



# Final Report

## Relative Value Guide Commission of Alberta

*February 28, 2001*



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Honorable Gary Mar  
Minister  
Alberta Health and Wellness

And

Dr. Clayne A. Steed  
President  
Alberta Medical Association

Dear Mr. Minister and Mr. President,

Accompanying this letter is the final report of the Relative Value Guide Commission. This report encompasses 30-plus months of work by the Commission. This achievement would not have occurred without the constant and timely support of both Alberta Health and Wellness and the Alberta Medical Association.

Kudos truly go to the representatives of each medical section of the AMA. The RVG Commission on the one hand, and their section members on the other, demanded much of the section advisors. It was not always smooth sailing for them. The Commission recommends that a copy of this report be distributed to each section advisor.

While the task was a challenging one, the Commission members remained diligent and committed to seeing the task through to completion. As Chair of the Commission, I am proud to have had the opportunity to work with a group of Commissioners with such a high degree of integrity, patience, good humour, and commitment to their profession.

The Commission sees our report as the first step of a "work in progress." Continuing commitment and support will be needed to maintain the momentum, implement the recommendations, and ensure that the RVG is maintained and updated on an ongoing basis.

We commend you on the initiative you took together to establish the Relative Value Guide Commission and we trust that this report is the genesis of an equitable and fair process to value medical services in the Province of Alberta.

With thanks,

John W. Atkinson, MD, FRCP  
Chair, Alberta RVG Commission

# Contents

## Executive Summary

i-viii

## Full Report

<b>1.</b>	<b>Introduction and Background</b>	<b>1</b>
1.1	Commission membership	1
1.2	Principles and objectives	2
1.3	Clarification of roles and mandate	3
1.4	Information-gathering and decision-making processes	4
1.5	Communication strategy	5
1.6	Process	5
1.7	Methodology	6
<b>2.</b>	<b>Developing the Common Scale</b>	<b>7</b>
2.1	Intra-sectional relative values	7
2.2	Cross-links to build the common scale	10
2.3	Visits and consultations	13
2.4	Other factors considered	18
2.5	The common scale – how it came together	20
<b>3.</b>	<b>Assessing Practice Expense Recovery</b>	<b>25</b>
3.1	Background	25
3.2	Work plan	26
3.3	Model office profiles	27
3.4	Indirect practice expense recovery	28
3.5	Direct cost recovery	28
<b>4.</b>	<b>Developing an Integrated RVG</b>	<b>31</b>
4.1	Relative value multipliers	31
4.2	General rules	32
4.3	Market modifiers	34
<b>5.</b>	<b>Outcomes</b>	<b>35</b>
5.1	Highlights	35
5.2	RVG 2000	36
5.3	Financial Impact	36
5.4	Evaluations of the Commission's methodology and process	39

<b>6.</b>	<b>Recommendations</b>	<b>41</b>
	A. Implementation process and strategy	41
	B. Maintenance process	44
	C. Unfinished business	45
	D. Further research	46
	E. Audit system	49
	F. Practice expense recovery	50
	<b>Attachments</b>	
	A. RVG Commission structure	52
	B. Glossary	57
	C. Bibliography	61
	D. Summaries of concluding meetings with sections	67
	E. List of documents	68
	<b>Appendix A</b>	
	• RVG 2000	
	• Human resource relative values 2000	
	• Multiplier tables (and instructions)	
	• Deletions, revisions and new codes as requested by sections	
	<b>Appendix B: Technical Papers</b>	
	B-1. Developing the Common Scale	
	B-2. Assessing Practice Expense Recovery	
	B-3. Evaluation of Commission's methodology and processes	

# Executive Summary

## Setting the stage

In 1998, Alberta Health and Wellness and the Alberta Medical Association agreed to establish a new Alberta Relative Value Guide Commission. The Commission's objective was to address longstanding concerns about fairness and equity in the fee schedule for Alberta physicians and to establish a new Relative Value Guide for Alberta. The mandate of the Commission was to make recommendations to the Minister on an indivisible, implementable and cost neutral Relative Value Guide.

*The objective was to address longstanding concerns about fairness and equity.*

The Commission began its work in the fall of 1998 with the appointment of the following members:

Chair

Dr. John Atkinson

Representing Alberta Health and Wellness:

Dr. Ron Dyck

Dr. Dennis Jirsch

Representing the Alberta Medical Association

Dr. Kabir Jivraj

Dr. Gerry Prince

A small staff also was established, led by Brian Spooner, Project Manager, and Nancy Rowan, Associate Project Manager.

Early work of the Commission focused on:

- Setting clear principles and objectives
- Clarifying roles and mandate
- Establishing a multi-dimensional process involving active participation by section advisors, building on existing information and experiences in Alberta and in other jurisdictions across Canada and North America, and undertaking original research where required

- Surveying physicians and establishing a communications strategy designed to keep physicians informed and involved in the process
- Developing an overall approach and methodology.

*Approved cross-links far exceeded the minimum number required.*

## Implementing a sound approach

Key components of the Commission's approach included the following steps:

- **Intra-sectional relative values were established for each section.**

Building on previous work done by the AMA, intra-sectional relative values were determined by each section using the "magnitude estimation" approach. This involved each section reviewing a cross section of their codes representing 85% of the dollars billed and 85% of the total units of services provided by physicians in each section. Section advisors assigned an RV to each of these codes and several reviews were undertaken with each section.

- **Cross-links were identified.**

Each section used its own scale to establish their intra-sectional relative values. For example, one section may have used a scale with values from 500 – 5000 while another section used values from 1000 – 35,000. If we used monetary currency as an analogy, one section expressed its values in yen, another in marks and another in dollars. To bring those values together into a common scale, "exchange rates" were developed using cross-link codes. More than 1000 codes were identified as potential cross-links. Following review by section representatives, an independent panel of experts, and an independent analysis, and subsequent validation, 633 cross-links were identified to use in developing the common scale. This far exceeds the minimum number of eight cross-links per section that were required.

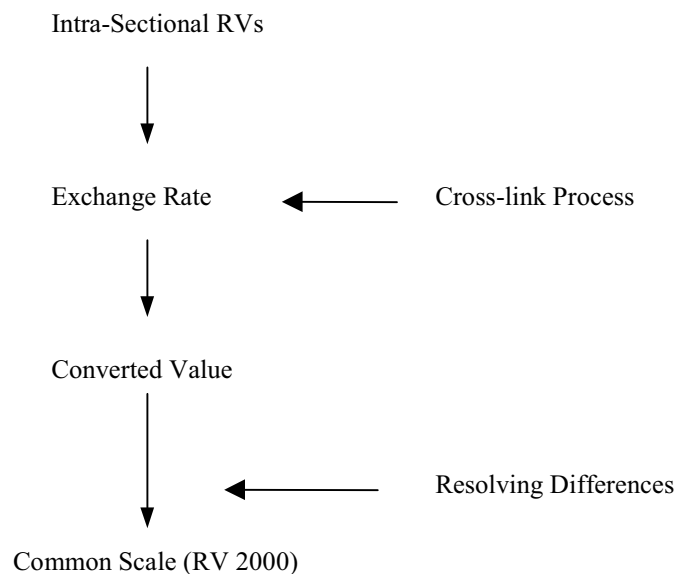
- **New research was done on the impact of patient complexity on visits and consults.**

Visits and consults make up about 50% of all services provided by physicians, including surgical specialties. While procedures performed by physicians are discrete and definable, visits and consults include a diverse array of services and have only a handful of billing codes compared with procedures. The Commission recognized that, to achieve an acceptable set of relative values for visits and consults, further work would be required to understand and measure physician work in this area. Building on previous research, a research project was designed to evaluate differing levels of patient complexity and identify the factors that contributed to patient complexity.

*Further work was required to understand and measure patient complexity in visits and consults.*

- **The common scale was developed.**

The process for developing the common scale involved the following key steps:



The result was a comprehensive study involving 274 physicians and generating a data base of 20,000 patient contacts. The study found that four-fifths of the 38% explainable variance in patient complexity was accounted for by three key variables: total physician time related to patient need, in-patient hospital status, and number of secondary diagnosis.

The outcomes of the study were used to adjust RVs for visit and consult codes involving different sections.

The initial draft of the common scale reflected a high level of agreement; 86% of the time, sections agreed on the respective relativity of a given service. Where differences were identified, two processes were used: a weighting approach was used to resolve differences in assessments for procedures, and the visits and consult study was used to resolve differences for visits and consult codes. The visits and consult study was specifically used to recognize the additional complexity of hospitalized in-patients.

*The initial draft common scale reflected a high level of agreement among sections.*

- **Practice expenses were studied and the results were used to develop practice expense multipliers.**

Practice expenses are significant and the Commission recognized that the Relative Value Guide must incorporate an effective mechanism for recovering practice expenses. A set of principles was developed by the Commission to guide the work. A multi-step work plan was implemented including:

- grouping individual physicians into clusters with similar practices.
- hiring Arthur Andersen Consulting to survey a sample of physicians.
- building model office profiles.
- separately assessing direct practice expenses including current tray fee and technical fees.
- reviewing the outcomes with physicians.
- incorporating overall results to establish a practice expense (OH) multiplier for each section. These multipliers are applied to the RV of any code to determine its OH component.

- **An integrated RVG 2000 was developed.**

The final step in developing the RVG 2000 was to bring together the physician services (human resource) component with the practice expense component into an integrated RVG. This was done by developing two relative value multipliers: one for the human resource component and one for the practice expense



component. These two RV multipliers are used with the common scale and are applied directly to the RV of any code to determine the dollar value of both the human resource and the practice expense components.

*The integrated RVG 2000 includes the human resource component and the practice expense component.*

## Assessing outcomes and impact

The process of developing a new Relative Value Guide for Alberta resulted in a number of significant outcomes.

- The most significant outcome is the development of a new RVG 2000 that includes a new relative value for each procedure, visit and consultation in the current Schedule of Medical Benefits, (except the anesthetic services of the Section of Anesthesia) as well as multipliers for each section for both the human resource (HR) and practice expense (OH) components.
- The new Relative Value Guide is the first comprehensive re-evaluation of all medical services provided by Alberta's physicians in many years.
- Consistent with changes in medical practice, new relative values were identified for all codes. While changes may not have been as extensive as some sections expected, the new Relative Value Guide more accurately reflects the relative value of services provided by physicians in different sections.
- Sections whose services have been relatively "under-valued" based on the data and on the views of physicians will see the most significant adjustments as a result of the new RVG.
- The Commission's objective was to achieve greater equity in the value of services provided by different physicians and in their ability to recover practice costs. Based on the outcomes and the impact assessment, considerable progress has been made in achieving this important objective.
- With the assumption that no section's payments would decrease, the new Relative Value Guide would result in an overall increase in revenue to physicians of 13% (\$118 million).
- The new Relative Value Guide would result in significant changes in the human resource component of physicians'

*Sectional changes in the human resource component ranged from 0% to 65%.*

incomes. The impact assessment shows that changes in the human resource component for the various sections ranges from 0% to 65%.

- The new approach to assessing practice recovery costs provides a sound method for recognizing the significant impact of practice costs on physicians' incomes.
- The process allowed for continuous and consistent input from section advisors and individual physicians. There is little doubt that, as a result of the process, physicians are more aware of the relative values of various services and the need to address inequities and changes in practice in a timely and efficient way. The Commission's recommendations on implementation and maintenance of the relative value guide are intended to ensure that the momentum achieved through the RVG process is not lost once the Commission's work is complete.

*Evaluations highlighted the strengths of the Commission's work and pointed to opportunities for future improvements.*

In addition to these specific outcomes, the Commission also requested and received external evaluations of its overall approach and, in particular, the method used to create the common scale. These evaluations highlighted the strengths of the Commission's work, provided external validation for the Commission's methodology, and pointed to areas where there are differences of opinion and opportunities for future improvements.

## Making recommendations and maintaining momentum

In addition to developing the RVG 2000 and making code-specific recommendations for change, the Commission also developed a comprehensive set of recommendations for implementing the new RVG 2000 and ensuring that the RVG can be maintained and updated on an ongoing basis. Ongoing maintenance and change is particularly important in view of the fact that the Commission has always viewed the development of an RVG as a work in progress. Timely and effective processes must be in place to ensure that ongoing changes can be made to reflect changes in medical practice.

*A comprehensive set of recommendations was made to guide implementation and ensure the RVG can be maintained and updated on an ongoing basis.*

Key recommendations from the Commission's final report include:

- Alberta Health and Wellness and the Alberta Medical Association accept the final report of the Alberta Relative Value Guide and the RVG 2000.
- An Implementation Committee should be established to ensure a smooth transition to the new RVG 2000. Suggestions for the mandate for the Implementation Committee have also been developed.
- Implementation should begin on or about April 1, 2001, with full implementation by April 1, 2004 or sooner.
- An appeal process should be developed and implemented on an ongoing basis.
- Incremental introduction of the RVG should be accepted as realistic, but the RVG should ultimately be fully implemented without any omissions.
- New, revised and deleted codes recommended by sections should be reviewed on a priority basis.
- Specific enhancements should be made to visit and consult codes including changes to the 03.04A code, introducing time release clauses, and providing an enhanced relative value for in-patient visits and consults.
- Initial implementation should include unbundling of visits and consults from identified procedures.
- A Maintenance and Update Committee should be established to maintain the integrity of the RVG, undertake further research and development, and recommend ongoing modifications to the RVG. The process should be timely and efficient. Specific suggestions for the mandate of this Committee have been developed by the Commission.
- A separate committee of knowledgeable individuals representing Alberta Health and Wellness and the Alberta Medical Association should be struck immediately to review and recommend changes to the rules. The Commission identified a set of principles to guide this review. This "rules committee" should report to the Maintenance and Update Committee.

*A key recommendation of the Commission is acceptance of the RVG 2000.*

- A new case management code should be introduced to recognize a physician's role and responsibility as a multi-disciplinary case manager for patients with complex therapeutic or rehabilitation needs.
- A review should be done of codes with a mix of professional and technical/overhead components.
- Further research should be undertaken in a number of areas identified by the Commission including physician work, visit and consult study enhancements, services provided in the academic/tertiary environment, increased range of visit and consult codes, and anesthesia intra-sectional RVs.
- An audit system should be implemented to ensure appropriate use of codes.
- Reimbursement of practice expense costs should be based on applying a practice expense multiplier for each unit of service, by section. A methodology should be developed to make adjustments over time. Changing practice expenses should be examined annually or at some predetermined period and should be dealt with separately in negotiations between Alberta Health and Wellness and the Alberta Medical Association.

*Any assessment of the relative values of physician services should be considered "a work in progress."*

## An ongoing work in progress

Members of the Commission and its staff, section advisors and individual physicians invested considerable time and energy in developing a new RVG 2000. It is essential that this work continue. Any assessment of the relative values of physician services should be considered "a work in progress." Physician practices change. Technology and medical techniques change. The relative value of services must also change to maintain a fair system of compensating physicians for what they do.

The Commission's recommendations provide a solid base for moving forward with implementation and ongoing maintenance. We encourage both Alberta Health and Wellness and the Alberta Medical Association to use this extensive work as a solid base for moving forward and continuing to ensure that the work of Alberta's physicians is valued fairly and appropriately.

# 1. Introduction and Background

Alberta Health and Wellness and the Alberta Medical Association agreed to establish an Alberta Relative Value Guide Commission in 1998 to address long-held concerns by Alberta physicians about fairness and equity within the fee schedule. Establishment of the Commission was outlined in Article 10 of the April 29, 1998 Alberta Health/AMA agreement. The Chair of the Commission was appointed in August 1998 and the first Commission meeting took place in October 1998.

The mandate of the Commission was to “make recommendations to the Minister on an indivisible, implementable and cost neutral Relative Value Guide.”

## 1.1 Commission membership

The following representatives were appointed to the Commission:

Chair:

Dr. John Atkinson, health management consultant of Ontario, appointed as neutral chair by mutual agreement of Alberta Health and Wellness and the AMA

Alberta Health and Wellness representatives:

- Dr. Ron Dyck, Executive Director, Corporate Services Division.
- Dr. Dennis Jirsch, Provincial Medical Care Consultant and practicing surgeon.

Alberta Medical Association representatives:

- Dr. Kabir Jivraj, former AMA president, anesthetist/intensivist and Senior Vice President and Chief Medical Officer of Calgary Regional Health Authority.
- Dr. Gerry Prince, former president Section of General Practice and practising family physician.

A small staff was also established, led by Brian Spooner, Project Manager, and Nancy Rowan, Associate Project Manager.

## **1.2 Principles and objectives**

The Commission's first task was to articulate its principles and objectives.

