

## Relative values arrive



In January the United States government began to phase in its new relative value system of paying doctors under Medicare. Based on Professor Hsiao's study at Harvard, its underlying principles had been first published in 1988.

At the time the American Medical Association supported the plan and the American College of Physicians testified in its favour before congress. It was understood that the scheme would not be used as a tool to cut the budget but would redress prevailing imbalances in reimbursement. Thus, as I reported earlier (29 April 1989), internists and family practitioners expected a raise largely at the expense of the procedure oriented doctors, but cynics suspected that in the long run everybody would lose out.

The bombshell did not burst until mid-1991, when outrage and cries of "betrayal"

greeted the administration's plan to cut the budget deficit by reducing overall payments by 16%. There was indignation over cutting the common multiplying factor to \$27, the 3% reduction to offset anticipated increases in volume, paying doctors less in their first five years of practice and over numerous other provisions. The American College of Physicians protested, the American Medical Association mobilised doctors to fight, and legislators received more than 95 000 letters, finally convincing congress and the administration that changes were needed. The new regulations, published in November, eliminated some of the cuts and restored some payments. The conversion factor on which all fees are based was raised to \$31 and other concessions were made. Fees will be raised for some office visits and may be cut by as much as 30% for procedures and surgical operations.

The details are complex and will take time to learn. Fees will be calculated by the time spent with the patient, the difficulty of the effort, the local cost of living and practice overheads and the cost of malpractice insurance. Young doctors will be paid 20% less in their first year of practice. Emphasis

will be on documentation, and Medicare inspectors will do periodic audits. The rules recognise four types of history and physical examinations (problem focused, expanded problem focused, detailed, and comprehensive) and four degrees of complexity in decision making. By combining these criteria doctors will determine which code to bill. Thus for new office visits there are five incremental codes from self limiting minor problems (\$28 in Illinois) to moderate or high severity (\$76). The guidelines indicate that doctors typically spend 10 minutes for the lowest code, 60 minutes for the highest. Similar rules apply for return visits, consultations and visits in the hospital, for procedures and operations, and there are numerous other rules and fee schedules.

The system has been hailed as the greatest change since doctors stopped accepting chickens and pigs in payment. The health secretary said it would bring greater predictability and equity to doctors' payment and go far toward correcting longstanding price distortions. Only time will tell if it is realistic and if it will work. —GEORGE DUNEA, *attending physician, Cook County Hospital, Chicago, USA*