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GOVERNMENT Storage

96th Congress
1st Session

COMMITTEE PRINT

THE CALIFORNIA RELATIVE VALUE STUDIES, AN OVERVIEW

AND THE

CALIFORNIA PHYSICIANS SERVICE, THE CORPORATION,

AND ITS RELATIONSHIP WITH THE

CALIFORNIA MEDICAL ASSOCIATION

A STUDY

PREPARED FOR THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE



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ON INVESTIGATIONS
WASHINGTON, D.C. 20510

April 20, 1979

TO: All Members of the Permanent
Subcommittee on Investigations

FROM: Sam Nunn, Chairman
Charles H. Percy, Ranking Minority Member

RE: Staff Study on the California Relative Value Studies

This Committee print presents a study entitled the "California Relative Value Studies, An Overview, and California Physicians Service, the Corporation, Its Relationship with the California Medical Association."

The California Relative Value Studies (CRVS), which is published by the California Medical Association (CMA), is a listing of descriptors of available medical procedures with non-monetary units to show the relativity of one procedure to other procedures. The CRVS is intended to provide standardized terminology for medical services so that physicians and the Government agency or other third party payor can identify with precision the services performed. The unit values are intended to serve as a guide to individual physicians in determining their respective fees and as a guide to Government agencies and insurance carriers in determining their commitments and in evaluating physician claims.

The California Physicians' Service was created by CMA, operates the State Blue Shield plan, and is one of the nation's largest processors of claims against Federally-financed health programs.

The study was prepared for the Subcommittee by members of the GAO staff who were detailed to the Subcommittee staff during a staff inquiry pursuant to its jurisdiction to investigate the economy and efficiency of Federally-funded health programs. The report does not contain formal conclusions or recommendations since the study was solely fact finding in nature. However,

the information in the report appears to suggest a number of significant questions bearing on health care programs. Therefore, the study is being sent to various Government agencies and Congressional committees for their consideration and such action as they deem appropriate. The study will also be made available to the subjects of the study and other interested persons.

The background of the inquiry and highlights of the study are discussed in the following summary prepared by the Subcommittee staff.

Attachment

April 16, 1979

M E M O R A N D U M

TO: Senator Sam Nunn, Chairman
Permanent Subcommittee on Investigations

THRU: LaVern J. Duffy, Acting Chief Counsel

FROM: Peter M. Sullivan, Assistant Counsel

RE: California Relative Value Studies

BACKGROUND

One of the most crucial domestic problems facing the President and the Congress is the continuing increase in health care costs for our citizens. The statistics are startling. For example, in 1950, health care expenditures in our nation accounted for 4.5 percent of our Gross National Product. Total health care costs in Fiscal Year 1977 accounted for 8.8 percent of the Gross National Product, or a total of $142.6 billion per year. The Department of Health, Education, and Welfare has estimated that by 1980, we could be spending more than $230 billion per year for health care. This means that, in Fiscal Year 1977, $737 per year was spent for every man, woman and child for health care services and this figure could rise to $1,000 by 1980.

In Fiscal Year 1978, the Federal Government alone is spending $34 billion for health care services in the Medicare and Medicaid programs, and is projected to spend approximately $46.6 billion by Fiscal Year 1980.

Almost 20 percent of all health care expenditures in Fiscal Year 1977 -- about $32 billion -- was for professional services rendered by physicians. A considerable portion of this amount was paid to physicians through various health insurance programs, such as Blue Cross-Blue Shield, Medicare and Medicaid.

There are several administrative methods by which doctors are reimbursed for their services by health insurance programs, and these methods usually involve computerized billing systems. Since computers are utilized, the reimbursement methods involve two important elements. First, standardized terminology is used to describe available medical services so that physicians and government or private agencies reimbursing them can identify with precision the services performed and can communicate those services to the computers which handle the billing and reimbursement functions. Second, criteria are developed for determining the amount of payment for each of the services described in the standard terminology.

In considering legislative and administrative approaches to revising the nation's health care programs, it seems appropriate for Congress, the Executive Branch, and private health care organizations to evaluate the existing methods used to compensate physicians for their professional services. In this regard, the Permanent Subcommittee on Investigations in 1977 authorized a staff inquiry into the California Relative Value Studies (CRVS), the first major effort to develop a comprehensive list of available medical services which could be used by physicians to identify and communicate their services to various health insurance programs for the purpose of being reimbursed for those services.

The CRVS was developed by the California Medical Association (CMA) in the 1950s. The CRVS was published in 1956 and subsequently revised in 1957, 1960, 1964, 1969 and 1974. Over the years, the CRVS has gained wide acceptance both within and outside of California by physicians, Government health agencies, and private health insurance companies and health service benefit plans.

The CMA states that the CRVS is a reflection of the practice of medicine in California, consisting of a numerically coded list of descriptors of physician services with non-monetary unit values to indicate the relative value of median charges by physicians for most of these services. The stated primary purpose of the CRVS is to precisely describe and code the services provided by physicians in California so that insurance carriers and Government agencies which accept CRVS can identify the services provided by physicians. The CMA states that with "appropriate consideration to individual and local variations in practice," CRVS may also be used as a guide to a physician in determining his charges, as a guide for insurance carriers and Government agencies in determining their commitment, and as a guide in evaluating individual claims. The CRVS provides instructions on how physicians may apply a dollar conversion factor to the unit values to develop a personal fee schedule reflecting the relativities of State-wide median charges. However, the CRVS declares that it in no way sets any physician's fees or any schedule of fees and is in "no sense a fee schedule."

Pursuant to the Subcommittee's jurisdiction to investigate the economy and efficiency of Federally-funded health programs, Senator Henry M. Jackson, then Chairman of the Subcommittee, authorized a staff inquiry in April 1977 into (a) the role of the CMA in the development and distribution of the CRVS; (b) the relationship of CMA with the California Physicians' Service (CPS) (CPS was created by CMA, operates the State Blue Shield plan

whose subscribers include Federal employees, and is one of the nation's largest processors of claims against Federally-financed health programs, including Medicare); and (c) the use of the CRVS by CPS in reimbursing physicians under such programs. This study was part of a broader Subcommittee inquiry opened in May 1975, when Senator Jackson authorized a review of private fiscal agents or intermediaries in various Government health related welfare programs, including Medicare and Medicaid. The private fiscal agents process claims under these programs for physician, hospital and other patient services.