### **Principles**

- The Commission will act without bias towards any concerned constituent.
- The decision making process for developing an RVG for Alberta physicians will be open and transparent.
- Consultation will be as extensive as is practical to assure an informed Commission.
- The RVG schedule will be indivisible, fair and equitable, and based on sound and defensible principles.
- The RVG schedule will be developed to be updated as circumstances change.

### **Objectives**

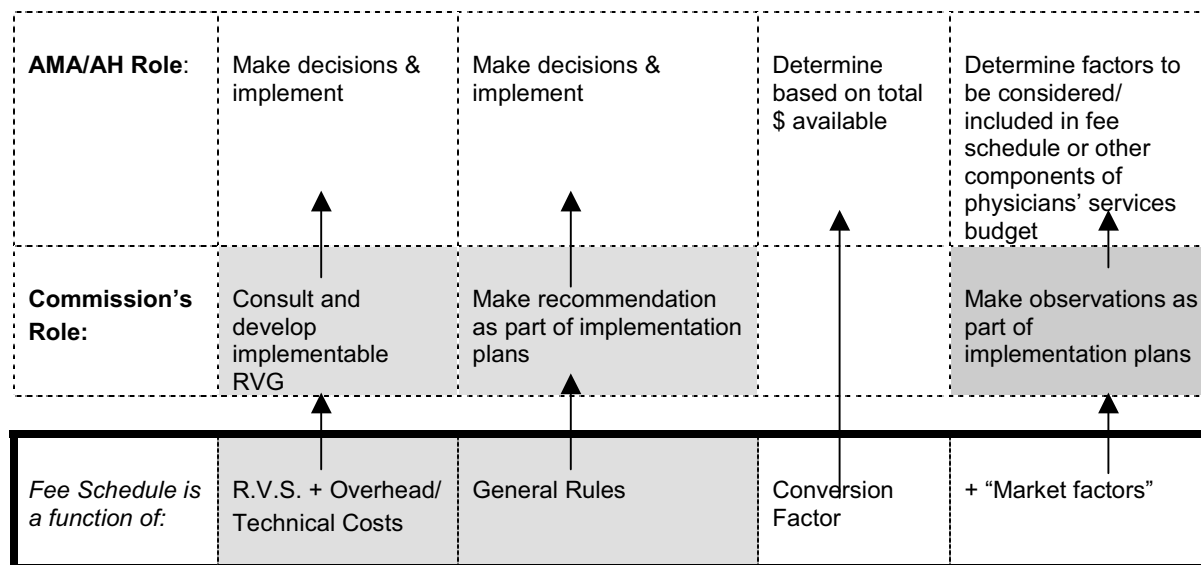
- To develop a relative value guide to serve as the basis for paying for physician services.
- To create an inter-sectional RVG that provides the flexibility for sections to determine their own intra-sectional relativity, subject to cross-sectional checks and balances.
- To consider the impact of the RVG at appropriate stages in its development.
- To ensure appropriate sectional input and feedback.
- To develop a realistic implementation plan.

### **Recommended principles to guide implementation**

- The new RVG should be implemented over a period of time.
- Positive changes should occur faster than negative changes, if any, taking into account the impact on sectional incomes.
- Additional funds will be required to implement the changes.

### 1.3 Clarification of roles and mandate

In response to questions about its role, the Commission developed the following schematic to visually represent the areas for which it was responsible – and areas of responsibility by Alberta Health and Wellness and the AMA.



(shaded areas indicate Commission's area of responsibility)

The Commission sought further clarification of its mandate in July 1999 on behalf of physicians who expressed concern about its meaning and intent. A joint letter from the Minister of Alberta Health and Wellness and the President of the AMA identified the following explanation and commitments:

- "We do not intend to remove funding from any section in order to enhance the funding of other sections."
- "New funding that is derived from negotiations between the AMA and AH&W, but not yet allocated, will be used to achieve relative fee equity among the sections. This includes funding currently agreed to and funding resulting from future negotiations."
- "The relative value of codes within each section will be adjusted based on the input of each section."
- "Implementation of the RVG will be achieved over time, as funding becomes available."
- "The RVG will be kept up to date to reflect changes in technology and practice."

The Commission noted a significant positive change in attitude among the physician community following the release of this commitment and clarification.

## **1.4 Information-gathering and decision-making processes**

The Commission determined from the outset that it would rely on a multi-dimensional approach to gathering the information required to meet its objectives. Following were key points:

- **Involvement of physicians through representation by two section advisors for each AMA section**

All sections were asked in December 1998 to appoint advisors whose role was to advise the Commission on the relative value of medical services, provide feedback regarding the RVG process and facilitate communication between the section and the Commission.

- **Building on existing information, experience and expertise.**

Published and non-published literature was reviewed to learn from both the positive and negative experiences of others. Previous experiences in British Columbia, Alberta, the United States and current experience in Ontario were reviewed. A review of topics such as the mandate, governance, methodology and validating processes influenced the Commission's decisions on structure and process. Meetings and discussions with individuals involved in experiences from other jurisdictions also took place.

Section advisors were the key resource to the Commission; however, other consulting expertise and technical and expert panels augmented the process. (See Attachment A for a list of advisors, staff, expert panels and consultants.)

- **Conducting original research where required.**

When proven methodologies did not exist, or existing methodologies could not be augmented to suit Alberta's needs, the Commission commissioned the original research required to provide the information needed.

While a multi-disciplinary approach was used to obtain information and advice, the Commission made it clear that decisions were the responsibility of the Commission, following consultation with the sections.



## 1.5 Communication strategy

The Commission made a commitment to a communication strategy built on:

- Clear, open two-way communication.
- Use of as many vehicles as possible, with an emphasis on face-to-face communication.

A survey of Alberta physicians by the Commission reinforced the need for ongoing open communication. A majority of the 1600 respondents said that fairness of fees was a critical issue in the profession and that it was important to have an RVG. However, most were not confident that the Commission would complete its task. Communication was identified as a clear priority. Most physicians said it was critical to have a clear understanding of the processes being used.

To respond to physicians' need to be informed, the Commission established a newsletter (*RVG Alberta Update*), a web site ([www.rvgalberta.org](http://www.rvgalberta.org)) and made presentations at AMA forums and other meetings upon invitation. A question-and-answer document was developed and circulated to all physicians.

To maintain two-way communication with section advisors, two group meetings and seven series of meetings with section advisors were held. Individual contact continued through letters, phone, e-mails and meetings. Other audiences including the AMA and Alberta Health and Wellness were identified and regular briefings initiated.

## 1.6 Process

The Commission's approach to its overall process was:

- multi-dimensional in methodology
- continuous and transparent in communication with multiple feedback and validation points
- verified internally and externally through multiple points and mechanisms.

The Commission's work plan set out a strategy for developing components of the RVG. The work plan was modified as understanding of the tasks involved developed. The plan included the following key steps:

- Establishing intra-sectional relative values
- Establishing cross-links toward building the common (inter-sectional) scale
- Building the common scale
- Assessing the impact of patient complexity on the relative value of visits and consults for sections of physicians.

- Identifying overhead and technical fees that will be added to the relative value of a service
- Identifying adjustments to general rules and fee modifiers that are directly related to the relative value of a service
- Modeling and testing the impact of RVG adjustments
- Making recommendations on implementation
- Recommending a system for maintaining the RVG on a continuous basis.

## **1.7 Methodology**

The methodology used by the Alberta Relative Value Guide Commission was developed based on past experiences in Alberta, a review of approaches used in other jurisdictions, and lessons learned both in Canada and the US. It provides an open, fair and technically sound approach.

The following critical success factors were applied to the Commission's methodology as it was developed and honed. The methodology was designed to be:

- Valid and reliable
- Understandable
- Implementable and sustainable
- Supported by a comprehensive communication plan.

Overall, the methodology encompassed the following main bodies of work:

1. Professional relative values for all fee codes (inter-sectional common scale)
2. Practice expense recovery
3. Integrated relative value guide

A description of the key steps involved follows in the next three sections.

## 2. Developing the Common Scale

Development of professional relative values for all fee codes – the inter-sectional common scale – involved several main bodies of work:

- Establishing intra-sectional relative values
- Selecting cross-links to build the common scale
- Refining the relative values of visits and consultations
- Considering other factors
- Building the common scale

These bodies of work are summarized below. Further detail is provided in Appendix B:

- Method for Creation of the Common Scale.
- Sample of survey instruments-cross-links.
- Cross-links used to develop the common scale.
- Correlation coefficient between intra-sectional RVs and RV 2000.
- Overview of Approach and Conclusions for Visits and Consults.
- PCS scores from visit and consult study.
- Procedure for Calculating the Final Common Scale Relative Values (the “RV 2000s”) for Office Visits & Consults – Use of the Patient Complexity Scores (“PCS”).

### 2.1 Intra-sectional relative values

#### A. Assess applicability of previous AMA RVG work

The Alberta Medical Association (AMA) undertook the development of an RVG starting in 1989. While much was accomplished in this time, the process drew to a halt in 1993 prior to its completion. A review was undertaken by the RVG Commission to understand the process and status of previous AMA work subsequently referred to as RVG’93.

With the cooperation of the AMA it was determined that the majority of sections had assessed intra-sectional relative values in full or in part. The Commission made a policy decision to build on the products of the RVG’93 process to both maximize the efforts of the previous initiative and reduce the work required of the sections.

To build on this previous work the following steps were taken:

- Convert the 1993 fee codes to the current health service codes.

- Build an RVG database of intra-sectional relative values using previous RVG '93 work.

### **B. Create intra-sectional relative values**

To capitalize on RVG efforts by the AMA in the late '80s and early '90s, the Commission decided to continue with the methodology for identifying intra-sectional relative values used in that process – “magnitude estimation.” Section advisors were asked to provide RVs to health service codes using a global assessment, which included time and intensity. Intensity was described as a combination of knowledge and judgement, technical skills, communication and interpersonal skills, risk and stress. Sections also were asked to unbundle visits and consultations from major procedures, to bring greater accuracy and equity and to allow for greater flexibility in the future. The RVs assigned were to be representative of the views of the section’s membership. The Commission provided assistance to sections at their request to facilitate the communication process with section members. Support ranged from mass mailings to organization of and assistance at meetings.

During this process, many sections expressed a desire to add or delete service codes so their intra-sectional RVs would more closely reflect the work they do. The Commission suggested sections include new/deleted codes and committed to outline lists of the new/deleted codes in the final report.

#### **Steps in the process included:**

- Established a database of sectional “benchmark codes” representing 85% of the dollars billed and 85% of the total units of services provided by the section.
- Section advisors assigned an RV to all benchmark codes.
- Met with sections on a one-to-one basis to discuss the first draft of RVs.
- Facilitated sectional completion of remaining unvalued codes by assigning estimated RVs based on the benchmark values (regression analysis).
- Met with sections following second draft of intra-sectional RVs to discuss issues and anomalies.
- Sections completed a third draft of their intra-sectional relative values for all codes followed by another series of Commission/sectional meetings.
- Sections assigned RVs to new or updated services for which there was not an appropriate code.
- Sections signed off on their intra-sectional RVs.

## Results

- Statistical analysis of the first drafts of the intra-sectional RVs indicated that, overall, sections felt there should be a change in their intra-sectional relativity of about 20%; that is, 80% of the health service codes would maintain their current relativity while the remaining 20% needed to go up or down.
- 25 of 29 sections actively participated throughout the process and achieved sectional support for their intra-sectional RVs.
- 4 sections had limited or no involvement in assigning intra-sectional RVs:
- 1 section chose not to participate at all.
- 2 sections chose to have partial involvement.
- 1 section asked the Commission to assign intra-sectional RVs based on the relative value equivalent of the current fee schedule.
- The Commission assigned intra-sectional RVs for non-participating sections based on RVG'93 relative values where available or straight conversion of current fee schedule relativities if RVG'93 values were unavailable.
- Most sections provided lists of recommended new codes or deletions.
- Some mixed professional/technical codes presented a challenge; see Part 5: Direct cost recovery.
- A list of new/deleted codes provided by sections is included in this report.

## Questions and Answers

**Q.** Is the “magnitude estimation” methodology of assigning time and intensity statically reliable?

**A.** Yes. Previous research done both by the Harvard research team and the Ontario Resource Based Relative Value of Services Commission demonstrated that physicians are good evaluators of physician services. Although there is some evidence of overvaluation of some services within a section, the Alberta RVG Commission’s methodology mitigates any effect that this bias may have.

**Q.** Does this methodology mean that sections were determining the values of their services relative to other sections?

**A.** No. Each section was responsible for determining the relative values of only the codes used within their own section. An arms-length method was used for integrating the 29 intra-sectional scales into a common scale. This process is described later under the heading of Cross-links.

**Q.** The Harvard study in the United States determined intra-sectional relative values through a physician survey process, whereas the RVG Commission relied on evaluations from the sections led by section advisors. Does this not add bias to the process?

**A.** No. The RVG Commission's process allowed for a larger sample which increases the validity of the results. Most section advisors invited input into the intra-sectional RVs by their entire membership.

## **2.2 Cross-links to build the common scale**

Sections' lists of relative values were integrated into a common scale using cross-links that determine "exchange rates" among the various scales used by different sections. The process for identifying cross-links included significant physician input. However, checks and balances were incorporated into the process to ensure validity. The Commission goal was to identify a minimum of eight cross-links per section within a range that spanned the majority of each section's services.

Cross-links could be either natural or derived or both.

A natural cross-link is a service that is billed by more than one section.

A derived cross-link involves two distinct services, performed by different sections, that are considered to involve similar time and intensity.

### **A. Determine cross-links**

A multi-step process with several checks and balances was used to determine cross-links.

#### **Steps in this process included:**

1. Identifying a pool of potential natural and derived cross-links that could be tested through a survey of Alberta physicians.
  - More than 1000 Alberta health service codes were identified as natural cross-links.
  - Potential derived cross-links were identified primarily from the Harvard research that led to development of the RVG in the United States.
  - Natural and derived cross-link codes were organized into a series of 35 survey instruments broken down by specialty and subspecialty.
2. Surveying section representatives to determine the validity of cross-links by rating the degree of similarity on a five-point scale.

- Sections were asked to submit the names of 10 section expert members, with a broad base of practice and knowledge, who could determine the similarity of services between their own and other sections.
3. Surveying an independent panel of experts to assess the degree of congruence with section responses.
- The Commission appointed a cross-sectional panel of experts, independent from the sections, to complete the cross-link survey. This 26-member cross-sectional panel included broad representation with regard to location, type of practice and range of experience. The function of this panel was to mitigate any bias that might arise from reliance solely on sectional representatives. Members of the panel are listed in Attachment A.

### **Results**

- Survey results were analyzed by the Population Research Lab at the University of Alberta under the direction and guidance of Dr. Mike Gillespie. A database of “potentially good” cross-links was established of services that scored 3.5 or greater on a five-point scale by both of the paired specialties and the cross-sectional panel.
- A better than 80% response rate to the survey was achieved by both the section representatives and cross-sectional panel.
- 779 potentially good cross-links were identified.
- Some sections had more than 100 links (much greater than the required eight).
- Very few derived cross-links survived the screening criteria.

### **B. Validate cross-links**

The cross-link pool was tested and refined as necessary to ensure that potential cross-links were comprehensive and met the common sense test. Low service volumes by a given section was not considered a good reason for eliminating a cross-link.

### **Steps in this process included:**

1. Submitting proposed cross-links to all section advisors for review and comment:
  - At a section’s request, the Commission facilitated a mailing to selected section members or the entire membership for a broader review of the potentially good cross-links.
  - Face-to-face meetings were held with section representatives to address any concerns.

- The Commission removed a handful of cross-links from the database where there was significant doubt about the similarity and comparability of services.
- Codes were deleted if a section indicated that the code was not relevant and chose not to give a relative value.

2. Screening the database to identify and remove potentially problematic codes:

- Technical codes were removed. These procedures, often done by a nurse or other health professional under physician supervision, did not make good professional cross-links.
- Cross-links were removed if there were three or less between two sections, because a minimum of three cross-links enhances the reliability of a correlation between sections.
- Extreme outliers were removed because they may potentially bias the linking process. Extreme outliers arise when the two sections have ranked the cross-link very differently within their intra-sectional relative values.
- Several codes were removed because sections felt they did not represent the same service.
- Several codes were removed because a section did not give an RV to the service.
- 1 cross-link (normal delivery) was added between two sections that failed to meet the score of 3.5 by all three involved sections.

3. Analyzing cross-links to determine if the range of cross-links covered a significant range of RVs within the section.

4. Conducting a correlation analysis to determine the degree of agreement among sections about the relative position of cross-links on the common scale.

