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Current Procedural Terminology (CPT) standardizes medical procedure coding for billing and reimbursement. Since adoption of CPT coding as the basis for the Medicare Fee Schedule (MFS) in 1992, CPT coding policies and policy changes have been influenced not only by medical necessity and customary practice, but also increasingly by Medicare payment policies. The MFS created regulatory price control in the United States medical market based on widespread adoption of modified MFS by private payers and benchmark MFS fees governed by federal budget limitations and set annually by government agency (Centers for Medicare and Medicaid Services).

KEY WORDS • Current Procedural Terminology • Relative Value Update Committee • Medicare Fee Schedule • Health Care Financing Administration

Abbreviations used in this paper: AMA = American Medical Association; CMS = Centers for Medicare and Medicaid Services; CPT = Current Procedural Terminology; HCFA = Health Care Financing Administration; MFS = Medicare Fee Schedule; RBRVS = Resource-Based Relative Value Scale; RUC = Relative Value Update Committee.

The loss of physicians’ ability to determine what to charge for a service began in the 1960s when the federal government assumed responsibility for paying for Medicare-related physician services. It was not until the advent of the MFS in 1992, however, that all control over charges was lost, due to the prohibition on balance billing for any Medicare service, a provision of the Omnibus Budget Reconciliation Act of 1989. The MFS effectively shifted the setting of all prices for Medicare services to the HCFA. The Federal Trade Commission actions against all of the Relative Value Guides (except the American Society of Anesthesiology Guide) in the mid-1970s resulted in consent agreements that effectively shut down all relative value guides except the RBRVS, which was developed for Medicare and controlled exclusively by HCFA. Physicians and medical groups were threatened by antitrust action whenever they attempted to set up or use a fee schedule during this period. As the MFS was gradually adopted as a basis for greater than 80% of all payers over the following 5 to 7 years, it became the de facto national relative value system for payment of all medical services.

TRANSITION TO THE MEDICARE FEE SCHEDULE

Prior to 1966 medical fees in the United States were based primarily on physician charges, and there was a
growing frequency of payment through indemnity insurance policies. Since 1992 medical fees have been based primarily on fee schedules established privately by health care insurance companies and publicly by federal policy. Between 1966 and 1992, the transition from charge–based to fee schedule–based payment occurred gradually through private physician–payer contracts and public program participation agreements. Finally, in 1992, the implementation of the MFS brought both public and private physician payments under the control of the federal budget, as will be described.

The Medicare program began in January 1967. The political compromise included in the legislation (the 1966 Title XVIII Amendment to the 1933 Social Security Act), to gain support of the medical lobby, was the modeling of Medicare payment on the existing health insurance market, specifically the Blue Cross–Blue Shield model, which was a modified fee-for-service model, in which payments were based on community usual, customary and reasonable rates, made directly to the physician. Using this model, the costs of the Medicare program rose parallel with health care costs in the general market for the first 15 years of its existence, increasing at a mean rate of 13%, and peaking at 18% in the early 1980s. This cost growth prompted federal legislation to gain control of Medicare’s two largest cost categories: hospital and physician payments. Hospital payment took a form comparable to a capitated payment plan, in which prospectively determined hospital payments were based on diagnosis-related groups. Medicare’s hospital-related prospective payment system was instituted in 1983; average historical hospital costs were used as the basis for the 473 categories of diagnosis. The aim then shifted to reforming the method by which a physician was reimbursed.

In the 1980s, a calculation of “customary, prevailing, and reasonable” cost was used by Medicare to determine physician payment. The actual charge was what the physician listed on the claim. “Customary” meant what the physician had charged in the past, “prevailing” indicated what other physicians in the locality and specialty charged, and “reasonable” meant the lowest among the three. This payment system was considered dysfunctional by members of the Physician Payment Review Commission for several reasons. First and foremost, it allowed Medicare Part B (physician payment), amounting to 19% of the Medicare budget, to increase at rapid rates ($8 billion in 1981 to $24 billion in 1991), while Part A (hospital payment) was more predictably controlled using prospective payment. Second, the commission members believed the payment system distorted reimbursement, with “surgical and technical procedures...increasingly overvalued relative to visits and consultations” and contributing “to the rapid growth in the provision of surgical and technical procedures compared with visits and consultations.”

