Editor's Note: Authors are invited to respond to Correspondence that cites their previously published work. Those responses appear after the related letter. In cases where there is no response, the author of the original article declined to respond or did not reply to our invitation.

The Critical Flaw in Physician Compensation Is Not the Sustainable Growth Rate!

To the Editor:

While there has been extensive discussion on the effect of the sustainable growth rate formula on physician compensation, the deeply flawed Resource-Based Relative Value Scale (RBRVS) system has received little notice. Two CHEST articles by Laugesen¹ (November 2014) and Kumetz and Goodson² (September 2013) should attract the attention of all who are interested in the complexity and inequity of physician compensation.¹² Both of these articles touch on the flaws within the system, and one must ask the question of whether accurate relative values can be established between cognitive and procedural interventions.

Inquiry into the origins of the RBRVS reveals that the initial framework was designed to be applied to procedural services; cognitive services were incorporated later in the process. The legislation that established the RBRVS included a requirement that values be reviewed at least every 5 years. As this legislation was evolving, the American Medical Association quickly established the Relative Value Scale Update Committee (RUC) with a membership heavily tilted toward procedural specialties. Centers for Medicare & Medicaid Services turned to that committee to meet the statutory requirement for review. Responsibility for reviewing final valuations was given to the Physician Payment Review Commission, which was disbanded in 1997 and replaced by the Medicare Payment Advisory Commission. Commissioners in the Medicare Payment Advisory Commission became highly critical of the RBRVS and the RUC and made their feelings clear in their June 2006 report to Congress. That criticism has been repeated in every annual report since then and resulted in the misvalued codes endeavor legislated in the Affordable Care Act. That legislation encouraged Centers for Medicare & Medicaid Services to conduct their own surveys and to employ independent contractors to analyze physician services.

Despite efforts to correct the system, cognitive services remain undervalued. For example, compare the valuation of screening colonoscopy (Current Procedural Terminology code [CPT] 45378) to the first hour of critical care (CPT 99291), recognizing that taking responsibility for a physiologically unstable patient requires not only a significant fund of knowledge and the ability to apply best practice recommendations that are constantly evolving, often on a month-to-month basis, but also the ability to deal with family dynamics in an emotionally charged situation. For the 2014 Medicare Physicians Fee Schedule, CPT 45378 is valued at 6.19 relative value units while 99291 is valued at 6.26 relative value units. Our societies have had representation at the RUC since its inception with no notable change in the value of codes specific to our services. We can hope that with more articles such as those by Laugesen¹ and Kumetz and Goodson², societies representing our practice domain will actively engage in efforts to improve this flawed system.

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References

Response

To the Editor:

With reference to my recent CHEST article,¹ as well as the prior work of Kumetz and Goodson² in this journal, Dr Mathers asks whether relativity between cognitive and
procedural service reimbursement in the Resource-Based Relative Value Scale (RBRVS) is feasible. Existing evidence points to persistent differences in cognitive and procedural service reimbursement.\textsuperscript{3,4}

Reimbursement for cognitive services should reflect the work associated with providing the service. One problem is that certain structural features of the RBRVS constrain and may contribute to undervaluation. Physicians providing cognitive services have a smaller bandwidth of billable codes; their billing is also more heavily scrutinized due to documentation requirements. The cut points are less precise for many cognitive services: Surgical and procedural services often appear to be more precisely distinguished. These gradations make a difference for physicians providing cognitive services—but especially if they are already operating at the margin of the work time and intensity involved. In the case of evaluation and management services, for example, the Relative Value Scale Update Committee time estimates used by the Centers for Medicare & Medicaid Services are closer to independently measured times for evaluation and management services than they are for surgical and procedural services.\textsuperscript{5} Current reimbursement for cognitive services likely fails to capture the full range of patient severity and/or the wide range of patient scenarios because a small number of cognitive service codes describe these services. However, this is not necessarily an argument to expand the complexity or number of codes for cognitive services. It suggests we should explore how to accurately translate the severity of patients and demands on physicians providing a wide range of services into meaningful payments.

At the same time, generalizing across the entire RBRVS is problematic since not all procedural and surgical services are alike. Many physicians providing cognitive services may support existing fees for high stakes and highly complex services. Cognitive physicians are likely to bristle at the reimbursement levels for less intensive and lower-risk services; these kinds of services usually decline in difficulty as familiarity increases. Unlike evaluation and management services, the times initially estimated by the Relative Value Scale Update Committee are likely to increasingly diverge from actual times. As Dr Mathers suggests, the valuation of colonoscopies is a prime example; likewise, endoscopy services and less complicated or low-risk surgeries are sometimes given as examples. Among noncognitive specialists, income from just a few highly valued services such as these significantly enhances practice revenue. Specialty society representatives refer to these kinds of codes that provide a good basis for their revenue as “bread and butter” codes.

At its core, there is a lack of clarity about how to measure different kinds of physician work. Before the RBRVS was created, people thought reimbursement for cognitive services would increase because the RBRVS sought to standardize physician work across a wide range of physician activities. The effort to standardize the estimates of physician work has been difficult to realize, or the standardization has not served cognitive services well; simultaneously, technological changes likely increased the gulf between procedural and cognitive physician reimbursement. New ways of understanding and calibrating the work of cognitive physicians are needed.

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**References**