### **Results**

- There was a significant level of agreement on the relative position of cross-links on the common scale – a correlation of .85.
- From the sectional and expert panel surveying process alone the validated cross-links captured 80-99% of the range of RVs for 26 sections.
- For two sections whose identified cross-links were either insufficient in number or did not capture the mainstream of their work, cross-links were augmented using data from the Visit and Consult Study.
- 633 of the 779 cross-links codes remained after the audit process.
- The common scale was built using the 633 cross-links (see list in Appendix B).



## Questions and Answers

- Q.** Would a randomized, controlled survey not have been superior methodology for assessing cross-links?
- A.** The Commission's survey process collected expert opinion from a wide range of physicians about the similarity of a service. The cross-sectional panel offered the checks and balances needed to assure the Commission of the validity of the result.
- Q.** Why was a value of 3.5 or greater established as representing a good cross-link?
- A.** A minimum of 3.5 was a policy decision of the Commission because it represented a level of agreement that was considered somewhat greater than "similar" – an adequate level in the Commission's view.
- Q.** Did removal of outliers affect the validity of the cross-linking process?
- A.** No. Removal of outliers is a commonly used statistical technique used to improve the validity of results.
- Q.** Were there enough cross-links to develop reliable exchange rates?
- A.** More than enough. The number of cross-links identified exceeded the Commission's goal threefold.
- Q.** Some sections had more than 100 cross-links while some had less than 10. Does this mean that some sections' exchange rates may not be as sound?
- A.** Only eight cross-links were required per section. Sections with the greatest numbers of cross-links were linked with a larger number of sections. These links with multiple sections simply added strength to the entire process because, by using this methodology, all sections are ultimately linked to each other.

## 2.3 Visits and consultations

There are currently two types of visit and consult codes within the Alberta Schedule of Medical Benefits:

- Those codes for which the service provided and amount of physician resource involved is the same for all physicians. The same fee therefore applies for all types of physicians.
- Those codes for which the general nature of the service provided is similar across specialties, but where significant differences exist in the amount of physician resource involved. Different fees therefore apply for different specialties, all using the same fee code.

In many cases, differences in fees for the second category of visit/consult codes have evolved over the years with little common understanding remaining of how the differences developed or whether they accurately reflect differences in physician work effort or patient complexity.

From the inception of the Commission, physicians from all specialties expressed concerns regarding the ability of both themselves and their colleagues to accurately assign relative values to visit and consult codes. The issue was of importance to general/family practitioners and specialists alike because of the high volume of services involved. Visits and consultations account for approximately 50% of services rendered, even by the surgical specialties.

#### **A. Ensure consistent basic approach for procedures and visits/consults**

The Commission used the same basic approach – intra-sectional RVs determined by magnitude estimation – to establish the relative values of procedures and visits/consults and then to convert the intra-sectional values into the common scale using more than 600 cross-links. This method ensured the relativity between procedures and visits/consults was maintained.

A second step was needed to further refine the relative values for visit/consults that have significant differences in the physician resource involved, for example 03.03A, 03.04A and 03.08A. The rationale for this was:

- Unlike procedures that are fundamentally discrete and definable, visits and consults are a set of activities performed by all physicians that include a large and diverse array of services. Sections feared that valuing these codes may be more subjective and that historical bias may be introduced. In addition, although visits and consults account for almost half of services billed, they have only a handful of billing codes compared to procedures. The Commission recognized that, to achieve an acceptable set of relative values for visits and consults, further work would be required to understand and measure physician effort in this area.
- The Commission believed there was a causal relationship between patient complexity (what the patient brings to the equation) and physician input or work (what the physician brings to the equation).

#### **B. Study patient complexity scores as indication of physician work**

Dr. Earle Snider of the University of Alberta was retained to conduct research to assist the Commission in more accurately understanding the relative value of visits and consults. Building on previous research conducted for the Sections of General Practice and Rural Medicine, a research project was designed to evaluate differing levels of

patient complexity and identify the factors that contributed to patient complexity. The Commission made a policy decision to use patient complexity as a surrogate for differences in physician work. (See Appendix B for further comments on the Visit and Consult study).

### **Steps in the process included:**

- Conducting a pre-test to determine if the patient complexity grid (developed in the previous research mentioned above) could be applied to specialists.
- Following favorable pre-test results, conducting a broader study to determine
  - a) if patient complexity scores could be used to differentiate physician work
  - b) the impact of variables such as time spent, age, sex, primary and secondary diagnosis
- Selecting a systematic and generalizable sample of 294 physicians across 29 specialties.
- Engaging those physicians in documenting their experiences with visits and consults according to a set of variables over a specified time period.
- Documenting the research findings.

### **Results**

- 271 physicians participated in the survey generating a database of 20,000 patient contacts.
- Three sections chose not to participate—Dermatology, Otolaryngology and Ophthalmology.
- The study confirmed that differences in patient complexity levels could be systematically measured across sections.
- Close to four-fifths of the 38% explainable variance in patient complexity was accounted for by the following variables:
  - a) Total physician time related to patient need (as represented by number of medical service categories and written/oral communications)
  - b) In-patient hospital status
  - c) Number of secondary diagnosis

- Two different patient complexity scores were identified for each participating section. One score consisted of the complexity of patients seen in the office or outpatient clinic. A second score was identified for the complexity of each section's in-patients. There was insufficient data to determine a patient complexity score for each code per section.

### **C. Adjusting common scale RVs using patient complexity scores**

The patient complexity scores (PCS) resulting from the Alberta Office Visit and Consult Patient Complexity Study were used as the form of external assessment needed to finalize RVs for visit and consult codes that involve different services for different sections. The Commission decided to develop the RV 2000 for each section by adjusting upwards or downwards in proportion to its PCS from the median of RVs established through the standard process.

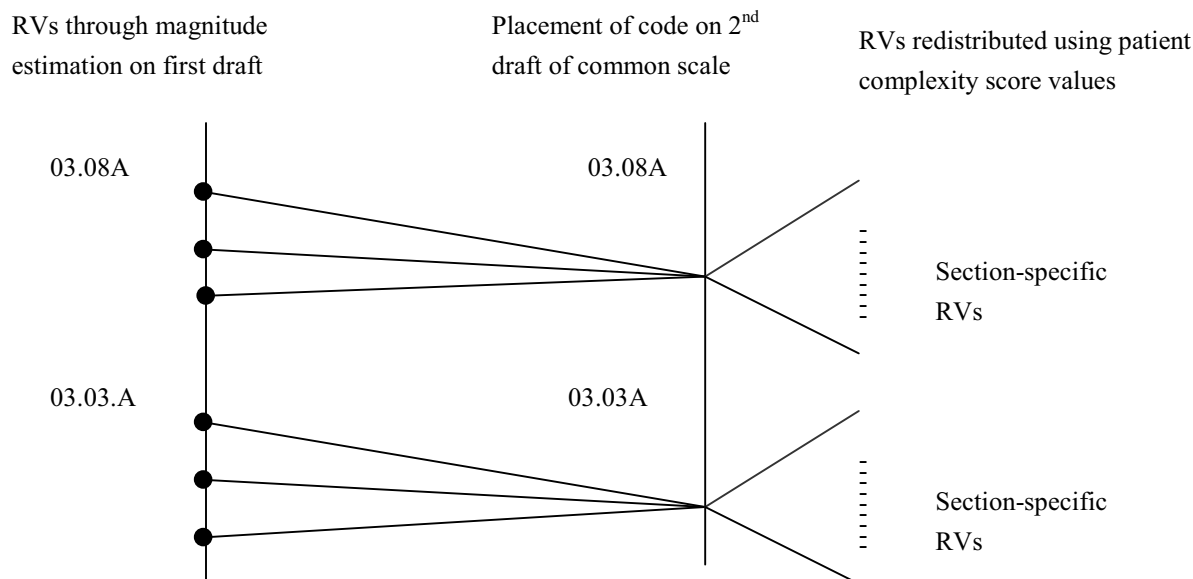
The rationale underlying this decision was:

- Although not a direct measure of physician resource, the PCS was believed to be the best available measure of the relative amounts of physician resource required to perform office visits and consults. The Commission believed that the higher the average PCS score, the more physician resource, on average, is required to perform office visits and consults.
- Given that no better or conflicting information was available, the Commission established the relation between physician resource and PCS as linear, in that a section with a PCS of 4 would expend roughly twice the amount of physician resource as a section with a PCS of 2.

#### **Steps in the process for both in-patient and out-patient/office settings included:**

- Converting the intra-sectional RV assigned by each section onto the common scale.
- Calculating the median of the converted RVs of all sections to define the general location of the code on the common scale.
- Establishing a modifying factor for each section, from the PCS value.
- Establishing an initial RV 2000 for each section by multiplying the median of the intra-sectional RVs by each section's modifying factor.
- Grouping sections according to the similarity of their PCS scores (because differences were not statistically significant) and averaging the group's initial RV 2000s to establish the final RV for each section within a group.

## Development of RVs using patient complexity score



### Results

- RVs for each visit and consultation code were established using a consistent methodology.
- Patient complexity scores were used to refine the RVs for those common visit and consult codes that involve different services for different sections.

## Questions and Answers

**Q.** Is physician time a surrogate for patient complexity?

**A.** No Time is a function of physician work associated with patient complexity. The work associated with patient need (as reflected by number of medical service categories and written/oral communications), not time spent, is the more accurate measure.

**Q.** Time does not appear to be sufficiently recognized in some RVs. Does the patient complexity data accurately reflect time differences among the sections?

**A.** Time is among the factors that the study found most reflects patient complexity – but time alone is not an equivalent for patient complexity. Rather, the study found

that physician effort – the physician time on a patient’s behalf that reflects number of medical service categories investigated and oral/written communication requirements – is one of three variables most affecting patient complexity. The other two are hospitalized in-patient status, and number of secondary diagnoses. The Commission recommended ‘time release’ options for some visit and consult codes when the time required to provide the service is significantly more than average as determined by the data. In addition, the Commission recommended a case management code be introduced to recognize physician effort required to coordinate patient care, even if a face-to-face encounter is not required. (See Recommendations).

**Q.** Why weren’t the RVs for procedures handled in the same way as visits and consults?

**A.** The process for assigning intra-sectional RVs and their conversion into the common scale was the same. Intra-sectional scales were drafted using a methodology called “magnitude estimation.” Sections placed their codes on their intra-sectional scales relative to one another using an integrated assessment of time and intensity. Intra-sectional scales were combined into a common scale using exchange rates derived through the cross-links. For more than 85% of the codes, sections agreed on the relative placement of codes on the common scale.

Codes that were disparate were reconciled using two methodologies. RVs for procedures were weighted in the common scale, giving proportionate recognition for volume of service. The Commission used a different methodology for resolving differences in visit and consult codes, because the visit/consult study showed that the same services were not provided under the same codes. RVs for visits and consults were adjusted based on section-specific patient complexity scores. In addition, the visit/consult study enabled the Commission to recognize the increased complexity of in-patients and augment the schedule by assigning a specific RV for major in-patient visit and consult codes where none currently exist.

The Commission recognized the need for further work for both visits and consults and procedures. Specifically, the Commission believed a system to help review recommendations for revised RVs or new codes would be helpful. Such a system could include but not be limited to establishing benchmark codes -- a small number of codes that reflect the range of complexities within their medical area -- against which recommended changes could be evaluated.

## 2.4 Other factors considered

Some specialists asked the Commission to include a factor for lost income associated with additional training. The Commission considered this issue and felt that other factors mitigated the financial burden of post-basic training.

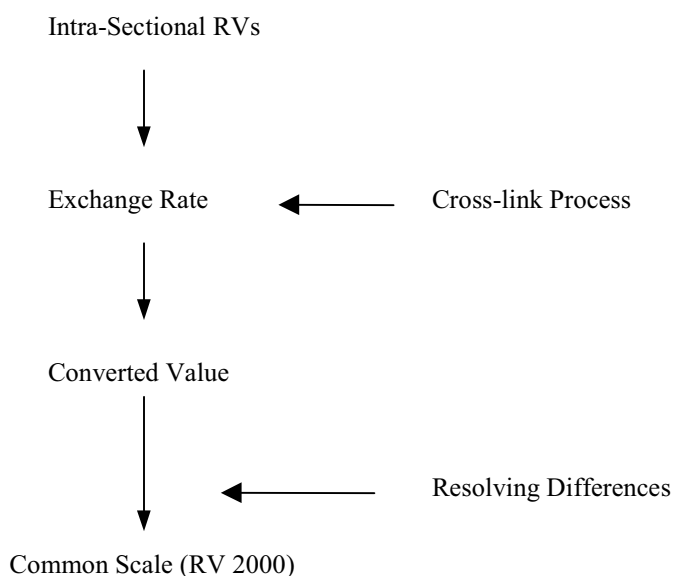
Compensation for specialist training is implicit in a fee-for-service compensation system based on relative values. The knowledge and skill required to perform a service is included in a determination of intensity. Thus, services requiring advanced knowledge and skills have a higher relative value. Physicians treating patients that require specialized training are in fact already compensated through the RVG.

In addition, residents now earn a substantial income during their residency years that helps offsets lost income they may otherwise have earned if they had entered practice as a general practitioner.

## 2.5 The Common Scale – how it came together

Determining the relative value for all professional services was accomplished by combining the relative values for each section's service codes (intra-sectional RVs) into a common scale.

The process is graphically represented as follows:



### A. Combine sectional lists using cross-links

As noted earlier, each section used its own scale in establishing relative values. For example one section may have used a scale with values from 500-5000 and another section from 1000-35,000. If we used monetary currency as an analogy, we could say that one section expressed its values in yen, another in marks and another in dollars.

To develop a Relative Value Guide, all RVs needed to be brought together on the same scale. To bring them together, exchange rates needed to be found between sections' currencies (for example, one yen equals 1.2 marks, one mark equals 0.9 dollars etc.) As previously outlined, the exchange rates were identified through the use of cross-links; the cross-links established the common denominators through which exchange rates were established.



## **B. Reconcile differences**

The first draft of the common scale reflected a high level of agreement (a correlation of .86) as to the relative position of health service codes. That means 86% of the time sections agreed on the respective relativity of a given service. Systematic reconciliation of differences then took place. Once these differences were reconciled, the common scale was subject to an audit to check and validate the results.

Two methodologies were used to reconcile differences on the common scale: weighting for procedures and the visit/consult study for visits and consultations.

**Weighting.** Where there were differences involving procedures performed more than 10 times a year, adjustments were made using a weighting methodology. The Commission established this as a policy decision to represent the most fair and reasonable way of resolving differences. The RV was adjusted with a proportionate weighting based on the number of services performed by each section. For example, if section 1 rated a service at 2500 RVs and provided 70% of the services, and section 2 rated the same service at 3400 RVs and provided 30% of the services, the final RV was established by combining 70% of section 1's RV with 30% of section 2's RV.

Accurate identification of physicians by specialty was required to ensure an accurate determination of the number of services performed by specialty. Because the existing Alberta databases were not accurate or adequate, the Commission developed a new comprehensive database as part of this work.

**Visit/Consult Study.** Differences in opinion within visits and consultations were resolved using the patient complexity score values determined through the research on visits and consults. The Commission believed that combining the two different methodologies (magnitude estimation by sections and the Visit/Consult Study) would produce the most accurate result. The Commission also recognized that visit and consult service codes often represented different work for different sections.

Determining a specific RV for each section or group of sections was achieved in the following manner. The median of the RVs assigned to a given code was adjusted by the patient complexity score for each section – resulting in a specific value for each section or group of sections. Since the visit/consult study demonstrated an increased patient complexity for hospitalized patients, a hospital factor was applied to consultation codes. For example, a major consultation done in an office has one RV while a major consultation done in hospital has an increased RV.

### **C. Consider need for increased range**

Some sections suggested more visit/consult codes were needed to cover the range of time and complexity in physician work. Based on the results of the Visit and Consult Study, the Commission concluded that the 03.03A code included a broad range of patient complexities.

Results of the study showed that 20 per cent of current 03.03A billings were complex enough to justifiably move into the 03.04A code. The Commission believed change should be made in the description and rules to better reflect the actual work done in 03.04A. The study results provided a general description for the patient population within the two codes (see Results next page). Rather than adding new codes, the Commission concluded the 03.03A and 03.04A must work on tandem and should be expanded. The Commission believes the 03.03A and 03.04A should have new definitions based on the patient population descriptions; this would be best handled during the implementation phase. In addition, rather than adding other new codes, the Commission saw the benefit of a time release clause for certain codes. This resulted from input from section advisors about the lack of equitable compensation for longer visits/consults with more complex patients.