To assist it in carrying out the CRVS study, the Subcommittee asked the Comptroller General to assign to the Subcommittee staff skilled personnel who had experience in the field of health financing programs. Felix Brunner and Maria Tice, both certified public accountants with the San Francisco Office of GAO, were given the task. They worked under the general supervision of David Vienna, an investigator who was on the Subcommittee staff until late last year. Mr. Brunner, assisted by Ms. Tice, examined a large volume of documents obtained from the CMA, CPS, and other sources and conducted several interviews. The results of their work were submitted by them in a report titled, "The California Relative Value Studies, An Overview, and California Physicians' Service, The Corporation, Its Relationship With The California Medical Association."

SUMMARY OF THE REPORT

The report includes a description of the structure of CPS and its relationship to CMA and gives certain examples of the interaction between these two organizations in the area of physician reimbursement. Briefly, since CPS was created by CMA in 1939, the organizations have maintained close formal and informal ties. In this connection, for example, the board of trustees of CPS until 1977 was elected by the CMA's House of Delegates, which were the voting administrative members of CPS. Since 1978, CPS voting administrative membership consists of about 55% CMA members of CPS, 5% Golden State Medical Association members of CPS, and 40% public-subscriber members of CPS.

The report states that CPS's primary purpose was to establish and maintain a fund obtained by means of periodic payments by its beneficiary members to be used to defray the cost of medical service to such members. Since its inception, CPS has been accorded federal tax-exempt status on the basis of its being a non-profit social welfare organization. In the early years of its operations, most of CPS's revenue was derived from administering Blue Shield health plans subscribed to by CPS

member beneficiaries and most benefits under these plans were paid to CPS member physicians who agreed to accept the CPS reimbursement as payment in full for their services to plan subscribers. The report points out that over the last several years, the nature of CPS's business has changed substantially so that most of its income has been derived from servicing government health programs such as Medicare and Medicaid. Under Medicaid, physicians are required to accept the government reimbursement level as payment in full while under Medicare they are not so required. Also, most of the benefits under CPS's regular Blue Shield health plans are now paid to physicians and organizations which are not members of CPS and are not required to accept the CPS reimbursement as payment in full.

The bulk of the study discusses the history and development of the CRVS, with special emphasis on the 1969 and 1974 revisions and the basis for determination of unit values given medical procedures described in the CRVS.

The report also discusses the "usual, customary, reasonable" (UCR) concept of determining physician payment, of which the CRVS is an adjunct. This concept is used by various health programs, including Medicare, although Medicare uses somewhat different terminology than do private programs. Under the UCR method, computers develop profiles on each physician and establish his "usual charge" (called "customary charge" under Medicare) for procedures coded and defined in the CRVS. The aggregate of all physicians' usual (customary) charges within specific geographic areas is used to develop an area-wide profile of "customary charges" and ("prevailing charges" under Medicare) fees for each procedure, once again using the CRVS codes and definitions. Under the UCR method, a provider is paid a fee for his service that is limited to the lower of the amount charged, his "usual customary" fee, or the "customary" (prevailing) fee in his geographic area. Under Medicare, prevailing charges are only allowed to increase by the percentage increase in an Economic Index that is intended to reflect increases in physicians' operating costs and changes in workers' earning levels. If a physician's charge exceeds both the "usual" and "customary" limits, it may still be paid in full if it is deemed to be "reasonable."

For its regular Blue Shield health service benefit plans and Medicare, CPS uses CRVS unit values as a guide in establishing payment screens which reject extremely high and low charges from usual and customary profiles. It also uses unit values to impute usual and customary charges when there is inadequate profile data. In contrast, the California Medicaid or Medi-Cal program uses a state-wide uniform reimbursement system. In this regard, the State of California sets specific dollar conversion factors by which CRVS unit values are multiplied to arrive at the maximum allowable amounts the State will pay physicians for such services.

The study prepared by Mr. Brunner and Ms. Tice points out that the original 1956 CRVS, which contained about 1,000 procedure descriptors, grew to a list of over 5,500 procedures in the 1974 version. The majority of procedures have been assigned relative unit values. The 1974 CRVS has 1,800 more procedures than the 1969 CRVS. These growth figures are the net effect of a greater number of changes in descriptors. Descriptor changes generally fall in the following categories: (1) Additions, deletions and modifications to reflect changes in the state-of-the-art of medical practice or clarifications in terminology; (2) procedure code number changes; (3) the consolidation of existing procedure descriptors; and (4) fragmentation of or breaking down existing procedure descriptors into component procedures. Of these, the changes resulting from fragmentation appear to be the subject of controversy, particularly when they create new procedures which have higher unit values and/or which may lead to the development of higher valued usual and customary profiles.

According to the report, critics of CRVS, including some physicians and the Department of Health, Education, and Welfare, believe that such fragmentation of medical procedures may lead to fee escalation by facilitating alteration of billing patterns (i.e., billing for newly created higher valued procedures instead of lower valued, single procedure described in the earlier version), especially when the fragmentation creates hard to evaluate differences in descriptors on the basis of the intensity of service performed, such as in the degree of difficulty of a surgical procedure or the time and skill involved in an office visit. 1/

1/ For example, two patient office descriptors were added to the 1974 CRVS for "unusually complex medical problems" (Code No. 90026) and "comprehensive re-examination or re-evaluation when complicated by chronically disabling condition" (Code No. 90085). Procedure Code No. 90026 was not assigned a unit value, since it was considered too variable in the nature of its performance, thus requiring justification of fees on a case-by-case or "by-report" basis. Code No. 90085 was assigned a unit value of 16.0. A critic cited in the report contends that these situations "could be comfortably described" by the previously established descriptors, which were also in the 1974 CRVS, for "initial comprehensive history and examination, including initiation of diagnostic treatment and treatment program" (Code No. 90020) and "comprehensive re-examination and/or re-evaluation" (Code No. 90080). Code No. 90020 is assigned a unit value of 17.5, versus the "by-report" designation for Code No. 90026. Code No. 90085 is assigned a unit value of 16.0 versus 13.0 for Code No. 90080.

There are three reasons Medicare costs for physician services can increase: (1) increased service utilization; that is, program beneficiaries receive more services; (2) increased physician charges; that is, physicians decided to charge more for a particular service; and (3) physicians billing for higher valued services. The CRVS could only have an impact on the third factor.

The report cites suggestions by critics that changes in descriptor terminology, brought about by certain CRVS revisions, have actually affected billing patterns and caused physician fee inflation. However, the report points out the difficulty of establishing any cause-effect relationship between CRVS revisions and changes in billing patterns and fee levels.