In 1985 Congress authorized development of a Medicare physician payment schedule in which a labor theory of value was used with payment based on the physician “resource inputs”—that is, the itemized costs of a physician’s time and practice expenses in performing the medical service. The contract for developing the relative values for physician work was awarded to William Hsiao, Ph.D., at Harvard School of Economics. Based on reports by Hsiao, et al., Congress authorized the creation of a MFS, based on the Hsiao (Harvard) RBRVS, in the 1989 Omnibus Budget Reconciliation Act. The MFS was instituted in January 1992, with a 4-year transition in work values from 1992 to 1996. The transition period was established to prevent disruptive practice income changes, because work values for surgical procedures fell a mean of 25%, whereas values for office evaluation and management services rose approximately 33%.

The reasons for the shift in payments from surgical to evaluation and management services were part of the philosophical and political basis for the RBRVS and its successor, the MFS. Hsiao, et al., quoted “a growing consensus” that the traditional payment system disproportionately rewarded specialty and surgical practice, while penalizing primary care services with low fees relative to the time spent on the service. This concept was organized by the American Society of Internal Medicine and began in the late 1970s with a concerted lobbying effort that emphasized the disproportionate value paid for procedural services, presumably at the expense of cognitive services (“Reimbursement for physicians’ cognitive and procedural services: A White Paper: American Society of Internal Medicine, 2550 M St. NW, Suite 620, Washington, DC 20037). The members pointed to a growing proportion of specialty-trained physicians, a shrinking share of primary care physicians, and a tendency to treat common medical problems by using high-cost specialty care. They convinced Congress that the uncontrolled growth of the Medicare budget was a result of specialty physician payments and hospital payments for the services they ordered or performed. The solution embedded in the RBRVS, and subsequently the MFS, was to shift money from specialty to primary care services, not only reducing payments for surgical care but creating incentives for physicians to train for primary care practice and to use less expensive primary care services to treat patients. The hope, as expressed by the Physician Payment Review Commission, was that not only would Medicare benefit from controlled cost and incentive shift in the RBRVS but also that private payers would adapt the RBRVS to their own fee schedules.

The tools used to effect these shifts in payments across specialties were based on the ability of HCFA to control a national fee schedule for Medicare. The RBRVS was based on a concept that only the resources consumed in provision of a medical or surgical service should be used as the basis for payment for such a service—that is, a resource-based value system. All procedures or services were divided into three parts: physician work, practice expense, and malpractice expense. Each part was valued separately, and to create a total relative value the three parts were summed. The total relative value units were then converted to a dollar amount by applying of a conversion factor, dollars per relative value unit, determined anew each year by HCFA. This, and some limits imposed on growth by Congress, effectively put a lid on the rapid rate of growth in federal health care expenditures in the early 1990s after the MFS was initiated. It also gave HCFA the ability to manipulate the redistribution of relative values, and thus payments, across specialties. The re-
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results were major shifts in payments, with increases to primary care at the expense of most surgical services.

FEDERAL PAYMENT POLICY LINKED TO AMA PROCEDURE CODING POLICY

In designing the RBRVS, Hsiao, et al., recognized that detailed description, commonly used nomenclature, and understandable codification of the medical and surgical services being valued were important to the success and acceptance of the RBRVS. The CPT coding system, created in 1966 and maintained by the AMA, was in common use for billing both within and outside the Medicare system in the 1970s and 1980s. In 1983, it was designated as the exclusive coding system for Medicare by HCFA, was used as the basis for research conducted by Hsiao, et al., and was included as the procedure coding system in the MFS. The adoption of CPT as the basis of procedure description ensured that the MFS would be familiar to physicians and avoid the confusion and chaos that would accompany an entirely new procedure coding system, making the MFS easily adaptable in practice and adoptable by non-Medicare payers. It meant transition to the MFS would be smooth and nondisruptive. It also meant that HCFA and the AMA would become interdependent: HCFA depended on the AMA to maintain or adjust the CPT coding system to conform with Medicare’s changing budget and patient-related benefit needs, and the AMA dependent on HCFA to accept and authorize CPT coding modifications that were negotiated and adopted by the CPT multispecialty panel.