#### **Steps in developing the common scale included:**

- Using cross-links to determine an exchange rate for each section's list of RVs (intra-sectional RVs).
- Using the exchange rates to create the first draft of the common scale.
- Applying a weighting methodology to reconcile different sections' opinions in RVs among procedures.
- Developing a database to aid in weighting methodology, including validation of specialty affiliation to determine number of services performed.
- Adjusting visit/consult RVs (where different services are provided by different sections) using patient complexity score values.
- Creating new RVs for visits and consultations done in hospital.
- Auditing the second draft of the common scale to identify anomalies.
- Making additional adjustments to encompass the range of time and complexity involved in physician work.
- Consulting with sections regarding the draft common scale.
- Finalizing the relative value scale for professional services.

## Results

- Each procedure was assigned a single RV that would apply to all sections providing the service.
  - In continued recognition of the differences in service provided by sections for some common visit/consult codes, different RVs were established for each section.
  - When the differences in visit/consult RVs between sections were not statistically relevant, sections were grouped and the same RV was applied to the group.
  - Additional patient complexity for hospitalized in-patients was recognized through adjusting RVs for in-patients.
- 
- A common relative value scale was established for all professional services in the current fee schedule.
  - The Commission recommended some significant adjustments to the visit/consult payment system, above and beyond the RVs established through development of the common scale.
- 
- **Descriptions:** The Commission described the most-used visit codes 03.03A and 03.04A to illustrate the difference between them. 03.04A was described to accommodate the “complex patient.” The descriptions are:
    - 03.03A Limited Visit
      - The average patient has a chief complaint of low severity, straightforward decision-making, has 2 or fewer secondary diagnosis and takes an average of 10 minutes including related communications and recording.
    - 03.04A Comprehensive Visit
      - The average patient has a chief complaint of moderate to high severity, has 3 or more secondary diagnosis, and moderate to complex decision-making and takes an average time of 20 minutes including related communications and recording.
  - **Time release.** The Commission recommended a time release clause on the two major visit and consult codes (03.04A and 03.08A). The TLC would activate at half of the mean length of time for each code, and at an equivalent to 75% of the RV for the same time unit. (i.e. relative value for the code ÷ 2 x 75%)

## Questions and Answers

- Q.** What happens if a section feels a code is not correctly valued?
- A.** An appeal process is recommended as part of the implementation process.

- Q.** Once the relative values are finalized is there any process to update the codes as technology and services change?
- A.** The Commission is recommending a continuing maintenance and appeal process.
- Q.** What is happening with new codes?
- A.** The Commission used the existing fee schedule as the base line for developing the new RVG. However, the Commission recognized from its initial meetings that many sections had suggestions for additions or deletions to make the schedule more relevant to today's practices. Sections provided lists of suggested additions or deletions and these suggestions are included in Appendix A (Deletions, Revisions and New Codes as Requested by Sections). The Commission is recommending that they be assessed and, where appropriate, added to the Schedule of Medical Benefits.
- Q.** Some sections have noted that some RVs don't "look right" when compared to what they believe are services of similar time and intensity. What is the Commission doing about them?
- A.** In their final review of the common scale, sections noted that the RVs for 40-50 or 1-2% of the (+/-) 3500 health service codes need adjustment. The Commission believes that the methodology used improves the SOMB significantly toward equity. However, continued refinement and development are both necessary and desirable. The Commission recommends that the next step in a refinement process is to assess groups of similar services against benchmark codes and to normalize the RVs as required.

## 3. Assessing Practice Expense Recovery

The development of a method for practice expense recovery was an integral component of the responsibilities of the RVG Commission. This work involved extensive use of consultants and input/feedback from section advisors for the following steps: establishing principles, setting a work plan, developing model office profiles, setting indirect practice expense recovery and setting direct cost recovery.

Further detail is provided in Appendices B (Practice Expense Recovery):

- Development of practice expense (OH) multipliers .
- Addendum to the study of physician practice expenses.

Interim Report No. 2:

- Study of Physician Practice Expenses, Arthur Andersen, October 10, 2000.
- Practice Cost Recovery in Resource-Based Relative Value Guides: Lessons from Canada, the United States and Australia, November 1999.
- Framework for the Recovery of Overhead Costs, January 2000.

### 3.1 Background

#### A. Principles of practice expense recovery

The Commission established six principles to guide the methodology for establishing practice expense recovery fees.

1. The framework for the recovery of overhead should not create economic incentives or disincentives around medical decision-making.
2. The costs of providing a service will be separately determined from the professional component of the service.
3. The cost or market value of physician time is not within the mandate of the RVG Commission.
4. Overhead cost recovery will be based on the concept of the “reasonably efficient practice” – on an efficient service volume and the efficient use of inputs, including both capital and labour.

5. Direct costing will be required where the costs are not homogenous over a set volume of services and where they are not included within the costs assigned to the reasonably efficient practice.
6. Where the typical physician supports the cost of an office, many costs continue whether the physician is continuously on site or not, and should be recoverable.

## **B. Practice expense recovery in the fee schedule**

The Commission determined that the basic structure for cost recovery in the RVG would be similar to that in place in the current Schedule of Medical Benefits. Cost recovery should occur in different ways for the two types of costs:

**Indirect costs**, i.e. those not tied to the provision of specific services, should be paid through one of the following means:

A general overhead recovery amount attached to each service

Reimbursement programs; e.g. the Medical Liability Reimbursement Program and the Continuing Medical Education Program.

**Direct costs**, i.e. those related to the provision of specific services, should be handled through the use of technical and tray fees.

Technical fees are usually associated with equipment, though they also are used to capture specialized labour and supplies that are not included in general overhead.

Tray fees are usually associated with consumables used during office procedures.

## **3.2 Work Plan**

A multi-step work plan for development of practice expense recovery included the following steps:

- Establishing a database that contains individual physician practice profiles and grouping the individual data into primary and secondary specialties.
- Hiring an accounting firm to help build model office templates and to conduct an interview-based survey of overhead costs, using a systematic sampling of physicians from within the database.
- Building model office profiles.
- Assessing current tray fee and technical fee structure for appropriateness.

- Reviewing proposed model offices and other costs with each section.
- Incorporating overall results into the framework for recovery of overhead costs.
- Establishing a practice expense (OH) modifier for each section that would be applied directly to the RV of any code for reimbursing its OH component.

### **3.3 Model office profiles**

The Commission contracted with the consulting firm Arthur Andersen to conduct an overhead survey for all sections except radiology. Their report, Study of Physician Practice Expenses, served as the primary source of information on physician overhead costs and model office profiles. A model office was comprised of one or more sections with similar overhead structures both with respect to total costs and to the underlying use of non-physician resources.

The survey was intended to model the expenses of the “reasonably efficient practice.” Certain other costs were reflected in the technical or tray fees.

A separate study of expenses for radiology practices was undertaken by a consultant for the section. Arthur Andersen ensured the same principles and methods for measuring and reflecting practice costs were applied and validated the results.

#### **Steps in the process included:**

- Determining the section target populations. The target populations were defined as physicians who received payment from Alberta Health and Wellness in each of the eight quarters beginning in 1998, and whose payments placed them in neither the extreme high end or low end of the payment range.
- Selecting a physician sample from the sectional target population.
- Surveying the sample by print questionnaire and in-person interview. Specific steps were taken to ensure physician confidentiality and ensure reasonable participation rates were obtained.
- Development of model offices through the following method:
  - Cluster analysis used to suggest groupings on a statistical basis
  - Suggested groupings reviewed from a medical practice perspective by the Commission
  - Groupings for non-participating sections suggested by Commission, given data from external sources.
  - Model office expenses determined based on groupings.

### 3.4 Indirect practice expense recovery

Using the model office profiles as a starting point, Arthur Andersen conducted other research and calculations as part of the recovery of indirect practice expenses.

#### Steps in the process included:

- Subtracting total tray and technical fees (direct costs) from the total model office practice expenses – resulting in total indirect model office expenses.
- Averaging indirect expenses for each model office.
- Separating the average indirect expenses into fixed and variable expenses.
- Adjusting the average variable expenses to reflect the average AH&W payments received by each section.
- Calculating each section's average indirect expenses by adding section-specific average variable expenses to the model office fixed expenses.
- Calculating the number of full time equivalent (FTE) physicians for each section.
- Calculating total indirect expenses for each section by multiplying the FTEs by the section's average indirect expenses.
- Adjusting total indirect expenses for each section to 2000 dollars.
- Calculating a practice expense multiplier for each section, based on total indirect expenses and the section's total RV units.

The Commission reviewed these steps and estimated results with section advisors throughout the process to obtain feedback and ensure accuracy.

#### Results

- Data was obtained from representatives of 24 sections
- Model office physician practice expenses were established for seven groupings of sections.
- Total and inflation adjusted total indirect expenses were calculated for each section.
- A practice expense multiplier was calculated for each section.

### 3.5 Direct cost recovery

The Commission's methodology recognized that direct costs related to the provision of specific services would be recovered through technical and tray fees. During its



process, the Commission recognized the need for codes with a mix of professional and technical/overhead components to be reviewed. Definitions and the set of services that are encompassed by a given code also needed to be clarified.

**Steps in the process for handling technical codes included:**

- Developing the RVG using current codes within the schedule of benefits, accepting the inconsistencies in the short-term.
- Where the RVG process has identified an irreconcilable dispute in assigning an RV within or between sections, i.e., skin testing, the Commission recommended maintaining the price relationship as it exists in the current fee schedule.
- Highlighting potentially problematic fee codes and recommending that these be addressed as part of the implementation process. Further data will need to be collected on technical tray fees and overhead costs associated with these services.
- Developing a set of principles that would govern subsequent review of mixed professional and technical/overhead codes (such as skin tests, PFT, EMGs).

**Results**

- The Commission established principles to guide the review of mixed professional/technical codes. These principles are as follows:

A. Professional RVs are established when the physician directly performs and/or supervises the test

- If the physician administers the test, then this is a professional service and an RV should be determined for this service.
- If the physician monitors and supervises the test, then this is a professional service and should have an RV.
- Tests administered by a physician should have a greater relative value than those administered by a nurse or technician.

B. Pure overhead costs are captured within the overhead component of the RVG

- The cost of the test materials and equipment, and the cost of emergency equipment or supplies that must be on hand as a result of the test, form part of overhead costs and are recovered as such. This would include drugs and equipment (IV, resuscitation) to treat anaphylaxis.
- If a technician performs the test this forms part of the overhead costs.
- Malpractice risk associated with the test is part of the overhead reimbursement package.

## **Questions and Answers**

**Q.** How confident is the Commission that sampling for overhead was adequate?

**A.** Although the Commission would have hoped for higher participation in the Arthur Andersen study of practice expenses, the consultants assure the Commission that the sample was adequate. The Commission's expense recovery methodology is based on model offices, not direct recovery of actual expenses which permits greater elasticity in the data. Participants were pre-selected to be full-time equivalents and reflect busy practices; results were adjusted to reflect the reasonably efficient practice so that overhead costs can be recouped over a reasonable workweek.

## 4. Developing an Integrated RVG

The final step in developing the RVG 2000 was to bring together the physician (human) resource and practice expense components into an integrated guide. The Commission also recognized throughout its process that the General Rules played a significant role in the integrated final RVG.

### 4.1 Relative value multipliers

Bringing the two parts of the RVG together was accomplished through development of relative value multipliers – one for the human resource (HR) component and one for the practice expense (OH) component. The RV multipliers are used with the common scale, and are applied directly to the RV of any code to determine its HR and OH dollar value. The HR multiplier was calculated based on 1999 fees and including the assumption that no section would lose income as a result of the RVG.

Dr. Edward Mansfield of Arthur Andersen conducted this work.

#### Steps in the process included:

- Calculating the total relative value units for each section, based on RVs that would have been generated by services billed in 1999-00 under the RVG and including the estimated effects of unbundling and rule changes.
- Determining the human resource (HR) multiplier for all sections by dividing the total dollars available for human resource by the total RV units generated by all sections.
- Determining the practice expense (OH) multiplier for each section by dividing the total RV units for that section by the total indirect practice expenses (inflated) for that section.
- Applying the shift differential multipliers to the HR components of codes 03.03K,L,M and 03.05D,E,N,P,Q,R,S.

#### Results

- A human resource (HR) multiplier was determined that applied to all sections.
- A practice expense (OH) multiplier was determined for each section.
- A shift differential multiplier was applied.
- The multipliers allow full use of the common scale as an integrated RVG.

## Questions and Answers

- Q.** Why do sections that are included in one model office grouping have different human resource and overhead multipliers?
- A.** Each section's multipliers were calculated according to the practice experience (including numbers of physicians and numbers of services provided) of that section. Although the average medical practice expenses were the same for each section within a group, other data used in the calculation of multipliers differed for each section:
- Total indirect expenses (based on number of physicians and services)
  - Inflated total indirect expenses
  - Total relative value units

Regardless of the OH multiplier, the dollar value of the expense recovery for all physicians within a model office grouping should be the same over the course of a year.

## 4.2 General rules

The Relative Value Guide Commission recognized the important relationship of the General Rules to its work on developing an RVG because of the rules' impact on the Schedule of Medical Benefits. Although a detailed review of the General Rules was far beyond its mandate, the Commission concluded that an in-depth review of the General Rules should be done during the RVG implementation process.

To promote fairness and equity between sections, the Commission articulated principles to govern a review of the General Rules.

At the outset of the RVG process, the Commission made a policy decision that had an overarching impact on the General Rules and RVs. The Commission established the policy of "unbundling" visits and consultations from major procedures to bring greater accuracy and equity and allow for greater flexibility in the future. This decision was intended to encompass visits and consults related to pre-operative and post-operative periods as listed in section 6.8.1 of the General Rules, May 1999. In addition, a few specific rule changes are included among the Commission's recommendations.

## **Results**

- Specific changes were recommended for visit/consult code 03.04A and two M+ codes (9822A and 3301A). See Recommendations.
- Principles were articulated to govern a review of General Rules.
  1. Rules should be kept to a minimum:
  2. Interpretation or limitations on a given code should be outlined in the Schedule of Medical Benefits as opposed to the rules.
  3. A new code(s) may be preferable to a rule.
  4. Visits and consults should be unbundled from identified procedures and valued separately.
  5. The relative value should represent the base value for a service, with modifiers and surcharges added as necessary.
  6. Surcharges and callbacks should be recognized for inconvenience and should be equitable across all sections.
  7. The rules and modifiers should be consistent across sections/or groups of practitioners.
  8. Revision surgery should have a consistent premium across sections.
  9. Discounted values for multiple procedures should be consistent across sections.
  10. Billing irregularities should be managed through an audit process, not by adding new rules.

## **Questions and Answers**

- Q.** How will the review of the General Rules, as recommended by the Commission, impact the end result?
- A.** The Commission believes that a major review and revision of the General Rules, based on the principles it has recommended, will have a significant impact on the implementation of the RVG. In several cases, concerns the Commission heard from section advisors related to the rules rather than the codes themselves. Key among its principles are that rules should be kept to a minimum and that consistency is needed across sections, whether for surcharges and callbacks, rules

and modifiers or such things as revision surgery and discounted values for multiple procedures.

**Q.** How will the RVG be implemented?

- A.** The Alberta Medical Association and Alberta Health and Wellness are responsible for implementation of the RVG, not the Commission. However, the Commission has provided some insights and recommendations relating to the RVG, including development of an appeal process and consideration of a short-term Transition Committee to oversee implementation. Recommendations for updating and maintaining the RVG are also provided. The Commission sees the RVG as a “work in progress.” Many improvements are being made in the RVG 2000, so it is an important beginning to the improvement process.

### **4.3 Market modifiers**

Early in its work, the RVG Commission recognized that work on market modifiers was not part of its mandate however, observations were appropriate as part of implementation planning.

The Commission observed that, from time to time, the implementation of market modifiers is appropriate to meet a specific need, such as the recruitment and retention of certain physicians to meet service demand. This should be a short-term solution. A further observation of the Commission is that such market modifier funding often occurs outside the Schedule of Medical Benefits pool, for example by a regional health authority.

The RVG is meant to form an equitable means of physician remuneration that can stand alone or be the template for other payment plans such as alternate funding or payment plans that flow from the SOMB pool. If this is achieved, then the Commission believes the need for market modifiers should be minimal and, when implemented, short-term.

## 5. Outcomes

### 5.1. Highlights

The work involved in developing a new Relative Value Guide for Alberta resulted in a number of significant achievements. Most importantly, it provides a solid base of information and a sound approach for making ongoing adjustments to reflect future changes in medical practice.