Apart from the direct impact of the adoption of CRVS revisions, billing patterns and charge levels, the study presents data on increased program costs for the Medicare and Medi-Cal programs due to shifts toward billing to higher valued patient visit services even when the options available for reporting the complexity of the service remained constant. In this regard, the report includes a letter from the Medical Director of CPS which states that (1) $8.3 million of the $80.4 million increase in charges to Medicare in 1977 versus 1974 and (2) $16 million of the $170.2 million increase in charges to Medi-Cal in the same period were attributable to changes in the pattern of billings to higher valued office, hospital and other patient visit procedures.2/ It should be noted that these figures represent amounts billed to Medicare and Medi-Cal. Thus, the $8.3 and $16 million amounts were not necessarily the full amount actually paid, although it appears that a substantial part of both would have been paid.

2/ The following table shows the categories of procedures included in the CPS study and the number of procedures in each category which reflect different levels of complexity:

1. Office Visits
   (a) Initial - 4 procedures
   (b) Follow-Up - 5 procedures

2. Hospital Visits
   (a) Initial - 3 procedures
   (b) Follow-Up - 4 procedures

3. Consultation Visits - 4 procedures

The foregoing procedure descriptors were accepted by Medicare and Medi-Cal.

In an attempt to explain changes in billing patterns for Medicare and Medicaid, the CPS Medical Director states that:

> We know, from numerous conferences and interviews, that many physicians have altered their billing patterns to use the higher valued numbers in order to realize an allowance closer to their fees to the general public. These conferences and interviews have also disclosed a general change in billing patterns from charging for one hospital visit per day to two visits per day. This pattern change, in our opinion, explains the significantly greater increase in additional follow-up hospital services than follow-up office visits. We also attribute this change in billing patterns as an effort to realize an allowance close to the general public fees from the government programs.

The study did not attempt to verify this explanation. However, this letter suggests the possibility that any system of procedure descriptors which recognizes legitimate differences in procedures on the basis of time, risk and skill, such as in the patient visit area, may be susceptible to some abuse by individual physicians seeking to circumvent limitations on reimbursement imposed by government health programs.

As noted above, the CRVS represents that unit values assigned to procedures show the relativity of median charges by physicians for those procedures. In this connection, the 1974 CRVS states that "All changes in relativity ... represent only charges in relativity that actually have occurred in medical practice," and that "Relativities reflect computer data, current surveys and/or comparability of procedures." The 1969 CRVS states that "Unit values for ... procedures for which little or no data were available and for many of the procedures newly introduced ... were determined on the basis of their relationship to procedures with known data."

The report discusses the results of its examination of the role several 1974 CRVS subcommittees played in developing unit values. The subcommittee chairmen generally indicated that adequate actual charge data was not available to establish the unit values

assigned to a high percentage of the procedures for which they were responsible. 3/ As a consequence, unit values for these procedures reflected in large part the subjective judgment of the CRVS authors. In some cases, these judgments were arrived at after consideration of responses from limited surveys of physician fees (as distinguished from actual charge data) and/or other factors such as the unit values of procedures for which there may have been adequate charge data. Unit values for most procedures in the 1969 CRVS appear to have been determined in a similar manner. Minutes of a June 1968 CMA Council meeting indicate that the 1969 CRVS Committee had to exercise judgment in determining the great majority of unit values because computer data was sufficient only for about 20 percent of the procedures.

The report indicates that the unit values in the 1974 and 1969 editions of the CRVS revisions were based on subjective judgment to a much greater extent than is revealed in the explanations of the basis of unit values contained in those editions. Also, to the extent such unit value judgments were made in the absence of actual charge data, it is difficult to independently verify whether such unit values reflect the actual relativity of median charges.

Some critics noted in the report have suggested that some procedures were assigned unit values that were not justified. However, the study did not assess the reasonableness of unit value judgments.

Whatever the merits of assertions by CRVS critics, the Department of HEW rejected most of the 1974 CRVS because of concern about its potential inflationary impact on billing practices. As a consequence, most bills submitted using 1974 descriptors are translated to 1969 terminology and related UCR profile data.

The study also indicates that the administrative cost of converting from one CRVS revision to another can be very expensive. In this regard, a CPS Task Force reported that the change from the 1964 to 1969 CRVS (which included modifying computer programs to accommodate five, rather than four digit code numbers) produced near chaos in program administration. The CPS Task Force also said that the conversion to the 1969 CRVS was one of the key factors leading to a $20 million loss experienced in the two years subsequent to the release of the 1969 CRVS.

The study points out the CRVS is used in many more areas than California. A chart included in the report shows that medical societies in 20 other States were using CRVS in some

---

3/ The 1974 CRVS subcommittees not considered by the study did not necessarily have the same experience.

form or other and that 16 other organizations (medical specialty societies, insurance companies, and State programs) were using CRVS in whole or in part. The study also notes that the third edition of the American Medical Association's Current Procedural Terminology (CPT-3) (a descriptor and coding system that does not include relative values) was based substantially upon the 1969 CRVS coding and terminology. CPT-3 was used by medical societies in 14 States according to the chart.

Regarding the UCR concept, some commentators cited in the study suggested that it is potentially inflationary since usual and customary profiles will increase as actual charges increase. In this connection, certain commentators suggested that physicians might remodel their usual profiles by charging higher fees than they know they can be reimbursed (perhaps without necessarily collecting any difference from the patient) and eventually obtain third party payment at higher levels as their usual and the area profiles move upward. One commentator felt that only a few physicians might charge higher fees in anticipation of profile updates. The study did not verify whether physicians have actually engaged in such a practice. However, the potential for artificial fee inflation under this method would appear to be a factor to consider in assessing the reliability of actual charges as a basis for a relative value guide or a reimbursement method.

The report also discusses allegations by some critics that CRVS may be abused as a fee fixing device in violation of the federal antitrust laws. Some critics, including federal antitrust enforcers, appear to take the position that the publication of a relative value guide by a physician group, with instructions on how an individual physician may apply dollar conversion factors to the unit values in order to develop a personal schedule of fees reflecting the relativities in the guide, is a per se violation of the antitrust laws (i.e., prohibited regardless of possible justifications of the necessity for, or benefits of CRVS). In this connection, the study indicates that the CMA has entered a provisional consent agreement in a proceeding brought against it by the Federal Trade Commission. Under the terms of the provisional agreement -- which has not yet been made final -- CMA (without admitting any violation) would cease and desist from developing any further relative value guides and would withdraw and cancel all existing CRVSs. The agreement would permit CMA to continue publishing medical procedure descriptors, provided no values are assigned. The report notes CMA's position that FTC has not demonstrated that CRVS is used as a price fixing tool. Also, as noted above, CMA asserts that the CRVS is only a guide and CRVS has consistently included a disclaimer that it is a fee schedule.

