The new payment methodology developed was called the resource based relative value scale (RBRVS). The RBRVS system, like its hospital correlate the DRG system, was only peripherally concerned with charges. In addition, at the direction of the Congress, the RBRVS system engendered a monetary shift away from invasive surgical procedures toward primary care services.

The commercial insurance industry, seeing clearly the gain to be realized by moving away from a charge-based reimbursement structure, quickly adopted RBRVS. The RBRVS system became the standard for physician reimbursement in America, both commercial and governmental.

Payments under RBRVS are similar to the DRG system and its variants in that reimbursement occurs as the result of a weight assigned to care delivered multiplied by a dollar conversion factor. In general, the weighting assigned to a particular service is comprised of a physician's total work (50%); practice costs (45%); and malpractice costs (5%). Total work is captured by six characteristics: technical skill; time; mental effort; physical effort; stress and judgment. Practice costs are overhead expenses including office rent, equipment, supplies, and non-physician salaries.

The RBRVS weighting version is typically updated annually by CMS for Medicare and Medicaid use. Most commercial carriers use the CMS updated versions directly, or with certain carrier specific modifications applied. The commercial carriers tend to use differing RBRVS versions, some may use the current version, others may use older iterations. Typi-

cally, the commercial carriers will not use versions that are more than 2-3 years old, although exceptions may occur. Note that reimbursement can then vary widely, depending on the conversion factor and RBRVS version utilized. The result can be extensive negotiations between the commercial carriers and providers, both over the conversion factor and the RBRVS version.

In 1997, Congress initiated the sustainable growth rate, or SGR, for the Medicare program. The SGR either increases or decreases physician reimbursement annually based on a comparison of total overall expenditures on physician services to per capita gross domestic product. In recent years the annual calculation has consistently called for decreases in payments to physicians for services provided to Medicare enrollees, with subsequent political debate and ultimately the elimination of planned decreases in payments. On June 25, 2010 President Obama signed legislation postponing the planned 21.3 percent cut in Medicare payments retroactive to June 1 and through November 30, 2010. This action also gave a 2.2 percent increase in Part B reimbursement for services delivered from June 1 through November 30.

Many believe that the current RBRVS based system is flawed, for a variety of reasons. The annual Medicare updates under SGR clearly do not keep pace with practice costs, and the annual drama surrounding the Medicare/SGR/Congressional process only heightens physician frustration. Momentum is building behind adaptation of reimbursement based on episodic care, or a medical home approach. Under this approach, reimbursement would reflect the value of care provided beyond that delivered in an individual patient/physician encounter, instead spanning the entirety of the spectrum of care delivered and providers participating in treating patients and keeping them well. There are many pilot projects existing at present related to medical home, but at present the traditional RBRVS system remains the standard.

In conclusion, physician reimbursement has been a complex and controversial issue for many decades. While the nature of physician reimbursement in the future may be uncertain, it is certain that the complexity and controversy surrounding it will continue.

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