The following are key outcomes of the process:

- The new Relative Value Guide is the first comprehensive re-evaluation of all medical services provided by Alberta’s physicians in many years.
- Consistent with changes in medical practice, new relative values were identified for all codes. While changes may not have been as extensive as some sections expected, the new relative value guide more accurately reflects the relative value of services provided by physicians in different sections.
- Sections whose services have been relatively “under-valued” based on the data and on the views of physicians will see the most significant adjustments as a result of the new RVG.
- The Commission’s objective was to achieve greater equity in the value of services provided by different physicians and in their ability to recover practice costs. Based on the outcomes and the impact assessment, considerable progress has been made in achieving this important objective.
- The current fee schedule, the new Relative Value Guide would result in an overall increase in revenue to physicians of 13% (\$118 million).
- The new Relative Value Guide would result in significant changes in the human resource component of physicians’ incomes. The impact assessment shows that changes in the human resource component for the various sections range from 0% to 65%.
- The new approach to assessing practice recovery costs provides a sound method for recognizing the significant impact of practice costs on physicians’ incomes.
- The process allowed for continuous and consistent input from section advisors and individual physicians. There is little doubt that, as a result of the process, physicians are more aware of the relative values of various services and the need to address inequities and changes in practice in a timely and efficient way. The Commission’s recommendations on implementation and maintenance of the relative value guide are intended to ensure that the momentum achieved through the RVG process is not lost once the Commission’s work is complete.

## 5.2 RVG 2000

The most significant outcome of the RVG Commission is the development of a new RVG 2000 that includes a new relative value for each procedure, visit and consultation in the current Schedule of Medical Benefits, (except the anesthetic services of the Section of Anesthesia) as well as multipliers for both the human resource (HR) and practice expense (OH) components. The RV multipliers are applied directly to the relative value of any code to determine its HR and OH dollar value. In addition, the current shift differential multipliers were applied for appropriate codes in order to assess the full impact of the new RVG on various sections.

Appendix A provides the complete new RVG 2000, including the human resource RVs and the multiplier tables for both the HR and OR components and a guide on “How to Use the Tables of Multipliers.”

## 5.3 Financial Impact

The results of the Relative Value Guide were “modeled” to estimate the net impact on sections and/or groups of physicians. These estimates can be monitored in future to track changes and the ongoing impact on physicians’ incomes.

The financial impact of the RVG was estimated based on the assumption that no section would receive a decrease in its total Alberta Health and Wellness billings. Highlights of the financial impact are as follows:

- Overall, 13% (\$118 million) increase in payments would be required to fully implement the RVG.
- While increases to individual sections vary, the most significant changes are reflected in the human resource component with increases for sections' ranging from 0% to 65%.

### The Financial Impact Table

The accompanying table displays the estimated financial impact of the RVG under the assumption that no section would receive a decrease in its total Alberta Health billings. There are several things to note when interpreting this table.

1. The first set of columns (labeled Actual 1999/00 Payments) are based on billing data from Alberta Health. These columns show the payments made on a section-by-section basis using the fees from the current fee schedule.



2. The second set of columns (labeled Estimated 1999/00 Payments Based on RVG 2000) show the payments that would have resulted from the 1999/00 billing data had the services been billed using the RVG under the scenario that no section should receive a decrease in its total payments. These payments include the projected effects of fee unbundling and proposed rule changes under the RVG.
3. The third set of columns show the percentage increase in payments that would have occurred under the RVG from the current fee schedule.
4. **Practice Expenses Component.** Practice expense payments were calculated using the model office expense profiles that were developed as part of the Study of Physician Practice Expenses. These expenses include only “indirect” expenses. Direct expenses, such as tray fees and technical fees, are not included in the impact calculations.

In the financial impact table, it is assumed that practice expenses would be the same regardless of whether payments would be paid on the basis of the current fee schedule or on the basis of the RVG. In other words, it is assumed the practice expenses that are incurred by a section do not depend on which type of fee schedule is used for payments.

5. **Human Resource Component.** The human resource component represents the “net” payments to a section after the deduction of practice expenses. The human resource component that would have resulted using the RVG is calculated directly by multiplying the total relative value units generated by each section by the human resource multiplier.

The human resource component that results from the current fee schedule cannot be calculated directly because the current fee schedule does not break a fee down into its human resource and overhead components. Instead, the human resource component is estimated by deducting the practice expenses from the actual payments. Because of this indirect method of estimation, the calculation of practice expenses affects the estimation of the human resource component.

6. **Changes in Practice Expenses from the January 2001 Interim Report.** At the time of the January interim report the practice expense calculations were not yet finalized (this was noted in the accompanying notes to the financial impact table and in other places in the interim report). The finalization of these figures has produced several changes in the financial impact table.

First, the sections of Endocrinology and Metabolism, Nephrology and Physical Medicine have been assigned the overheads of Model Office Group 3. This results in a significantly higher estimate of practice expenses for these sections, which in turn results in a significantly lower estimate of their human resource components under the existing fee schedule. As a consequence, the % changes for these sections appear

significantly higher than those given in the interim report. It is important to note, however, that this increase is primarily due to the lowered estimate of the human resource component under the existing fee rather than due a change in the estimated human resource component that would result under the RVG. (In other words, the % change appears greater because the “starting value”, i.e., the human resource component under the existing fee schedule, has been lowered, not because the “ending value”, i.e. the human resource component under the RVG, has been increased.)

Second, the finalized practice expense figures for several other sections (including Gastroenterology, Respiratory Medicine and Neurology) have also changed from the interim report, as the treatment of technical fees has been completed since the time of the interim report. Again, this results in changes to the estimated human resource component under the existing fee schedule, which is again reflected in changes in the % change column.

Finally, changes in relative values that arose as a result of feedback from the sections to the interim report have been incorporated in the financial impact table. This also results in changes in the % change column from the interim report.

## Financial Impact

	Actual 1999/00 Payments				Estimated 1999/00 Payments Based on RVG 2000					
Section	Practice Expense (PE) Component	Human Resource (HR) Component	Shift Diff. and Call Back Payments	Actual Payments	Practice Expense (PE) Component	Human Resource (HR) Component	Shift Diff. and Call Back Payments	Total Payments	% Change Total	% Change HR
Anaesthesia	6,408,222	30,630,917	2,612	37,041,751	6,408,222	36,767,174	4,065	43,179,461	16.6%	20.0%
Cardiology	9,092,109	14,808,080	17,800	23,917,988	9,092,109	17,796,538	26,880	26,915,526	12.5%	20.2%
Critical Care	2,298,065	8,238,896	4,688	10,541,649	2,298,065	8,781,868	7,296	11,087,229	5.2%	6.6%
Dermatology	6,176,312	8,776,559	1,916	14,954,786	6,176,312	8,942,835	1,882	15,121,028	1.1%	1.9%
Diag. Imag.	59,023,567	27,268,208	-	86,291,776	59,023,567	27,333,643	-	86,357,210	0.1%	0.2%
Endo. & Meta.	1,643,678	2,014,685	2,386	3,660,748	1,643,678	2,523,618	3,216	4,170,512	13.9%	25.3%
Emerg. Med.	5,662,872	15,859,647	4,454,004	25,976,523	5,662,872	19,897,194	5,507,027	31,067,094	19.6%	25.5%
Gastroenterology	5,839,719	5,880,669	6,012	11,726,400	5,839,719	7,890,496	9,356	13,739,571	17.2%	34.2%
General Surgery	10,268,590	19,743,382	100,989	30,112,961	10,268,590	21,272,440	99,398	31,640,428	5.1%	7.7%
General Practice	173,768,524	185,122,615	22,180,423	381,071,562	173,768,524	245,945,688	22,708,083	442,422,295	16.1%	32.9%
Infectious Dis.	938,755	1,071,424	-	2,010,179	938,755	1,342,244	(0)	2,280,999	13.5%	25.3%
Internal Medicine	11,909,528	17,280,881	-	29,190,409	11,909,528	20,736,877	0	32,646,406	11.8%	20.0%
Nephrology	3,352,147	4,309,873	8,787	7,670,806	3,352,147	5,483,450	13,676	8,849,272	15.4%	27.2%
Neurology	3,385,939	4,617,298	1,347	8,004,583	3,385,939	6,306,698	1,419	9,694,057	21.1%	36.6%
Neurosurgery	1,613,436	3,117,949	44	4,731,429	1,613,436	3,745,208	68	5,358,713	13.3%	20.1%
Obstetrics & Gyn.	9,965,281	18,185,251	-	28,150,532	9,965,281	22,967,918	(0)	32,933,198	17.0%	26.3%
Ophthalmology	18,062,808	17,537,781	26,251	35,626,840	18,062,808	17,541,935	24,861	35,629,603	0.0%	0.0%
Orthopaedic Surg.	7,788,241	13,957,461	9,190	21,754,891	7,788,241	17,157,011	9,665	24,954,917	14.7%	22.9%
Otolaryngology	4,941,615	7,333,540	17,437	12,292,593	4,941,615	8,389,847	18,137	13,349,599	8.6%	14.4%
Paediatrics	11,379,512	13,382,735	357,973	25,120,220	11,379,512	15,594,338	414,368	27,388,218	9.0%	16.5%
Physical Medicine	1,349,793	1,302,060	-	2,651,853	1,349,793	2,152,555	0	3,502,348	32.1%	65.3%
Plastic Surgery	3,873,972	5,411,300	4,812	9,290,084	3,873,972	6,844,477	4,577	10,723,027	15.4%	26.5%
Psychiatry	20,337,780	35,225,432	4,493	55,567,705	20,337,780	50,130,928	6,992	70,475,701	26.8%	42.3%
Respiratory Med.	2,378,870	4,524,988	31,543	6,935,401	2,378,870	5,163,473	43,082	7,585,426	9.4%	14.1%
Card. & Thor. Surg.	2,779,382	5,371,318	-	8,150,700	2,779,382	5,764,157	(0)	8,543,539	4.8%	7.3%
Urology	3,501,194	6,755,285	10,955	10,267,434	3,501,194	7,167,723	12,793	10,681,709	4.0%	6.1%
Vascular Surgery	826,966	1,598,166	-	2,425,133	826,966	2,038,158	(0)	2,865,124	18.1%	27.5%
<b>Total</b>	<b>388,566,877</b>	<b>479,326,399</b>	<b>27,243,662</b>	<b>895,136,938</b>	<b>388,566,877</b>	<b>595,678,492</b>	<b>28,916,842</b>	<b>1,013,162,210</b>	<b>13.2%</b>	<b>24.3%</b>

### NOTES:

1. Payment data for 1999/00 is estimated from Alberta Health Data.
2. Practice Expenses do not include direct costs (e.g., tray fees, technical fees).
3. Shift Differential Payments include payments for only 03.03K,L,M and 03.05D,E,N,P,Q,R,S.
4. Payments do not include other types of surcharges.
5. Estimated 1999/00 RVG Payments include the estimated effects of fee unbundling and proposed rule changes.

## 5.4. Evaluations of the Commission's methodology and processes

The Commission requested external evaluations of its overall approach and, in particular, the method used to create the common scale. These evaluations highlighted the strengths of the Commission's work while also pointing out some differences of opinion and areas for future improvement.

Appendix B provides the following letters and responses relating to the evaluation of the Commission's methodology:

- Letter from Prof. Mark E. Glickman – review of Method for Creation of Common Scale
  - Response from Edward J. Mansfield, PhD, Arthur Andersen
- Review of Alberta RVG Interim Report No. 2 – Peter Braun, M.D.
  - Response of Earle Snider, PhD, University of Alberta
  - Response of the Commission to input on Office Visit and Consult Patient Complexity Study.

Overall, the Commission is pleased with the positive endorsement of the methodology used to develop RVG 2000. As noted in Dr. Peter Braun's evaluation:

The Relative Value Guide Commission of Alberta has made significant advances in the methodology and technical aspects of measuring the resource costs. Notable progress has been made with respect to measuring practice expenses and cross-linking of the services in different sections. The report gives generous attention and weight to the views of individual physicians and the voices of their organizations.

Dr. Braun goes on to indicate that:

- The investigators used a sound approach to intra-sectional relative values.
- The approach used to cross-link the sections' scales makes valuable progress on previous methods of producing a common scale.
- The work by Arthur Andersen Consulting represents a major and valuable advance in the measurement of physicians' practice expenses.

The Commission acknowledges that a number of concerns were raised about the Office Visit and Consult Patient Complexity Study. Based on its review of the various concerns, the Commission concluded that:

- The patient complexity data collected in the study are fundamentally sound.
- The manner in which the study's results have been used is the most reliable method currently available.
- Together, the data and the method of application represent a significant improvement over previous methods for determining the relative value of office visits and consults.
- The Commission's goal in initiating the study was not to obtain the "perfect measure" of the physician resource required to perform office visits and consults. Rather, the Commission's goal was to obtain reliable data that would lead to an improved method for determining the relative values of office visits and consults. The Commission believes that this goal has been achieved.

A more detailed response to these concerns is included in Appendix B.

## 6. Recommendations

In keeping with its mandate, the Relative Value Guide Commission developed a number of specific recommendations in the areas of:

- Implementation process and strategy
- Maintenance process
- Unfinished business
- Further research
- Audit system
- Practice expense recovery

### A. IMPLEMENTATION PROCESS AND STRATEGY

The Commission was asked to make recommendations on a strategy for implementing the RVG and for ongoing maintenance and updating to keep it current with actual physician services in Alberta. Several actions and decisions will be necessary to ensure the new RVG is implemented in a timely and effective manner.

Because the RVG Commission's process was focused on establishing relative values for existing fee codes, certain limitations exist that should be addressed during the implementation phase of the Relative Value Guide. Some of these limitations are:

**New Codes.** Sections submitted a number of new codes they would like to have introduced into the fee schedule. In some cases, sections indicated that the description of some codes does not accurately reflect the actual service now being provided. In other cases, new medical services have evolved for which there is no acceptable existing code. In these cases, either changes to existing descriptions or new codes are required to accurately reflect physician practices. The suggested new codes were not assessed by the Commission.

**Appeal Process.** The RVG assigned relative values to more than 3500 fee codes with the contribution of more than 1000 physicians. New databases needed to be created and millions of pieces of data were analyzed and inputted. Given the enormity and complexity of this task, it would be unrealistic to expect that the database contained no misunderstandings or errors. An appeal process should be in place during the implementation phase to allow sections to identify concerns or questions about the relative value of specific codes.

In addition to addressing those specific limitations, considerable work needs to be done to ensure both the timely implementation a new RVG and ongoing maintenance and updating of the RVG to reflect continuing changes in medical practice. Two distinct committees are required: an Implementation Committee responsible for short-term implementation of the new RVG and the Commission's recommendations, and a Maintenance and Update Committee responsible for long-term actions and decisions. There is some similarity in the responsibilities of both committees; however, the Implementation Committee would only be in place for a limited term.

**It is recommended that:**

1. Alberta Health and Wellness and the Alberta Medical Association should accept the RVG Commission's report and the Relative Value Guide 2000, including both the common scale and the multipliers for both the human resource and practice expense components.
2. AH&W and the AMA should form an Implementation Committee to facilitate a smooth transition from the current billing system to the RVG 2000. Consideration should be given to including a third party as independent Chair.
3. The mandate of the Implementation Committee should include:
  - Assessing initial appeals for revision of established RVs (see recommendation 6).
  - Reviewing the Commission's specific recommendations for changes to rules.
  - Integrating revisions made to the fee schedule after the 1999-2000 fiscal year.
  - Recommending a process for assessing and introducing new codes (see recommendations 8 – 10). Recommendations would be provided to the Maintenance and Update Committee.
  - Addressing issues relative to mixed professional/technical codes.
  - Liaising with AMA and AH&W regarding modifications of the infrastructure to accommodate the new RVG.
4. Implementation should begin on or about April 1, 2001, with full implementation by April 1, 2004 or sooner.
5. The longer-term implementation strategy should be defined no later than July 1, 2001.
6. An appeal process should be developed as a critical element of the implementation process to deal with any misaligned codes in a timely manner. The Implementation Committee would be responsible for initial appeals but, in the longer term, this should be the responsibility of the Maintenance and Update Committee.