The study did obtain information indicating that some Foundations for Medical Care in California, which are sponsored by county medical societies and operate health service plans, apply conversion factors to the CRVS to develop physician payment levels under such plans. These conversion factors appear to be widely disseminated to Foundation membership. For example, the Foundation for Medical Care of Orange County, in a memorandum to "All Orange County Physicians" proposed dollar conversion factors to be applied to the 1974 CRVS. In announcing the conversion factors, the Foundation's Board of Trustees said:

> The Foundation for Medical Care of Orange County is undertaking an active role in the guidance and leadership of the provision of medical services in our county. We are working closely with, and have the endorsement and parallel philosophies of the Orange County Medical Association.
>
> Recently the Board of Trustees of the Foundation proposed raising the conversion factors in order to keep pace with these inflationary times and to offer a fair reimbursement to its providers, and the membership was polled for its opinion. The results of this referendum have been tabulated, and commencing with all new and renewed contracts as of January 1, 1978, providers will be reimbursed on a sliding scale (based on the 1974 California Relative Value Studies) as follows:

Surgery	$110.00
Medicine	5.39
Anesthesiology	20.90
Radiology	9.13
Pathology	1.30

The effects and other implications of Foundations' activities relating to the CRVS were not determined by the study.

The study alludes to the concern of the Federal Trade Commission that a relative value guide published by the government or some other non-physician group might become an anti-competitive device. Similarly, consideration might be given to the potential impact on competition of the public availability under the Freedom of Information Act of Medicare profile data on individual and area physician charges.

QUESTIONS SUGGESTED BY THE REPORT

The information in the report appears to suggest a number of significant factual, legal and policy issues as to the foregoing and other matters which should be of interest to government and private agencies and individuals concerned about health care financing. Among the more important questions are:

(1) Whether the mere creation and promulgation of the CRVS by the CMA is a per se violation of the federal antitrust laws?

(2) Whether, if CRVS constitutes a per se violation of the antitrust laws, there is any basis for a legislatively mandated antitrust exemption for the use of relative value studies on the ground that they serve some over-riding public purpose? In resolving this issue, questions (3) through (5) appear to be directly relevant.

(3) Whether the CRVS has actually been used by physicians to fix or stabilize physician fees in various localities of California by agreements to use specified conversion factors to be applied to the CRVS units?

(4) Whether, as the CMA claims, the CRVS is a true reflection of the actual practice of medicine in California and unit values reflect the relativity of median charges of services provided by physicians, or whether, as some critics suggest, CRVS unit values and terminologies reflect, in large part, the subjective judgments of the authors of CRVS as to how medicine should be practiced and what physician charges should be?

(5) Whether the CRVS and modifications in terminologies and unit values in various revisions of the CRVS have actually facilitated or otherwise contributed to artificial and inflationary alterations of billing patterns and increases in government health program costs?

(6) Whether the potential anticompetitive and inflationary aspects of a relative value guide created by physicians can be avoided or minimized by having the government or non-physician dominated third party payors develop terminologies and unit values?

(7) Whether the "usual, customary, reasonable" (UCR) method of determining physician payment has actually facilitated or otherwise contributed to artificial inflation of physician charges and increases in government health program costs and whether there are viable alternatives to the present UCR method (for example, ceilings on the UCR such as those provided in the Medicare Economic Index)?

(8) Whether a change in CPS's business -- whereby the major portion of its income is now derived from servicing government health programs rather than CPS-sponsored health benefit plans and most benefits under CPS-sponsored health plans are paid to non-members who are not required to accept the CPS reimbursement as payment in full -- warrants any modification in CPS's status as a tax-exempt organization under the Internal Revenue Code or the exempt status of its income under the Code?

The report does not contain formal conclusions and recommendations since the study was solely fact-finding in nature. Also, the subject matter of the study is highly technical and complex, and it appears that additional information and analysis will be necessary before definitive conclusions can be drawn as to some issues. In view of the foregoing and the lack of expertise on the Subcommittee staff to resolve these matters, it is recommended that the report be released as a study. This will enable the study and the issues it raises to be considered by the Congressional committees and federal agencies with substantive responsibilities in the health care and antitrust areas, as well as by experts in the appropriate fields of law and medical economics and other interested persons inside and outside of government.

PMS/kd

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APPENDIX J California Physicians and Blue Shield of California Member Physician Statistics

SCOPE

The scope of this report is a preliminary examination of documents subpoenaed by the Chairman of the Senate Permanent Subcommittee on Investigations, Committee on Government Operations, from California Physicians Service, San Francisco, California; California Medical Association, San Francisco, California; and Electronic Data Systems, Inc. Discussions were held with officials of the above organizations, the Office of the Insurance Commissioner of the State of California, and a number of physicians who participated in the preparation of the 1974 revision of the California Relative Value Studies.

INTRODUCTION

The California Physicians Service (CPS)[1] is a voluntary service organization that was sponsored and formed by the California Medical Association (CMA). CPS was incorporated on February 2, 1939, with the approval of the CMA as a nonprofit social civic corporation under California Civil Code Section 593, now California Corporation Code Section 9200. The primary purpose of the corporation was to establish and maintain a fund obtained by means of periodic payments by its beneficiary members to be used to defray the cost to such members of medical services, hospital care, and other health services and facilities.

Corporation Code Section 9200 provides as follows:

> "A nonprofit corporation may be formed ... for any lawful purposes which do not contemplate the distribution of gains, profits, or dividends to the members thereof ... Carrying on business at a profit as an incident to the main purposes of the corporation and the distribution of assets to members on dissolution are not forbidden to nonprofit corporations but no corporation formed or existing ... shall distribute any gains, profits, or dividends to any of its members as such except upon dissolution or winding up."

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[1] Also known as California Blue Shield and currently doing business as Blue Shield of California.

Amendments to the Corporation Code added among other provisions the following:

1. "At least one-fourth of all licentiates of the particular profession residing in California become members.

2. Membership[1] in the corporation and an opportunity to render professional services upon a uniform basis are available to all licensed members of the particular profession."

CPS was declared a tax exempt corporation by the Internal Revenue Service under Section 101(8) of the 1939 Internal Revenue Code -- now Section 501(c)(4).

Section 501(c)(4) of the code defines tax exempt organization as follows:

> "...Civic leagues or organizations not organized for profit but, operated exclusively for the promotion of social welfare or local associations of employees, the membership of which is limited to the employees of a designated person or persons in a particular municipality and the net earnings of which are devoted exclusively to charitable, educational, or recreation purposes."

Structure of the Corporation

CPS' articles of incorporation establish three classes of membership: 1) Administrative members who are elected by the CMA have the right to vote and hold office in the corporation. Administrative members are usually physicians, however this is not a requirement. 2) Professional members, also known as physician members have no voting rights. 3) Beneficiary members also known as subscriber members have no voting rights.

