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The Impact Of RBRVS On Oncology Practices

By Carol S. Miller, M.B.A.

This article presents the results of a survey of oncology practices that attempted to measure the impact of Medicare's new RBRVS system of physician payment. Based on the survey results, the author discusses the potential impact of RBRVS on charges and reimbursement for office visits and chemotherapy drugs.

In conjunction with the Association of Community Cancer Centers, a survey of seven office-based oncology practices and one hospital-based oncology practice was conducted to measure the impact of Medicare's new Resource Based Relative Value Scale (RBRVS) system of payment, and its affiliated regulations, on the charges and reimbursement for office visits and chemotherapy drugs as it related to the practices' Medicare populations. The results of this survey were presented at the ACCC Fall Leadership Conference in La Jolla, CA, in September.

Prior to conducting the survey, and with a Health Care Financing Administration (HCFA) mindset, a group of oncologists, including Lloyd K. Everson, M.D., President of ACCC, tried to project how the descriptive vignettes by Dr. Hsiao would align in the current five-level coding structure for office visits. In addition, the group tried to determine which vignettes could be included if HCFA developed a sixth level in the yet-to-be-released Evaluation Management (EM) codes.

In reviewing the proposed descriptions, the oncologists felt that none of the vignettes fell into a "brief" or "limited" EM code. In fact, the majority of oncology descriptors seemed to more readily align with the higher levels of visit codes.

Examples of the proposed vignettes for the various levels of visits are as follows. (Please note that these examples are based on the oncologists' assumptions of how the federal government might describe different visits for an oncology practice.)

> *"The survey obtained and analyzed charge, frequency, and Medicare reimbursement data from eight oncology practices"*

Intermediate EM Visit

- Weekly office visit for 5-FU therapy for an established, ambulatory patient with metastatic colon cancer and increasing shortness of breath.

Extended EM Visit

- Routine follow-up office evaluation at a three-month interval for a 77-year-old female with small cleaved-cell lymphoma.
- Follow-up office visit for a stable, 80-year-old female with metastatic breast cancer.
- Follow-up office visit for a stable, 50-year-old female with metastatic breast cancer.

Comprehensive EM Visit

- Initial office consultation for an 80-year-old male with newly diagnosed adenocarcinoma of the prostate and negative metastatic work-up.
- Office visit for restaging of an established patient with new lymphadenopathy one year post therapy for lymphoma.

Proposed Level 6 EM Visit
(Based on the assumption that HCFA will consider developing an additional level of visit for oncology services.)

- Initial office visit for a 73-year-old male with an unexplained 20-pound weight loss.

Data Analysis

As mentioned previously, the charge, frequency, and Medicare reimbursement data from eight oncology practices were obtained and analyzed for the survey. These data represented the five levels of office visits presently utilized in an oncology practice and the 10 most frequently utilized chemotherapeutic drugs.

It is important to note, as referenced in the June *Federal Register*, that the Evaluation Management codes being developed by HCFA will pertain not only to office practices, but to outpatient cancer centers, and that reimbursement will vary depending on geographic location.

In addition, the data collected from the physician offices for "comprehensive office consults" and their affiliated reimbursement were designated as being comparable to the proposed Level 6 Evaluation Management code. Because another level of visit was assumed in our analysis, three separate dollar conversions were portrayed in the

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TABLE A
OFFICE PRACTICE SUMMARY
OFFICE VISIT CODES: LEVELS 1–5

Visit	Frequency	Low Charge	High Charge	Low Allowable	High Allowable	Low RBRVS	High RBRVS
Brief	729	$20.42	$33.46	$16.20	$26.25	$18.00	$20.54
Intermediate	3,940	$21.12	$70.00	$19.40	$30.80	$23.52	$28.13
Limited	6,625	$22.75	$90.00	$25.76	$36.00	$23.52	$28.13
Extended	2,493	$50.12	$110.00	$35.80	$46.50	$37.87	$44.64
Comprehensive	338	$47.50	$196.00	$55.60	$110.00	$58.77	$66.08

assumptions—$28, $29, and $30. It was also assumed that this additional level of visit, or perhaps others, could be developed based on the vignette descriptions and the services rendered in an oncology practice.