7. Incremental introduction of the RVG should be accepted as realistic, but the RVG should ultimately be fully implemented because adjustments to one area may affect another area.
8. New, revised and deleted codes recommended by sections as part of the RVG process should be assessed and, where appropriate, introduced.
  - 8.1. High priority should be given to the implementation of new codes in Orthopedics and Neurosurgery because the current codes need updating to reflect changes in practice.
9. Initial RVG implementation should include the following enhancements to visit/consult codes on a priority basis:
  - 9.1 Redefining code 03.04A and removing the rule restricting the frequency of the use of the code.
  - 9.2 Introducing a time release clause for 03.04A that triggers after 30 minutes with a relative value of:  $(\text{relative value for the code} \div 2 \times 75\%)$  for each 10-minute increment.
  - 9.3 Introducing a time release clause for 03.08A that triggers after 45 minutes with a relative value of:  $(\text{relative value for the code} \div 2 \times 75\%)$  for each 15-minute increment.
  - 9.4. Providing an enhanced relative value for in-patient visits and consultations as included in the RVG 2000.
10. Initial implementation should include unbundling of visits and consults from identified procedures as defined in section 6.8.1 of the General Rules. The rules related to category M codes should be reviewed in keeping with the principles of the Commission. (No changes are recommended to the outpatient M+ codes which are already unbundled.)

Sections were asked to provide RVs for procedures independent of visits and consults. This clearly included visits/consults related to pre-operative and post-operative periods as listed in section 6.8.1 of the General Rules, May 1999. Some confusion arose around minor procedures or category “M” codes. While some codes were unbundled by the sections for evaluation, the Commission believes these do not represent two distinct services and should remain bundled. Minor procedures that clearly represent a separate service from the diagnostic visit, should remain unbundled.

- 10.1 Two Emergency section codes - 98.22A and 33.01A - should be reclassified to M+ codes.



## **B. MAINTENANCE PROCESS**

Although significant work has been done to establish a new RVG, in many ways an RVG should always be a “work in progress.” Ongoing changes are needed to reflect changes in medical practice and to refine the RVG.

The Commission heard repeated concerns about the current process for dealing with these issues. The process was consistently described as “slow and laborious.” Such a process will not meet the extensive needs for ongoing maintenance of the RVG. A streamlined and efficient process is needed to make decisions on a timely basis, including adding new codes, deleting inappropriate existing codes, and re-defining some existing codes, all of which result from rapidly changing medical services.

As noted earlier, the Commission feels that an ongoing Maintenance and Update Committee is required to follow through on the Commission’s report, continue the work of the short-term Implementation Committee, and ensure that continuous changes can be made to the RVG.

### **It is recommended that:**

11. An immediate review should be undertaken of the process presently in place dealing with changes to the Schedule of Medical Benefits.
12. A Maintenance and Update Committee should be established and be responsible for maintaining the integrity of the RVG, undertaking further research and development, and recommending ongoing modifications to the RVG.
  - 12.1 The Maintenance and Update Committee should report jointly to AH&W and the AMA. Procedures should be established to ensure that decisions can be made on a timely and efficient basis.
  - 12.2 The mandate for a Maintenance and Update Committee should include establishing processes and making recommendations on:
    - Implementing an ongoing appeal process
    - Including new codes and establishing their relative value (based on recommendations from the Implementation Committee)
    - Deleting inappropriate codes
    - Changing rules governing the application and use of existing and new codes (see also Recommendation 13)
    - Re-defining descriptors of codes

- Considering new coding systems for certain sections (i.e. Anesthesia, a visit and consult grid, etc.)
- Reconciling differences in RVs among groups of similar codes
- Establishing a set of benchmark codes (approximately 10 per section) to be used for validating the new relative values and establishing relative values for new codes.

## **C. UNFINISHED BUSINESS**

A number of issues were identified during the work of the RVG Commission and require further work.

### **a) Rules**

The Commission found the multiplicity and complexity of existing rules to be overwhelming. Some recommendations for change are made (See Recommendations 9 and 10), but the Commission believes a complete overhaul is necessary to resolve key concerns raised by several sections. The RVG cannot be fairly implemented without a review of and changes to the existing rules.

#### **It is recommended that:**

13. A separate committee of knowledgeable individuals representing AH&W and the AMA should be immediately struck to review and recommend changes to the rules.
  - 13.1 This "Rules Committee" should follow the principles developed by the Commission to guide the review of the rules. (See Section 4).
  - 13.2 The Rules Committee should report to the Maintenance and Update Committee.

### **b) Mixed Technical/Professional Codes**

Codes with a mix of professional and technical/overhead components also need to be reviewed. Definitions and the set of services that are encompassed by a given code need to be clarified. Examples of such service codes include skin tests, PFT and EMGs.

#### **It is recommended that:**

14. Codes that include both a professional and technical service should be identified and an RV should be established for the professional service independent from the technical service.

14.1 This review should follow the principles developed by the Commission. (See Section 4).

**c) Case Management**

Many sections expressed the need for a case management code to recognize a physician's role and responsibility as a multi-disciplinary case manager for patients with complex therapeutic or rehabilitation needs.

**It is recommended that:**

15. The AMA and AH&W should introduce a new case management code.

15.1 .High priority should be given to development of a new code for Nephrology that recognizes the management of patients with chronic renal failure treated by out-centre dialysis (home hemodialysis, satellite hemodialysis, peritoneal dialysis).

**d) Unresolved Issues from Sections**

As part of the final review process, the Commission agreed to identify outstanding, unresolved issues identified by the various sections. In the final weeks of the process, several specific issues were identified by sections and most were resolved as part of the final adjustments to the RVG 2000. However, a number of issues were either outside the mandate of the Commission, required extensive further work that was not possible given the timeline, or where the Commission had no basis for making the requested adjustments. Summaries of the concluding sectional meetings with the RVG Commission are included in Attachment D.

**D. FURTHER RESEARCH**

**a) Physician Work**

As noted earlier, an independent study was done for the Commission regarding the complexity of visits and consults for the average spectrum of patients seen by sample physicians within each medical section of the AMA.

The Commission believes that further research needs to be done both in the area of visits and consults, as well as with procedures. This research should facilitate the development of benchmark codes to assist in updating and adding codes.

**It is recommended that:**

16. Further research should be conducted in the area of visits and consults as appropriate to address emerging issues and needs.
17. Research should be conducted into procedures to identify factors that measure physician work.

**b) Specific Visit and Consult Study Enhancements**

There was concern that the in-patient sample size in the Alberta Office Visit and Consult Patient Complexity Study was too small for four sections – Gastroenterology, Neurology, Plastic surgery and Urology. A more representative sample is required to increase confidence in the results of the patient complexity scores and RVs.

**It is recommended that:**

18. Further review be conducted for in-patients of Gastroenterology, Neurology, Plastic surgery and Urology, with the results used to validate or adjust the RVs for in-patient visits and consults.

**c) Services Provided in the Academic/Tertiary Environment**

Within a given specialty, medical services are delivered in primary, secondary and tertiary/academic hospitals. The RVs established by the Commission are the same regardless of the site of service. There is however, some evidence of increased patient complexity for visit/consult services within the academic environment.

A specific example of this situation is Pediatric Medicine. The range of SOMB incomes for pediatricians in Alberta for the year 1999/2000 is wide, from less than \$50,000 to greater than \$700,000. Pediatricians identified as geographic full time (GFT) are at the lower end of the scale, compared to non-GFTs. The average GFT income is \$65,000 from the SOMB pool (and it is assumed that varying university funding augments this). The average non-GFT, SOMB income is \$185,000.

**It is recommended that:**

19. A further study be made into the relationship of the academic/tertiary environment to the relative value of physician work.
  - 19.1 Priority be given to a review of Pediatric Medicine within the academic/tertiary environment.

#### **d) Increased Range of Visit and Consult Codes**

Several sections have requested the addition of further visit and consult codes that would better reflect the variable complexities of patients in any one practice.

The RVG Commission's recommendations around rule changes, time release clauses for certain codes, and an in-patient modifier, increase the options available and will go a long way to addressing sections' concerns. However, if after a reasonable period of implementation of these changes, they prove to be inadequate, new codes should be considered.

#### **It is recommended that:**

20. As outlined in recommendation No. 9, the recommended rule changes to selected visit and consult codes should be made as soon as possible.
21. An evaluation of these rule changes should take place after 12 months.
22. If further options are necessary, then additional research should be initiated to develop new visit and consult codes.

#### **e) Anesthesia Intra-sectional RVs**

There continues to be dispute within the Section of Anesthesia regarding intra-sectional relative values. These concerns exist despite extensive efforts by the Commission to get broad input from the section. In particular, significant concerns have been raised about intra-sectional RVs related to the duration of anesthetics. The Commission analyzed the proposed changes to the intra-sectional scale and confirmed that there has been a considerable shift, increasing the relativity of lower paying anesthetics to higher paying anesthetic services. The Commission is not in a position to unilaterally adjust the section's intra-sectional RVs and could not accept the section's advocacy that there be a one-to-one parity with surgical services.

The Commission believes the RVs for visits/consults and procedural services by anesthesiologists are valid. The visits and consults methodology was consistently applied for all sections, and these services were used in the cross-linking process to bring the anesthesia services onto the common scale. Therefore, the Commission is satisfied that the overall placement of anesthesia on the common scale is sound.

#### **It is recommended that:**

23. The placement of the Section of Anesthesia in the RVG 2000 be conducted as follows:

- The positive financial impact of on the human resource component of 20% for the section, as defined in this final report, should be preserved.
- Anesthesia provides three types of services: visit/consults, procedures and anesthetics. Relative values for anesthesia's visits/consults and procedural services should be assigned according to this report (i.e. RVs are not assigned to anesthetic services).
- A revision of anesthetic RVs within the intra-sectional scale should be undertaken, with representation from appropriate sub-specialty groups within the section.
- The process of reassessing anesthesia intra-sectional relative values should be facilitated by an independent third party as it is the Commission's belief that the section itself will not be able to reach agreement on this issue. The process should start immediately so anesthesia can be included in the RVG implementation process.
- The total number of RV units assigned for anesthetic services (3,482,472,447\*) should be maintained for this revision. In this manner, the portion of new funds available for this sub-set of services is fixed. (\*This figure is based on: total RV units for Anesthesia, after unbundling and rule changes, of 4,509,380,895, minus RV units for visits, consults and procedures of 1,026,908,448.)

24. The Section of Anesthesia should explore the feasibility of adopting a reimbursement system that is more specific to the nature of anesthesia services such as "load plus time."

## **E. AUDIT SYSTEM**

Some concern has been expressed about the potential for inappropriate use of codes if the Commission's recommended visit/consult rule changes are implemented (particularly related to 03.03A and 03.04A). The Commission believes that precise definitions for codes are preferable to an over-reliance on rules to govern the use of codes. There is considerable support for a reliable system of audit to ensure appropriate use of codes.

### **It is recommended that:**

25. A system of audit be implemented to ensure appropriate use of codes.

## **F. PRACTICE EXPENSE RECOVERY**

The Commission's study of practice expense costs provided the basis for identifying an appropriate practice expense multiplier to be applied to each unit of service. As part of this work, the Commission noted several issues related to how physicians are categorized into sections. A number of physicians belong to certain specialties but that designation does not necessarily reflect the work they do (e.g. up to 50% of Nephrologists are billing as Internists). An updated and accurate registry of physicians is needed to address this issue.

### **It is recommended that:**

26. Reimbursement of practice/overhead costs should be based on the application of a practice expense multiplier for each unit of service, by section.
27. A methodology should be developed to identify changes in practice costs over time.
28. Changing practice expenses should be examined annually or at some predetermined period and be segregated from discussions on professional services within contract negotiations between AH&W and the AMA.
29. A registry of physicians should be developed and/or revised that recognizes a physician's dominant practice in a manner that permits fair and equitable reimbursement of practice expenses. The registry developed in the course of the Commission's work may be useful.

## **7. Attachments**

**A. Commission Structure**

**B. Glossary**

**C. Bibliography**

**D. Summaries of Concluding Meetings With Sections**

**E. List of Documents**



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**Attachment A**

# **RVG COMMISSION STRUCTURE**

## **Commission Members**

Dr. John Atkinson, Chair

Alberta Medical Association Representatives:

- Dr. Gerry Prince
- Dr. Kabir Jivraj

Alberta Health Representatives:

- Dr. Ron Dyck (to June 2000)
- Dr. Dennis Jirsch

## **Commission Staff**

Project Manager:

- Brian Spooner

Associate Project Manager:

- Nancy Rowan

Secretaries:

- Bea Hartt
- Joanne Askewe

## RVG Section Advisors

Section	Advisor	City/town	Advisor	City/town
Anesthesia	Dr. Richard Bergstrom	Edmonton	Dr. Warren Bean	Calgary
Cardiology	Dr. Dean Traboulsi	Calgary	Dr. Dylan Taylor	Edmonton
Cardiothoracic Surgery	Dr. Dennis Modry	Edmonton	Dr. Gary Gelfand	Calgary
Dermatology	Dr. Jim Kulak	Edmonton	Dr. Gordon Searles	Edmonton
Diagnostic Imaging	Dr. Alan Poole	Red Deer	Dr. Tom Spiers	Edmonton
Emergency Med.	Dr. Jim Brown	Edmonton	Dr. Chris Evans	Edmonton
Endocrinology	Dr. Jody Ginsberg	Edmonton	Dr. Peter Grundy	Calgary
Gastroenterology	Dr. Connie Switzer	Edmonton	Dr. Lawrence Price	Calgary
General Practice	Dr. Remo Di Palma	Calgary	Dr. Dianne Brox	Edmonton
General Surgery	Dr. Lawrence Farries	Red Deer	Dr. Paul. Hardy	Red Deer
Infectious Diseases	Dr. Dennis Kunimoto	Edmonton	Dr. Tom Louie	Calgary
Intensive Care	Dr. Christopher Doig	Calgary	Dr. Noel Gibney	Edmonton
Internal Medicine	Dr. Richard Sherbaniuk	Edmonton	Dr. Michael Mant	Edmonton
Lab Medicine	Dr. Michael. O'Connor	Medicine Hat		
Nephrology	Dr. Farshad Sepandj	Calgary	Dr. Sandra Cockfield	Edmonton
Neurology	Dr. Keith Hoyte	Calgary	Dr. Chris White	Calgary
Neurosurgery	Dr. Terence Myles	Calgary	Dr. Elizabeth MacRae	Calgary
OBGYN	Dr. Bill Young	Red Deer	Dr. Robert Black	Edmonton
Ophthalmology	Dr. Michael Ashenhurst	Calgary	Dr. Gary Chornell	Edmonton
Orthopaedics	Dr. John McIvor	Edmonton	Dr. Nicholas Mohtadi	Calgary
Otolaryngology	Dr. Bud Shandro	Calgary		
Pediatrics	Dr. Neil Cooper	Calgary	Dr. Mark Montgomery	Calgary
Physical Medicine	Dr. Mario DiPersio	Edmonton	Dr. Dan McGowan	Calgary
Plastic Surgery	Dr. Martin Giuffre	Edmonton	Dr. Mark Haugrud	Calgary
Psychiatry	Dr. Roger Rampling	Lethbridge	Dr. Kent Sargeant	Calgary
Respiratory	Dr. Dale Lien	Edmonton	Dr. Dan Zuege	Calgary
Rural Medicine	Dr. Tony Mucciarone	Bassano	Dr. Mike Boorman	Rimbey
Urology	Dr. Davd Mador	Edmonton	Dr. Eric Estey	Edmonton
Vascular Surgery	Dr. Randy Moore	Calgary		

## RVG Cross-Sectional Panel Members

Name	Specialty	City/Town
Dave Adams	General Surgery	Edmonton
Richard Anderson	Family Practice	Calgary
George Andrew	Diagnostic Imaging	Edmonton
Bob Bear	Nephrology	Edmonton
Noorali Bharwani	General Surgery	Medicine Hat
Bill Black	Cardiology	Edmonton
Chris Eagle	Anaesthesia	Calgary
Ron Fraser	General Surgery	Edmonton
Charlotte Foulston	Pediatrics	Medicine Hat
Bob Hallgren	General Surgery	Edmonton
Ray Howard	Family Practice	High Prairie
John Jarrell	Obstetrics/CMO	Calgary
Vern Jubber	Family Practice	Lethbridge
Eugene Kretzul	Internal Medicine	Edmonton
James Metcalfe	Urology	Edmonton
David Moores	Family Practice	Edmonton
Sandy MacKay	Ophthalmology	Medicine Hat
Sandy Murray	Family Practice	Red Deer
Michael O'Connor	Pathology	Medicine Hat
Lloyd Sutherland	Gastroenterology	Calgary
Paul Toye	Family Practice	Fort McMurray
Ron Wensel	Gastroenterology	Edmonton
Randy Williams	Cardiology	Edmonton
Tom Williams	General Surgery	Edmonton

## RVG Methodology Resource Group

Name	Credentials	Position	Organization
Dr. Mike Gillespie	BA, MA, PhD	Associate Professor, Department of Sociology	University of Alberta
Dr. Devidas Menon	MHSA, PhD	Professor, Dept. of Public Health Services	University of Alberta
		Executive Director & CEO	Institute of Health Economics
Dr. Cam Donaldson	Svare Chair, AB Heritage Senior Scholar	Professor, Department of Community Health Sciences and Economics	University of Calgary
Dr. Edward Mansfield	B.Sc., MA, PhD	Director of Statistical Consulting Services	Arthur Andersen LLP Chartered Accountants
Judith Davidson- Palmer	B.A., MA.	CEO	J. Davidson-Palmer & Associates Inc.