The bylaws of CPS provide that each voting delegate in the House of the CMA elected in accordance with the constitution and bylaws of the CMA, each officer of the CMA and each member of the CPS Board of Trustees becomes automatically an administrative member. The bylaws further provide that physician members are those physicians and surgeons who hold certificates issued by the Board of Medical Examiners of the State of California,

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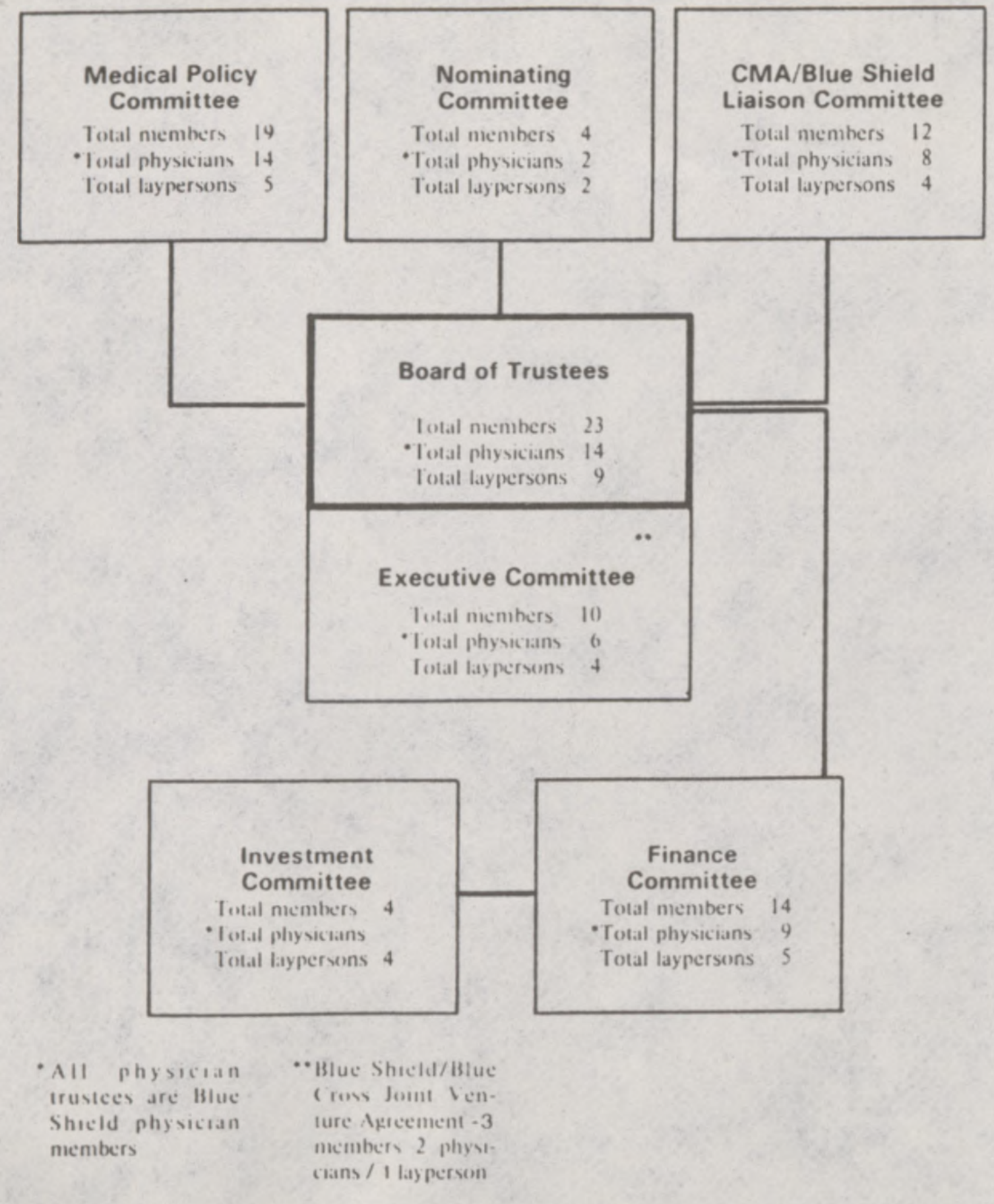
[1] Only persons licensed as physicians or surgeons may become members of CPS.

and who apply and become physician members of CPS. Subscriber members are those to whom a membership certificate has been issued and who are entitled to secure medical services when needed in accordance with the terms and conditions of the certificate they hold.

The corporate powers are vested in a Board of Trustees consisting of twenty-three trustees. Twenty trustees are elected by the administrative members (also known as members of the House of Delegates of the CMA) at the annual meeting of the CMA House of Delegates and serve three-year terms. Three ex-officio members who serve one-year terms are elected by the CMA Council. A 1976 amendment to the bylaws requires that "at least one-third of the Trustees shall be Subscriber Members who are not providers of care."

The CPS Board has several committees. For a more detailed explanation of the interrelationships, functions and composition of committee memberships, and the responsibilities of the various committees see the following charts:

CPS
Board of Trustees — Pertinent Committees & Their Functions
June 1977



*All physician trustees are Blue Shield physician members

**Blue Shield/Blue Cross Joint Venture Agreement -3 members 2 physicians / 1 layperson

MEDICAL POLICY COMMITTEE: This committee establishes sound bases for handling major health care problems. The committee seeks to assure the quality of services Blue Shield is purchasing for its subscribers and the government program health care recipients.

Most of the problems which reach the committee are initially brought to light through local medical society review action and by Blue Shield's team of medical advisors.

The committee also acts as a communications channel, acquainting physicians with Blue Shield's operations, problems and programs and receiving comments and suggestions from organized medicine. Nine of the 19 members are on the Board of Trustees.

NOMINATING COMMITTEE: The nominating committee selects nominees for vacancies of the board and board officers. All 4 members are on the Board of Trustees.

CMA-BLUE SHIELD LIAISON COMMITTEE: The California Medical Association-Blue Shield Liaison Committee was established in February, 1960 under a resolution adopted by the CMA House of Delegates.

This committee serves a a coordinating body between CMA and Blue Shield. It is comprised of the Executive Committees of Blue Shield and CMA, plus the Blue Shield trustees who are Council appointees. All 12 members are on the Board of Trustees.

THE BOARD OF TRUSTEES: The Board of Trustees is the policy-making body of Blue Shield of California (California Physicians' Service) with the executive functions carried out by management. The Board of Trustees are elected by the California Medical Association voting delegates.

EXECUTIVE COMMITTEE: The Executive Committee's principal function is to act on behalf of the Blue Shield Board of Trustees between regular Board mmetings. The Executive Committee also, whenever possible, reviews committee reports prior to Board meetings. The Executive Committee coordinates the activities of all the other permanent committees and carries out such functions as are assigned to it by the Board at either regular or executive session. All 10 members are on the Board of Trustees.