The allowable high and low ranges of reimbursement under RBRVS in this survey were calculated on the basis of the June *Federal Register* guidelines, and they are specific to the geographic locations of the oncologists who participated in the survey.

As mentioned previously, the survey also included data on chemotherapy drugs. In the June *Federal Register*, HCFA stated that these drugs would be reimbursed at 85 percent of the Average Wholesale Price (AWP). Therefore, in the survey, we compared the current level of drug reimbursement to 85 percent of AWP. However, because of the numerous comments HCFA has received from physicians about the negative impact of such a policy, the survey also compares current drug reimbursement to 90 percent and 95 percent of AWP. Finally, the survey reflects the "allowable charge" without removing the Medicare deductible or the coinsurance of 20 percent.

The Survey Results

Tables A, B, and C reflect low and high charges over a six-month period, current allowable charges under the reasonable charge payment system, and the projected payment under RBRVS. (The latter was calculated on the basis of data published in the June *Federal Register*.) In addition, Table B reflects the creation of a new Level 6 code, along with comparisons of this level of visit to a "comprehensive office consult" and the assumption that the new level of visit could be based on any one of three different dollar conversion factors.

It is interesting to note that in Table A, the allowable "high" charges under the current Medicare reimbursement system of reasonable, customary, and prevailing, is higher than the projected approved high charges under the new RBRVS reimbursement system to be implemented in 1992. Unfortunately, the same scenario occurs when the proposed Level 6 codes (referenced in Table B) are projected forward utilizing three different, but higher, conversion factors. In short, the current Medicare allowable is higher than the projected level of payment under RBRVS. Therefore, one can only assume from these figures that the original intent of allowing a higher level of reimbursement for cognitive skills under RBRVS will not occur.

In addition, at *Oncology Issues* deadline, HCFA was further redefining

TABLE B
OFFICE PRACTICE VISITS
PROPOSED LEVEL

Visit	Frequency	Low Charge	High Charge	Low Allowable	High Allowable
Comp. Office Consult	1,231	$105.90	$188.00	$75.10	$109.60

Level 6 Conversion	Low RBRVS	High RBRVS
$28.00	$95.89	$107.98
$29.00	$99.41	$111.83
$30.00	$102.83	$115.69

the Evaluation Management codes not only for the office setting, but the hospital and outpatient settings. The formula, groupings, and vignettes, in their final form, will be available in November and, hopefully, provide oncologists with a full understanding of the impact of RBRVS.

Table C, which reflects the current allowable for chemotherapy drugs, along with the variables of 85, 90, and 95 percent of AWP, is an enlightening example of the impact of reducing payments for drugs. Currently, physicians across the United States receive varying levels of reimbursement for antineoplastic agents, ranging from cost to AWP to AWP plus. This varies according to the policies and procedures of local Medicare carriers. Most commercial insurance companies allow the physician's charge, which reflect payments that range from 10 to 45 percent over the physician's cost.

As stated in the beginning of this article, the June *Federal Register* stated that drugs would be paid at 85 percent of AWP. However, because of the numerous letters appealing the negative impact of such a reimbursement policy, HCFA will probably rescind this payment structure in the final regulations and, instead, allow a reimbursement level of at least AWP for drugs.

Nevertheless, keep in mind that oncologists will continue to experience the same difficulties with carriers regarding whether or not reimbursement for a particular drug will be allowed.

The Projected Impact of RBRVS

The RBRVS system of payment was designed with the intent of reducing surgical charges and increasing payments for medical specialities and subspecialties while maintaining budget neutrality.