## RVG Consultants

### Communication

- Peggy Garritty, PG Communications
- Terri Taylor, TT Communication

### Data base design, development and management

- Sue Salimaki, Salimaki Mangagement

### Mathematical and statistical processes

- Mike Gillespie, PhD, University of Alberta
- Ed Mansfield, PhD, consultant with Arthur Andersen

### **Overhead Study**

Arthur Andersen

- John Anderlic
- Daryl Johannesen
- Michael Krawchuk
- Michelle Didow

### **Overhead and technical assessment methodologies**

- Michael Gormley, health economist

### **Visit/Consult Study**

- Earle Snider, PhD, Clinical Epidemiologist and Professor Emeritus at the University of Alberta

## Attachment B

### GLOSSARY

Term	Meaning
<b>Acronyms</b>	
CCP - Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures	Current system of fee codes in the Alberta Schedule of Medical Benefits.
INRV - intra-sectional relativity	Relative value of services within one section.
RVG - relative value guide	A list of physician services in which each service is rated in relation to other services, according to defined factors
RVS - relative value of a service	The non-monetary value assigned to each visit, consultation and procedure that can be related to the values assigned to other services. One of two parts that goes into developing the relative value guide.
PCS Patient complexity score	An aggregate measure of a number of variables that represent the complexity of the patient's presenting condition. It is calculated by section for both in-patients and Out-patients for use by the Commission.
SOMB - Schedule of Medical Benefits	List of medical services that are provided by public funding in Alberta.
TRC - Time release clause	A mechanism that allows physician compensation to increase on certain codes according to specified time intervals and values.
<b>Words and Phrases</b>	
Alberta cross-sectional panel	One of a number of expert panels used in the Commission's validation process. This panel evaluated the cross-links to ensure the sectional relative values are valid.
Benchmark codes	A small number of codes that reflect the range of complexities within a medical area.
Complexity	A type of factor used to assess the relative value of a service, including such things as technical and diagnostic skills required to select therapy and carry out service.
Conversion factor	A financial multiplier that is applied to the RVG to develop a fee schedule. The multiplier is determined by the total amount of funding, number of relative value units and number of services provided.
Cost neutral	Being independent of the medical services budget. An RVG that is developed based on conditions at a single point in time.
Cross-links	Services of equivalent value. Used as basic building blocks for bringing together all section's relative values to develop the RVG.
- Natural cross-link	The same service that is performed by more than one section of physicians.
- Derived cross-link	Different services performed by different sections that are considered to involve similar time and intensity.
Direct costs	Practice expense costs that are related to the provision of specific services.

Fee modifiers	Factors that can be used to adjust fees based on, for example, whether a service was delivered during the day or night, callbacks at night, or where the services are provided.
Global methodology	One method (also called “magnitude estimation”) for determining the relative value of services, in which each service is rated as a complete entity inclusive of time and intensity.
Implementation	The process of introducing the RVG into real use through the fee schedule.
Indirect costs	Practice expense costs that are not tied to the provision of specific services.
Indivisible	Complete. Meaning one section’s RVG will not be implemented unless all others are implemented.
Intensity	A combination of factors used to assess the value of a service, based on the level of physical and mental effort required and including such things as knowledge and judgement, technical skills, communication and interpersonal skills, risk and stress.
Intra-sectional	Within a section.
Inter-sectional	Between or among different sections.
Magnitude estimation	See Global methodology.
Market modifiers	Factors relating to market conditions that can be used to adjust fees, such as the supply of physicians by location or specialty.
Methodology panel	A group of experts, including economist, human resources consultant, researcher and mathematician/statistician, that assisted in assessing the reliability and validity of the Commission’s processes.
Model office	A medical office that is determined to represent the norm for each section.
Modifiers	Factors that can be used to adjust fees for specific circumstances, policy issues or market conditions. (see Fee modifiers and Market modifiers)
Office overhead	The costs for such items as supplies, staff, rent and utilities required to run a medical office.
Opportunity costs	A factor designed to reflect the cost of lost earnings while gaining specialty training.
Physician (human) resource	Includes such variables as knowledge and skills, technical expertise, communication skills and risk of stress
Practice expenses	The costs associated with running a medical practice, including overhead and other.
Resource inputs	The resources (such as time, intensity and complexity) needed to deliver a service.
Section advisors	Representatives appointed by AMA sections to provide advice and feedback to the RVG Commission and to facilitate communication between the Commission and physicians.
Technical costs	Costs for such items as special equipment or supplies

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	above the costs for regular office equipment in a particular section.
Time	One of a number of factors used to assess the value of a service based on actual or average minutes required.
Unbundling	The act of dividing what is currently considered a complete service into its parts; e.g. separating the visits/consults associated with a procedure. (The opposite is Bundling).
Validation process	A system of checks and balances built into the Commission's process of determining the relative values.
Value	A non-monetary number assigned to a service that can be compared to other service's values to determine relativity.



**SPECIALIST LEGEND**

Section	Symbol
Anesthesia	ANES
Cardiology	CARD
Cardiothoracic Surgery	CTSG
Clinical Immunology	CLIM
Community Medicine	CMSP
Critical Care Medicine	CRCM
Dermatology	DERM
Diagnostic Imaging	DIRD
Emergency Med.	EMSP
Endocrinology	E/M
Gastroenterology	GAST
General Mental Health	GNMH
General Practice	GP
General Surgery	GNSG
Geriatric Medicine	GEMD
Hematology	HEM
Infectious Diseases	IDIS
Internal Medicine	INMD
Hemopathology	HEPA
Medical Oncology	MDON
Medical Microbiology	MDMI
Nephrology	NEPH
Neurology	NEUR
Neurosurgery	NUSG
Obstetrics & Gynecology	OBGY
Occupational Medicine	OCMD
Ophthalmology	OPHT
Orthopedics	ORTH
Otolaryngology	OTOL
Pathology	PATH
Pediatrics	PED
Pediatric Cardiology	PEDC
Pediatric General Surgery	PDSG
Physical Medicine	PHMD
Plastic Surgery	PLAS
Psychiatry	PSYC
Radiation Oncology	ROSP
Respiratory Medicine	RSMD
Rheumatology	RHEU
Thoracic Surgery	THOR
Urology	UROL
Vascular Surgery	VSSG

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**Attachment D**

**Summaries of Concluding Meetings with Sections**



**Relative Value Guide Commission  
Summary of Sectional Issues**

*Plastic Surgery, via teleconference*

**Thursday February 15, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan, RVG Associate Project Manager

**Section Representative:**

▸ Dr. Mark Haugrud

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**Issues:**

The section was concerned about the placement of the 03.03A code on the common scale. The Commission agreed to make an adjustment to the 03.03A in keeping with adjustments to Dermatology and Otolaryngology. The new RV for 03.03A is 1410.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
***OBGYN***

**Thursday February 15, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan, RVG Associate Project Manager

Terri Taylor, Communication Consultant

**Section Representative:**

▸ Dr. Bill Young

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**Issues:**

Inter-sectional RVs

- a) 77.019A, 77.2 have lower RVs than 66.19A Laparotomy. It doesn't make sense that a simple procedure has a lower RV than a more complex procedure. The RVG Commission will take a second look at this issue. As a continued maintenance procedure the Commission has recommended that groups of similar codes be reviewed.

Cataract- The section feels that RV is valued too high.

Post Script: The Commission review identified one cross-link with surgery that upon review was determined that the services offered by OBGYN and surgery under that code were not the same. That cross-link was removed resulting in an upward adjustment to the OBGYN conversion in the common scale.

Patient Complexity Study:

The section questioned if other sections included secondary diagnosis even if they were not relevant to the presenting problem.

The Commission confirmed that a secondary diagnosis was included only as it affected the patient management at that visit or consult.

Sectional Profiles: It is hard to get doctors to do Obstetrics. Dr. Young is concerned about ordinary vaginal deliveries. He feels that in the Section profile, this procedure is now paying less.

The Commission revisited the cross-links. The findings are cited above.

Intra Sectional Adjustment: The apparent 23% adjustment to the Gyne fees were discussed. The Commission concluded that without this adjustment in OBGYN the intra-sectional scale did not translate well into the common scale.

Dr. Young commented that the change in visits was a good step forward. He noted the importance of making it clear what is unbundled, for the next group working with the RVG.

## Relative Value Guide Commission

### Summary of Sectional Issues: *Respiratory Medicine*

Thursday February 15, 2001

#### **Present:**

Dr. John Atkinson, RVG Chair  
Nancy Rowan RVG Associate Project Manager  
Dr. Edward Mansfield, Statistical Consultant

#### **Section Representatives:**

- Dr. Dale Lien
- Dr. Dan Zuege

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#### **Issues:**

Dr. Lien and Dr. Zuege noted that issues other than overhead were minor. Major concern is with overhead.

Overhead: There was an error in the overhead calculation received by respiratory . It would appear that technical fees were removed twice. Issues regarding overhead are being reworked and Ed will correct the error and revise the overhead figures.

Representatives raised a concern regarding some doctor's use of fancy cars, travel etc. They feel some sections may have benefited in this expense item.

The Commission clarified that there is a maximum amount you can write off for a vehicle-\$27,000.00. Therefore, luxury cars were not a factor.

#### Codes:

03.38B- They feel this value is too high.

Surcharges for callbacks: Section representatives were concerned that the same value was given regardless of the time of day.

The Commission clarified that the time of day surcharges are separate and that the RV is for the base value only of the service. The Commissions final report will note that surcharges need to be added back into the codes as indicated.

Representatives suggested that these codes shouldn't vary by specialty

The Commission used PCS for each section to adjust the codes. This is consistent the methodology used for other visit/consult codes.

Technical fees: Costs were explained -Technical costs were included in a sections indirect costs where the technology was present in the offices of the majority of section members. The overhead calculation has nothing to do with PCS.

#### Uninsured Services:

Section reps wanted to know if equipment for uninsured services was included in the overhead expenses.

The Commission clarified it was not included.

Pulmonary function- Question about RVs for some specific items.

The Commission stated that the difference in RVs was likely attributable to weighting by the different sections.

Patient Complexity Study: Section reps were concerned about the possible abuse of secondary diagnosis in inflating the PCS value..

The findings were audited to confirm that the secondary diagnosis was included only as it affected the patient management at that visit.

Assignment of Physician's to Sections:

Section reps wanted to know how a physician's assignment to a particular section was verified.

The Commission went through a thorough validation process with section input and review.

The Commission will note the importance of a registry in its final report in order to assign physicians to the appropriate overhead grouping.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Infectious Diseases*

**Tuesday February 20, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

**Section Representative:**

- Dr. Dennis Kunimoto
- 

**Issues:**

03.03G: Is valued less than a hospital visit which doesn't make sense.

The Commission explained that this code was handled in the same manner as all visit/consult codes. The result is where sections' placed the code on the common sale. The Commission is recommending that in the next phase of the RVG that sets of similar codes be reviewed.

Patient Complexity Score: Dr. Kunimoto argues that there is a discrepancy between factors defining patient complexity and PCS results.

The Commission advised that a variety of alternate studies were done on the data and that overall the mathematicians/statisticians could not find a methodology to support a adjustment to the PCS value. The PCS value encompasses all variables including time of secondary diagnoses, the latter two variables account for only 40% of the variance.

03.08A: Dr. Kunimoto was concerned about the limitation of the rule in this area.

The Commission has debated this issue but feels on the whole that due to the complexity of the rules that it would not recommend rule changes on a case-by-case basis. They would suggest that there be a systematic review of the rules. The rule on 03.04A was removed to recognize two distinct populations within the 03.03A code. Removal of the rule on that code allows for the appropriate billing of that subset of patients i.e., complex patients can be billed as a 03.04A rather than introducing a new code such as 03.03AB

Specific Issues:

- The RVs for chronic renal dialysis. The value for a stable patient is 5000-6000 points. It is felt that this is overvalued.
- Cat Scan could be looked at in subsequent validation of procedures.
- The renal transplant management code 13.99V, Vs post-liver transplant. 13.99X seems to have a discrepancy.

The Commission agreed that the codes should be looked at when reviewing sets of similar codes as part of the maintenance process.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Psychiatry*

**Tuesday February 20, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty ( Communication Consultant)

**Section Representative:**

- Dr. Roger Rampling

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**Issues:**

Overhead:

(i) Cost identification and Recovery: Dr. Rampling asked what exists in overhead.

He contends that the cost of running an office is the difference from all groups minus group I who does not have the cost of maintaining an office.

Dr. Rampling inquired as to whether physicians with higher incomes were able to spend more on overhead costs? Was the adjustment for Psychiatry in terms of salaries & benefits sufficient?

The Commission did not make a judgment on what overhead costs should be.

The Commission did not allocate the costs. Costs were measured and validated per section. The only section that the Commission adjusted was Psychiatry due to the section's argument that there were historical differences that affected office staffing. The Commission added the equivalent of one FTE to Psychiatry's model office so that historical differences were not perpetuated. Dr. Rampling contends that the value of the FTE should be increased by \$6200.00. The Commission believes that the figure allocated is fair and reasonable given the available data.

Time Release Clause: Dr. Rampling feels that the TRC on the 03.04A & 03.08A codes ultimately under value the 03.08G. After it was clarified that the time release was at a reduced rate he felt this was no longer an issue.

Code Comparisons: Dr. Rampling questioned the value of the ECT to other procedures.

The Commission clarified that the methodology takes the fee schedule to a new level. The Commission is recommending that during the maintenance process a group of similar codes be reviewed and validated.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Emergency Medicine*

**Tuesday February 20, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty (Communication Consultant)

**Section Representatives:**

- Dr. Jim Brown
- Dr. Chris Evans

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**Issues:**

Unbundling: The Commission clarified what unbundling applies to i.e., major procedures. The Commission is not recommending any changes to the M+ codes. M codes should be reviewed given the principles of the Commission. Further to the discussion the Commission will recommend that the 98.22A and 33.01A codes be reclassified to M+ codes.

03.04A: With the broadening of 03.04A then EMSP feels this should be open to them. Dr. Snider will be asked to look at the model distribution of the 03.05 C, D and E codes.

Post Script: Dr. Snider conducted an analysis related to time spend under these codes. It is normally distributed and correlates highly with the PCS value. The Commission concluded there was no evidence to support a time release or access to the 03.04A code at this time. Given this information, however, Emergency medicine still concludes, "we do not feel that Emergency medicine's unique problem relating to the relative value of our visits (03.05C, 03.05D, 03.05E) has been addressed."

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Physical Medicine*

**Tuesday February 20, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty (Communication Consultant)

**Section Representatives:**

‣ Dr. Mario DiPersio

‣ Dr. Dan McGowan

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**Issues:**

Overhead: The Commission explained that overhead figures will change as their section will be grouped with model office #3. Therefore, Physical Medicine will get more overhead recovery..

03.08A: The in-patient value for Physical Medicine is lower than the value for their out-patients. The representatives asked that both be valued the same. There is no methodology to support moving in-patient values up, but Commission agreed that the values of both in-patient and out-patient RVs should be the same. Therefore, the Commission recommends that the weighted average of the two values should be used. Physical Medicine would have a single value for in-patients/out-patients.



**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Internal Medicine*

**Tuesday February 20, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty (Communication Consultant)

**Section Representatives:**

▸ Dr. Richard Sherbaniuk

▸ Dr. Michael Mant

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**Issues:**

- (i) % Change: The Section advisors felt that the outcome of the RVG did not result in a sufficient increase relative to surgical specialties. It was the Commission's opinion that the methodology was systematically & equitably applied and the result was what the data showed. The methodology was subject to external validation.
- (ii) Visit /Consult Study: Dr. Mant & Dr. Sherbaniuk believe that the patient complexity scores do not adequately capture complexity in Internal Medicine.
- (iii) Intra-sectional issues: Issues regarding the RVs for allergy testing codes remain unresolved

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
***Pediatrics – Teleconference***

**Wednesday February 21, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty, Communication Consultant

**Section Representatives:**

▶ Dr. Neil Cooper

▶ Dr. Mark Montgomery

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**Issues**

The proposed recommendation regarding Academic Pediatrics was reviewed. Dr. Cooper and Dr. Montgomery suggested that three groups be identified and studied i.e., Primary Care Pediatrics, Academic Medicine and Mixed Community/Hospital practice.