FINANCE COMMITTEE AND INVESTMENT SUB-COMMITTEE: The Finance Committee has two general functions. First, it oversees and assists in the administration of Blue Shield and reports to and advises the Board of Trustees. Second, it supervises the administration of capital assets and protects the financial stability of the company, not only for investments, but also for financially sound contracts. An Investment Sub-Committee is authorized by the Board of Trustees to effect needed changes in the investment portfolio. Thirteen of the 14 members are on the Board of Trustees.

Objectives of the Corporation

Under its articles of incorporation and bylaws CPS acts as a service type company and not as an insurer or indemnifier. The difference being, that in the normal insurance agreement[1] an insured may pay a certain amount per month for indemnification by an insurer for medical services for particular covered benefits. The insured must pay the difference between what the provider bills and the amount for which the insurer is indemnifying the insured. In a health plan arrangement the health plan provides all the specific services and the subscribing member is not liable for the difference between what the provider bills and what the health plan pays the provider.

The plan defrays the cost of medical services the subscribing member incurred with the provider, the provider accepting the risk of any difference between what the provider charges and what the plan pays. If the patient with whom the health plan contracts obtains medical services requring payments which exceed the pool of money the plan has collected from each subscriber the plan itself does not assume the risk. Rather, the medical providers who have an agreement with the plan assume the risk by accepting compensation, if any, as determined by CPS.[2] For example, CPS could pay 75 percent of a physician member's bill, and there is no riskexposure on the part of CPS or the subscriber patient to pay the remaining 25 percent.[3]

Thus a health plan renders a personal service for a fee where an insurance company indemnifies and assumes the risk.

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1 Insurance is a contract whereby one undertakes to indemnify another against loss, damages, or liability arising from a contingent or unknown event. The person who undertakes to indemnify another by insurance is the insurer and the person indemnified is the insured.

2 A list showing the number of California Physicians and Blue Shield of California Physicians is contained in Appendix J.

3 In 1971 when CPS was in financial difficulty it withheld 5 percent from physician members' benefit payments. During the 6-month period July to December 1971 $655,000 was withheld from physician members. Amounts withheld were subsequently paid to physicians on October 8, 1973.

To carry out its objectives as a service company, CPS enters into contracts with individual subscribers, corporations, employers, and public entities such as the Federal Government (Federal Employee Benefit Program).[1] Payments to physician members of CPS rendering services under these contracts are made in accordance with membership agreements. Payment schedules are established to allow for a contingency reserve against increasing demand for services, and unforeseen financial burdens. Funds so retained are placed in a Unit Stabilization Reserve.[2]

Reimbursement for services rendered by non-member physicians or non-participating providers (See page 11) such as hospitals is determined on the same basis as payment to CPS physician members. However, non-member physicians and non-participating providers are not obligated to CPS to accept these reimbursements as payment in full and may bill the subscriber patient in full for the difference between their fee charges and CPS' payment.

Payment for services rendered by physician members is generally made by CPS directly to the physician member. Payment for services rendered by non-member physicians or other providers is generally made to the subscriber patient who must then settle his account with his non-member physician. A subscriber has the right to seek treatment from either a member or a non-member physician.

Changes in CPS Business Activities

During the past 20 years there has been a substantial shift in CPS business activities in that revenues and benefit payments related to its original tax exempt

1 Revenues from these contracts have been designated by CPS as Standard Business Revenue. The Federal Employee Benefit Program administered by the Civil Service Commission represents about 22 percent of CPS' total 1976 Standard Business.

2 The Unit Stabilization Reserve is basically the difference between assets and liabilities. In a "profit" type corporation it would be the stockholder/owner's accumulated equity in the business.

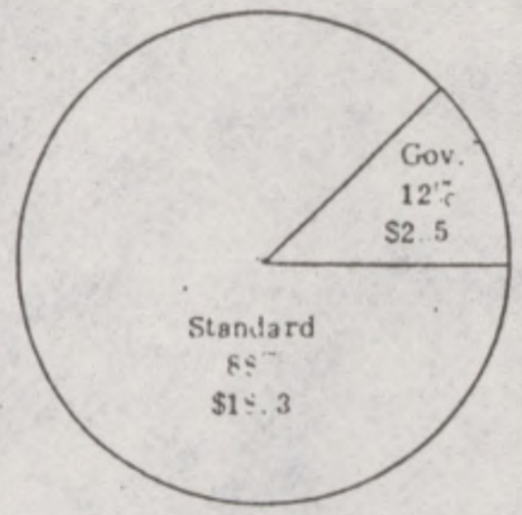
status have substantially decreased while revenues from other activities such as government programs have increased.

The following charts compare CPS earlier, 1950 and 1965, business activity to its activities in 1976:

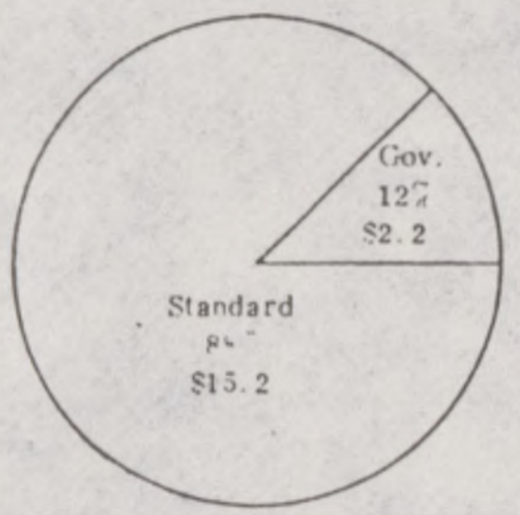
BLUE SHIELD OF CALIFORNIA
Comparison of Revenue & Benefits - All Programs
For the 12 Months Ending March 31, 1950

($ in millions)