Unfortunately, as the new payment system is further scrutinized, modifications have been made that restrict its original mission. A preliminary analysis, based on the proposed regulations in the June *Federal Register* and current physician billing charges and reimbursement, reflect the refinements that HCFA has made to the system. In further reviewing the potential impact on office- and hospital-based practices, we can make the following projections:

Table C
CHEMOTHERAPY DRUG SUMMARY

Agent	Low Charge	High Charge	Low Allowable	High Allowable
Leucovorin 50 mg.	$25.00	$135.00	$20.44	$97.00
Carboplatin 50 mg.	63.50	85.00	51.00	63.50
5FU 100 mg.	2.00	27.50	1.02	3.00
5FU 500 mg.	6.00	40.00	2.04	2.70
Methotrexate 50 mg.	10.00	36.00	2.63	22.00
VP-16 100 mg.	110.00	400.00	91.05	234.00
Cytoxan 500 mg.	20.30	32.00	13.00	24.73
Cytoxan 1 gm.	41.64	64.00	25.00	49.45
Adriamcyin 10 mg.	38.25	62.00	33.75	45.08
Adriamycin 50 mg.	186.27	308.00	168.75	234.60

	85% AWP	90% AWP	95% AWP
Leucovorin 50 mg.	$ 45.90	$ 48.60	$ 51.30
Carboplatin 50 mg.	55.20	58.40	61.70
5FU 100 mg.	1.39	1.47	1.55
5FU 500 mg.	2.71	2.93	3.10
Methotrexate 50 mg.	8.72	9.23	9.75
VP-16 100 mg.	99.50	105.30	111.30
Cytoxan 500 mg.	21.00	22.25	23.50
Cytoxan 1 gm.	40.36	42.73	45.10
Adriamycin 10 mg.	38.25	40.50	42.75
Adriamycin 50 mg.	196.00	207.00	219.00

Office-Based Practices

- Reimbursement for chemotherapy administration will continue to be reimbursed in the office practice setting; it will be classified as a strictly technical service, and it will be reimbursed based on a national average for this service. In our opinion, this will represent a lower level of reimbursement for at least 40 to 45 percent of all physicians. Final RBRVS allowances for chemotherapy administration will be published in November in the *Federal Register.*
- RBRVS will reimburse for certain trays and supplies which will minimally assist with the current expenses for these services.

- Offices will receive less reimbursement for drugs at either 85 percent of AWP, a higher percent of AWP, or at AWP. Regardless of the percentage, this policy will have a negative impact on many office practices across the United States.

- Under the new Evaluation Management codes, office visits and chemotherapy administration will be allowed during the same visit. However, one cannot predict which level of office visit will be allowed or what justification carriers will require.

- Office practices will continue to experience a high level of overhead with continually increasing expenses.

Overall, it is our assumption that office practices will experience a slight net loss.

Hospital-Based Practices

- Office-related expenses, such as salaries, postage, marketing, copying, etc. will not be borne by the physician. These expenses will become the hospital's responsibility.

"Overall, office practices will lose slightly, hospital-based practices will gain slightly, and hospital reimbursement for in- and outpatient cancer programs will maintain status quo"

- Physicians will be reimbursed for their visit and chemotherapy codes under the new Evaluation Management codes, which are projected to provide a higher level of reimbursement than in the past. Once again, these allowances will be published in November in the *Federal Register.*

Overall, it is our assumption that the hospital-based oncology practice will experience a slight net gain.

The Impact on Hospitals

- AWP or AWP minus 15 percent will not apply to hospital reimbursement for drugs.

- Chemotherapy administration will be classified as a technical fee and will be billed by the hospital under "facility fees."

- Reimbursement for supplies, trays, etc., can still be paid to the hospital as a technical component.

- Traditional drug and laboratory payments will continue to flow to the hospital.

Overall, it is our assumption that hospital reimbursement for oncology services in an outpatient cancer program will remain at the status quo.

Summary

HCFA is moving forward with its new reimbursement system, scheduled to be implemented on January 1, 1992, even though not all of the final reimbursement figures or guidelines are yet available to the public. Therefore, no one, including Medicare carriers, physicians, and especially patients, will understand the full impact of RBRVS until all of the calculations, formulas, guidelines, and visit codes are released. However, it is expected that the final regulations due in November will vary only slightly from the proposed regulations released in June. ■

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