Time: The section feels that time is not represented in the work conducted by the patient complexity study. It was suggested by Dr. Cooper and Dr. Montgomery that the only way to achieve equity is to determine an hourly rate for physician specialties. The parties discussed the effect of the time release clause for the section of Pediatrics.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Intensive Care*

**Wednesday February 21, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

Peggy Garritty, Communication Consultant

**Section Representatives:**

- ▶ Dr. Noel Gibney
  - ▶ Dr. Christopher Doig
- 

**Issues**

Overhead: The Commission believes that overhead recovery should be based on dominant practice.

Section advisors were concerned that academics regardless of specialty, pay the same amount to the practice plan. However, different specialties will recover different overhead amounts and that is not equitable in terms of cost recovery for academics. The Commission has not addressed the specific overhead issues in an academic institution. This is an issue that will need to be addressed in the context of individual practice plans.

Patient Complexity Study: The section presented a breakdown of data indicating that adult ICU patients are more complex than pediatric ICU patients. The data provided is a window to a potential problem. However, the sample size of physician is inadequate for the Commission to address this issue.

New Code: There may be the need for a separate code for a step down type patient. Step down ICU services may now be handled by an internist on the unit. It is recommended that the section consider submitting a new code to the "Equity Committee".

Patient Specific Complexity Issue: The Commission indicated that in one of its recommendations, if adjustments in the visit/consult area were insufficient and that future RVG maintenance committee may wish pursue the notion of a grid to accommodate varying patient complexities.

Code Specific RV issues:

The Section argued that the RV's for codes 13.62A and 13.99 are somehow distorted.

Upon review of the data the Commission noted that within their intra-sectional scale ICU rated the above codes @600 of 900 RV points respectively.

ICU now recommends that in fact, the RVs for these services should be the same. They suggest blending RVs into a common value of 750.

The Commission does not believe that it is reasonable to make adjustments this late in the process. The Commission noted that the discrepancy cited in their letter misrepresents the “problems” with these codes. They are in fact consistent with ICU’s submission on their intra-sectional scale.

Shift Differential and Day/Evening Modifier: The RBG has given a base value and modifiers will be added to this base.

Code Cluster: Several issues were raised relative to clusters of similar codes.

The Commission is recommending that these cluster be examined as part of the ongoing development and maintenance process.

03.05A: This code may need to be applied differently at different sites. We agreed that the value should be the same in tertiary level ICU but perhaps the specialty differentiation should apply on step down units.

Feb 28, 2001: The Commission received a letter from the section on February 26, 2001 outlining recommended new codes and RV modifications.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Orthopedics;Teleconference*

**Wednesday February 21, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield , Statistical Consultant

**Section Representative:**

► Dr. Nicholas Mohtadi

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**Issues:**

New Codes: The section feels that it is improper not to include the new codes within the RVG submission. The Commission has identified a specific recommendation recommending that the introducing of new codes identified by the section be given a high priority in the implementation process.

Unbundling: The Commission clarified that the surgical codes are unbundled. This also applies to new codes.

Overhead: The section is pleased with the overhead study.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Cardiology*

**Wednesday February 21, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

**Section Representatives:**

▶ Dr. Dean Traboulsi

▶ Dylan Taylor

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**Issues:**

Modifiers:

A) Coronary Angiography: Cardiology would like a modifier for coronary angioplasties involving more than one coronary vessel. This modifier would mean that each additional vessel receives 43,606 RV points in addition to the initial vessel.

B) Catheterization for complicated congenital heart disease (adult & child). The section recommends that there be a modifier applied of 50% of the value of the code billed (6000 RVs).

New Code: The section would like to see a fee introduced for assisting in CATH labs (should be equivalent to 2<sup>nd</sup> assist surgeon fee).

New Code: Cardiology would like a new code for vascular access under 6yrs of age, the RV should be 6000.

Rule Change: The section would like to remove the cap at three coronary angioplasties, particularly for congenital heart defects.

The section questioned if a echo cardio and necular cardiology was part of the D.I. submission. They do not want this group overlooked.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
**Nephrology**

**Thursday February 22, 2001**

**Present:**

Dr. John Atkinson, RVG Chair  
Brian Spooner, Project Manager  
Nancy Rowan RVG Associate Project Manager  
Dr. Edward Mansfield, Statistical Consultant  
Terri Taylor, Communication Consultant

**Section Representatives:**

- ▶ Dr. Sandra Cockfield
  - ▶ Attending by phone: Dr. Farshad Sepandj
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**1. Agenda**

New Codes: **A)** Nephrologists provide ongoing long term management and supervision of out-service management of end stage renal disease. Currently there is no code that can be billed to compensate Nephrologists for this ongoing management.

The Commission will add a recommendation to its report that priority be placed on the implementation of a new code recognizing the management of patients with chronic renal failure treated by out-centre dialysis (home hemodialysis, satellite hemodialysis, peritoneal dialysis) per week.

**b) 13.99A Pediatric Nephrology:** The section feels that the area of Pediatric Nephrology should have a new code for the treatment of children. It is suggested that the first dialysis have a RV of 700 with subsequent dialysis having a value of 2000.

Overhead:

The Commission identified an error in the overhead calculation. In the final RVG the overhead multiplier will go up.

## 2. Care of dialysis patients in satellite hemodialysis units remote from nephrologists, on home hemodialysis or on peritoneal dialysis.

Relative value proposed: 460 per week

Treatment of the patient with chronic renal failure requiring dialysis support requires management of the dialysis procedure and the complications of the metabolic abnormalities associated with uremia, the dialysis procedure and the frequent co-morbid conditions of diabetes and vascular disease. Monitoring of outcomes and adherence to published clinical practice guidelines (DOQI and CSN guidelines) is required. Many of the patients live in areas remote from Calgary and Edmonton, in areas without general internists and nephrologists. Most primary care physicians are uneasy managing such patients, given the dialysis requirements, co-morbidity, and difficulties with drug dosing in this setting. Monitoring and treatment of this patient population requires frequent telephone contact with the patients and their families, family physicians, local hospital, and local nursing staff.

Services include:

- ✓ supervision of the dialysis procedure
- ✓ treatment of acute complications during and between dialysis sessions (including clotted or infected AV hemodialysis accesses, bacterial peritonitis and exit site infections in peritoneal dialysis patients, catheter malfunction)
- ✓ review of blood work and adjustment of dialysis prescription to provide adequate dialysis dose
- ✓ review of dialysis access type and integrity
- ✓ control of uremic symptoms by use of appropriate medications (anti-hypertensives, phosphate binders, vitamin D3, erythropoietin, iron, etc. See Appendix for details.
- ✓ review of outcomes relative to adopted clinical practice guidelines for adequacy of dialysis, vascular access, management of anemia, and management of other uremic complications
- ✓ provide weekly telephone review of patient status with hemodialysis unit staff in local community
- ✓ direct outpatient review in regional centre every 2 to 3 months
- ✓ 24 hour emergency on-call support for all patients through regional call system
- ✓ attend weekly clinical and administrative meetings on behalf of patients receiving this therapy

This fee does not cover care provided when the patient is admitted to hospital or when receiving care in the Emergency Department.

Comment:

Virtually every other province recognizes the need for ongoing input and review of dialysis-dependent patients even when remote from the location of the nephrologist. Examples include:

Ontario	\$123.33 per week (weekly capitation fee for all hemodialysis and peritoneal dialysis patients)
Manitoba	\$24.05 per week for home hemodialysis, satellite hemodialysis and peritoneal dialysis patients. A "sessional fee" is also billed which amounts to \$2400/year such that each patient results in net billings of \$3648/year or (~\$70/wk) to provide care to each community dialysis patient.
BC	\$49.55 per week for home dialysis and peritoneal dialysis patients



**Relative Value Guide Commission**  
**Sectional Issues**  
***General Practice & Rural Medicine***

**Thursday February 22, 2001**

**Present:**

Dr. John Atkinson, RVG Chair  
Nancy Rowan RVG Associate Project Manager  
Dr. Edward Mansfield , Statistical Consultant  
Terri Taylor, Communication Consultant

**Section Representatives:**

- Dr. Michael Boorman & Dr. Tony Mucciarone (Rural Med.)
  - Dr. Dianne Brox, Dr. Remo Di Palma
- 

**Issues:**

03.03A code: Codes 03.03A and 03.04A are tied together and both sections feel that this is inappropriate to ignore the recommendation on the rule change for 03.04A.

Audit: General Practice and Rural Medicine believe that the Commission should emphasize that the SOMB should be monitored and controlled through an audit process rather than limiting access to codes by attaching rules to them.

The Commission agreed to add a new recommendation to the report stating that a system of audit should be implemented to assure appropriate use of codes. The Commission does not feel that limiting the use of a code(s) through restrictive rules results in equitable remuneration for the services provided.

Maintenance: The Commission's vision is that a series of benchmark codes be identified to adjust current codes and add new codes. In the short term groups of similar codes should be reviewed and RVs normalized.

13.99F: the sections question why the value of the 13.99F is less than the 13.99E.

The Commissions understanding of the 13.99F is that it refers to a newborn suctioning and not the life saving resuscitation as indicated in 13.99E.

The sections questioned why patients seen in the emergency department under codes 03.03K,L and M were not equivalent to the 03.05C, D, E codes.

The Commission upon review felt that there was insufficient data to equate the two sets of codes.

Market Modifiers: The section of Rural Medicine feels that the complexity of services delivered in rural areas are more intense due to the lack of back up. Therefore, there should be a modifier applied.

The Commission did not feel it was within its mandate to recommend market modifiers. However, it does recognize that market modifiers need to be considered within the medical services budget.

**Relative Value Guide Commission**  
**Summary of Sectional Issues**  
*Anesthesia*

**Thursday February 22, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Gerry Prince, Alberta Medical Association Representative

Dr. Edward Mansfield, Statistical Consultant

**Section Representatives:**

▸ Dr. Warren Bean

▸ Dr. Richard Bergstrom

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**Issues:**

Cross-links: The section representatives maintain the belief that the cross-links are invalid. They continue to promote 1-to-1 parity with surgeons as the only valid cross-link. The Commission explained that a consistent process was used for all sections including Anesthesiology. It is not prepared to deviate from its process for any one section. The 23 cross-links used for Anesthesia were a result of a survey of Anesthesiologists, paired sections and the Cross-sectional Panel and met the Commission standards for valid cross-links.

Intra-sectional RVs: The Commission provided section reps with an analysis demonstrating that intra-sectional RVs are weighted toward the lower paying procedures. This distortion does not give the Commission confidence that anesthesia's intra-sectional values are valid.

The Commission reviewed its recommendation that the RVs for anesthetics should be re-evaluated under the direction of an independent facilitator. The Commission will not include the sections RV for anesthesia in their report.

RVs for visits and consults and procedural services should be maintained as the methodology for calculating these included several steps that would give credence to their value.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Gastroenterology*

**Friday February 23, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Brian Spooner

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Edward Mansfield, Statistical Consultant

Terri Taylor, Communication Consultant

**Section Representatives:**

▸ Dr. Connie Switzer

▸ Dr. Mario Millan

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**Issues:**

Sample size in in-patient population

- The section is advocating a more specific recommendation regarding small sample size for in-patients.

The Commission will enhance its recommendations in this area.

Endoscopic Procedures: The section believes that GI sees more difficult patients under this code. Gastroscopy with therapeutic intervention is much more difficult. The section reps feel that due to the position of this code on the common scale it has distorted their perception of its relativity with other G.I. procedures.

Code Specific Issues:

**64.77A:** The value of this code changed by about 16% due to corrections to the exchange rate.

**54.99A:** Very few services were performed on this code. The rule that was used to reconcile differences was a simple average vs a weighted average. 13 services are done by G.I., 5 are done by CVT.

Other Code Issues: The Commission is recommending that codes which the sections believe should have a similar RV be reviewed in a type of cluster analysis.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
*Neurology*

**Friday February 23, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Edward Mansfield , Statistical Consultant

**Section Representatives:**

▸ Dr. Keith Hoyte

▸ Dr. Chris White

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**Issues:**

EMG : The section feels that the value of the EMG is over rated compared to consults. The intra-sectional RVs were not maintained due to adjustments made to visits and consults as a result of the patient complexity study. Discussed that the intra-sectionals RV could not be 100% maintained as the intra-sectional scales were brought onto the common scale.

Cardiology Consult: The section feels that the RV for a cardiology consult is abnormally high. They discussed the need for ongoing research and analysis in the area of visits and consults. They agreed that the time release clause has a significant positive effect.

03.03K, L, & M codes :The Commission explained that the common scale includes the human resource value but surcharges need to be added back into the codes.

In-patient/Outpatient differentiation:

The section supports this direction of increased RVs for visits and consults in hospitalized patients.

**Relative Value Guide Commission**  
**Summary of Sectional Issues:**  
***Diagnostic Radiology***

**Friday February 23, 2001**

**Present:**

Dr. John Atkinson, RVG Chair

Brian Spooner, Project Manager

Nancy Rowan RVG Associate Project Manager

Dr. Dennis Jirsch, Alberta Health and Wellness Representative

Dr. Edward Mansfield, Statistical Consultant

**Section Representative:**

▸ Dr. Alan Poole

▸ Dr. David Vickar

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**Issues:**

Overhead adjustment:

- The section was advised that spousal salaries are slated at \$3500 to be consistent with other sections.
- CMPA Dues: Expense was calculated at \$1000.00 per physician.
- Cost of Capital: the section challenges the cost of capital. They do not feel that the Arthur Andersen's estimate was sufficiently high enough. Daryl Johannesen from Arthur Andersen will have one more communication with DI's accountant, Don Zinyk at KPMG prior to finalizing this figure.

Feb 27, 2001: Further analysis indicated a disagreement between KPMG and Arthur Andersen of \$7000.00 on this issue. The Commission will use the Arthur Andersen figure.

Common Scale: DI believes that the cross-links unfairly disadvantage their section because they do not recognize the unique nature of the work. The section feels that the inadequacies of the existing schedule contributed to the problem. E.g. a biopsy by a surgeon is the insertion of a needle into a lump where as DI does a radiologically guided biopsy. DI believes their procedure is more complex. The commission confirmed that a new mutually agreed upon cross-links with obstetrics and cardiology were added to DI's cross-links, and that this should remove any doubt about the cross-linking process.

Code Issues:

**X216B and X216D:** DI feels that the RV units are flipped. Upon review of this concern it appears that X216B is not billed at all because it is a redundant code.

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## **Attachment E**

### **List of Documents**

#### **Overview documents**

- Interim Report No.2-October 2000
- Report to section advisors-January 2001
- Interim Report No.1-October 1999
- RVG Physician opinion survey results
- Comparison of RVG initiatives in Canada and the U.S.

#### **Developing the Common Scale**

- Method for Creation of the Common Scale
- Sample of survey instruments – cross-links
- Cross-links Used to Develop the Common Scale
- Correlation coefficient between intra-sectional RVs and RV 2000
- Overview of Approach and Conclusions for Visits and Consults
- Alberta Office Visit and Consult Patient Complexity Study, Earle L. Snider, PhD
- PCS Scores from Visit and Consult Study
- Procedure for Calculating the Final Common Scale Relative Values (the “RV 2000s”) for Office Visits & Consults – Use of the Patient Complexity Scores (“PCS”)

#### **Assessing Practice Expense Recovery**

- Practice Cost Recovery in Resource-Based Relative Value Guides: Lessons from Canada, the United States and Australia
- Framework for the Recovery of Overhead Costs
- Practice Expense Recovery in the Alberta RVG: Status Report to Sections
- Study of Physician Practice Expenses, Arthur Andersen
- Addendum to the Study of Physician Practice Expenses
- Development of Practice Expense (OH) Multipliers

**Evaluation of Commission's methodology and processes**

- Review of Method for Creation of Common Scale
  - Letter from Prof. Mark E. Glickman, Boston University
  - Response from Edward J. Mansfield, PhD, Arthur Andersen
- Review of Alberta RVG Interim Report No. 2
  - Review by Peter Braun, M.D., Boston University
  - Response of the Commission to input on Office Visit and Consult Patient Complexity Study
  - Response from Earle Snider, PhD, University of Alberta