Revenue



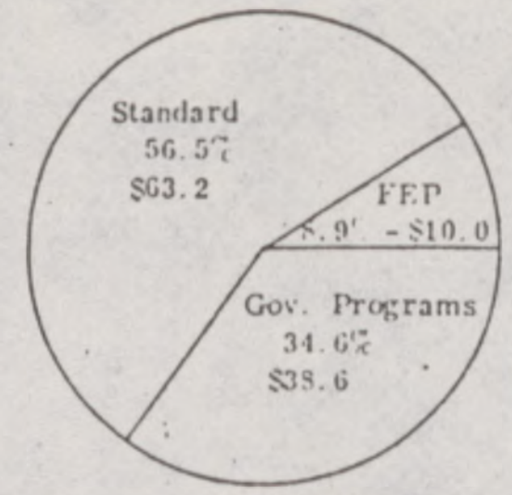
Benefits



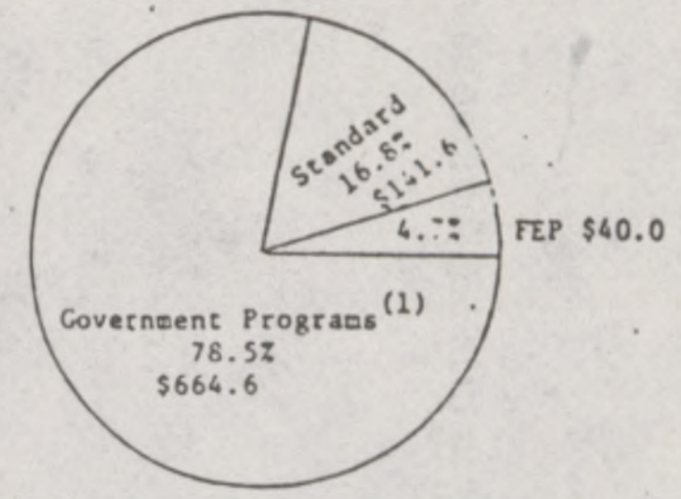
BLUE SHIELD OF CALIFORNIA
Comparison of Revenue & Benefits - All Programs
For The 12 Months Ending December 31, 1965 & 1976
($ in millions)

1965

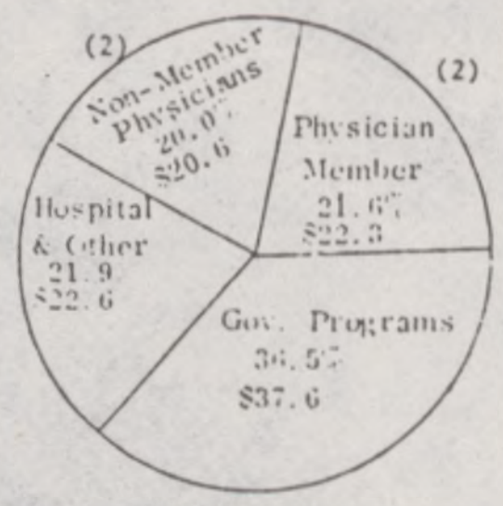
Revenue

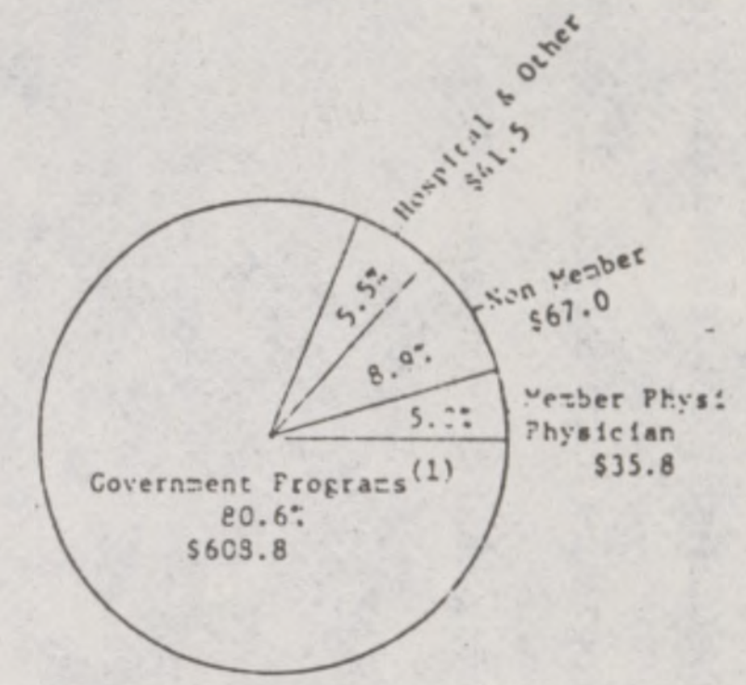


1976



Benefits



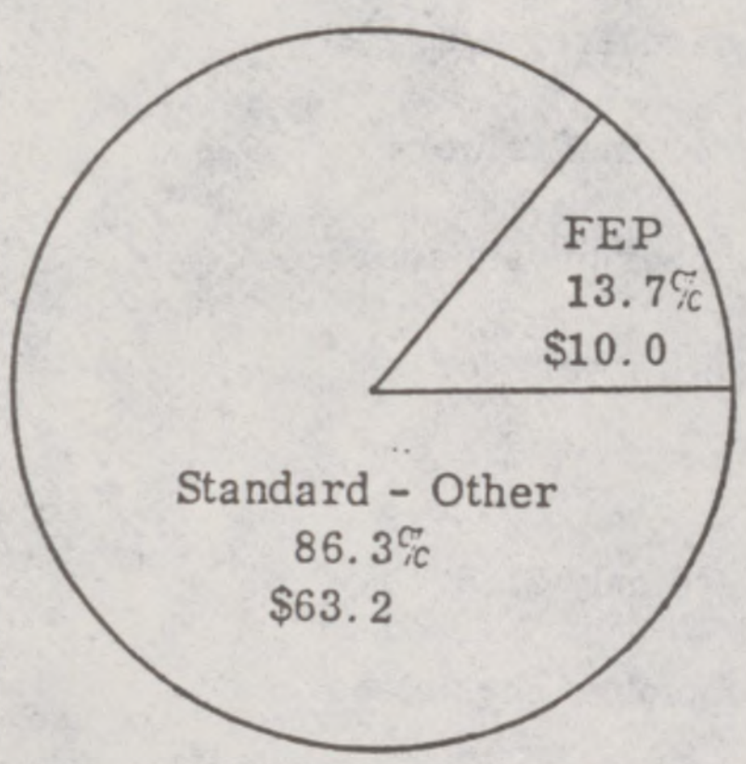


(1) Excludes Government Program pass through payments for Blue Cross North & South Medi-Cal Institutional claims of $1,224,331.