The use of the CPT coding system as the basis of the MFS meant that organized medicine retained the authority and responsibility to recommend what services qualified as “medically indicated and appropriate” and thus were eligible for Medicare reimbursement. Further, because the determination of the relative work involved in each service was something only physicians could accurately estimate, organized medicine (the AMA) seized the added opportunity to assert authoritative judgments and recommendations concerning the value of future work and revaluation of current work. An unacknowledged restraint, however, was associated with the privilege of determining work values. It also meant CPT became, in effect, an instrument of federal payment policy and budgetary fiscal restraint. The AMA’s CPT could no longer create codes based solely on clarity, accuracy, and physician needs; each code change considered would be judged not only on medical necessity but also on its implications for the federal budget, its potential valuation within the RBRVS, its effect on other CPT code values, its effect on the Medicare conversion factor, and the penetration of that valuation into the private payer market. In this complex calculation, independence of CPT coding policies was lost and dependency of CPT coding policy on Medicare payment policy was born.

The AMA created a CPT editorial panel at the inception of the CPT coding system in 1966 to provide a mechanism by which to delete or revise old codes and adopt new codes as technology advanced and medical practice evolved. This editorial panel was designed as a multispecialty board to reach professional consensus on new code requests, with broad specialty representation intended to ensure broad input, balance competing or conflicting interests, and ensure that the coding system would be accepted by all specialties. Requests for CPT code change may be submitted to the CPT panel not only by physicians but also by medical equipment vendors or other interested medically related organizations or businesses. Decisions related to CPT alterations are based on majority approval of code proposals by a panel that includes 11 medical or surgical specialty members, and they are significantly influenced by hospital, insurance, and Medicare (CMS) panel members.

The original RBRVS values were assigned following a lengthy process of creating families of related codes, appointing benchmark codes in each family as the keystone code with which others in the family were compared, surveying physicians in each specialty for values for representative codes, extrapolating values to nonsurveyed codes, and cross-walking values between specialties by using codes shared among several specialties. When the MFS was authorized by Congress, it was recognized that new CPT codes would have to be accepted as new procedures were added to routine practice, and new values for the codes would have to be decided. The RUC was created by the AMA, authorized as a government agency advisory committee to the HCFA, and entrusted with the responsibility for using physician-related experience and judgment to recommend accurate relative values to the HCFA for new or revised CPT codes. Seats on this committee were assigned to the principal specialties, including neurosurgery, similar to the wide representation of specialties on the editorial panel, but with a greater number of specialties represented and with permanent seats assigned to most specialties, rather than rotating seats, as occurs on the editorial panel.

The panels of the CPT and the RUC meet and decide their respective policies independently of each other. Each group, however, has representation on the other’s panel, and discussion within CPT panel often includes potential RUC values and CMS payment policies following CPT policy changes.

CONCLUSIONS

Payment for physician services has undergone a fundamental transition since 1966. The pre–Medicare market-driven fee-for-service system has been transformed, by federal policies adopted in the Medicare program and adapted in the private health care market, into a regulated economic market based on HCFA (CMS) payment rules and regulations, limited federal tax-based resources, and Medicare program financing limitations. The MFS has become a de facto national medical fee schedule, further secured through its voluntary adoption and use as a benchmark by most private health care insurers.

The CPT coding system is, on the surface, an independent AMA product used universally for medical billing purposes within the United States. Federal policy adopting CPT as the procedural coding basis for the MFS, however, has permanently linked CPT policy decisions to Medicare payment policy, eliminating the independence of the AMA CPT policies from direct federal influence.
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