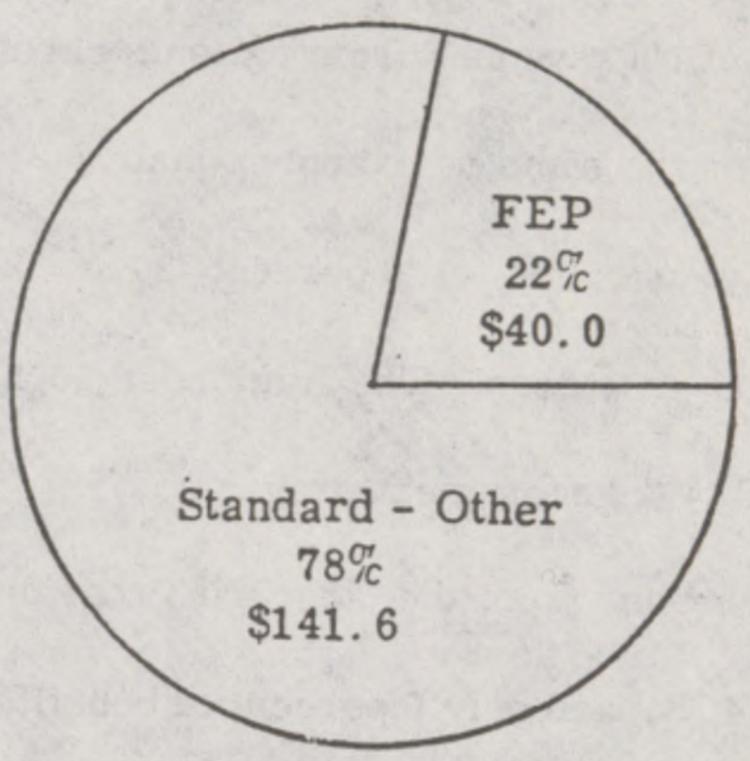
(2) Estimated. In 1965 CPS did not maintain a breakdown of benefit payments by member and non-member physician.

BLUE SHIELD OF CALIFORNIA
Comparison of Revenue & Benefits - Standard Business
For The 12 Months Ending December 31, 1965 & 1976
($ in millions)

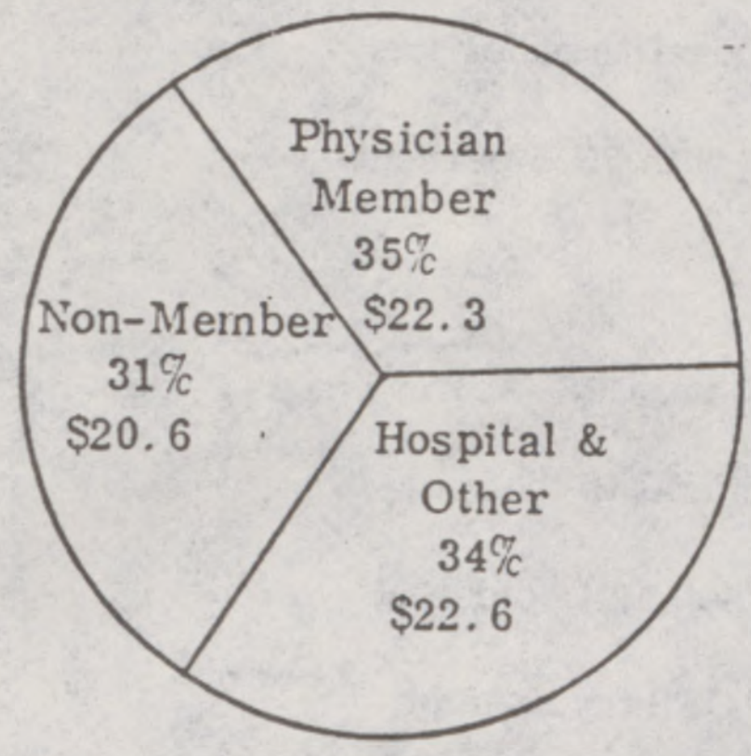
1965 Revenue

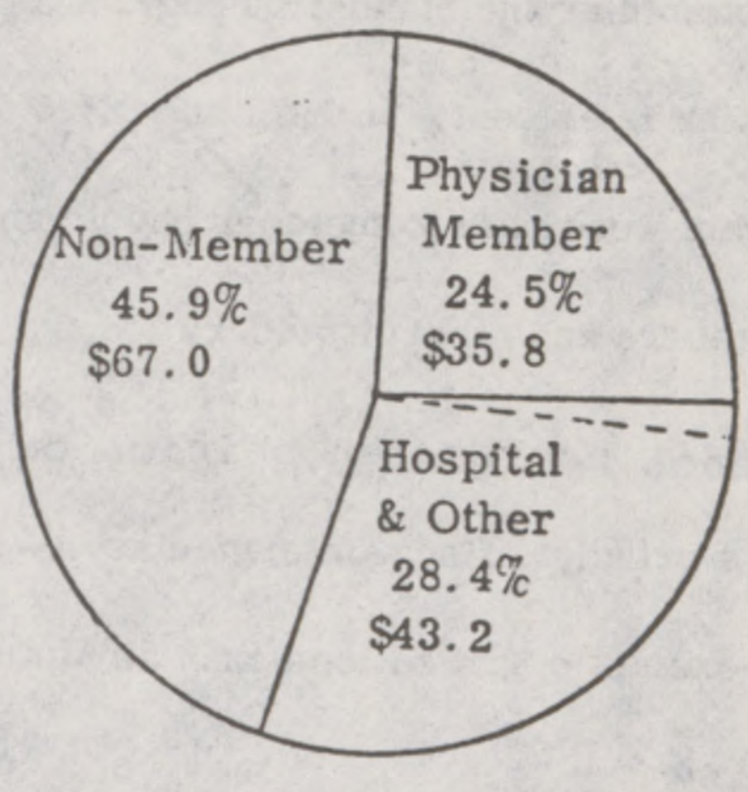


1976 Revenue



Benefits





Close analysis of the charts demonstrates the dramatic change in the sources of revenues and expenditure of funds. In 1950, CPS received 88 percent of its revenues from the Standard Program and 88 percent of its expenditures were payment of benefits for Standard Program patients.

In 1965, already very active in government public health service, CPS received over 65 percent of its revenues from patients enrolled in the Standard Program (56.5 + 8.9). For the same year approximately 21.6 percent of the benefits were paid to member physicians, 41.9 percent (20.0 + 21.9) to non-member physicians and other medical providers. The remainder 36.5 percent of benefits were for patients covered by a government program.

By 1976, revenues from the Standard Program enrollment were only 21.5 percent (16.8 + 4.7), and only 5 percent of benefits paid were to member physicians. Payments to non-members and hospitals and other providers amounted to 14.4 percent (5.5 + 8.9). Over 80 percent of all benefits paid were for patients enrolled in a government program. Benefits paid to non-member physicians in 1976 far exceed the benefits paid to member physicians.

Even after eliminating the dramatic effect of the no-profit, no-loss governmental contracts and examining the Standard Program alone, the change in the character of the organization is evident. In 1976 only 24.5 percent of the benefits under the Standard Program were paid to member physicians as compared with 75.5 percent paid to non-members and other providers (45.9 + 28.4 + 1.2).

While we cannot express an opinion on the change in CPS activities, its engagement as a principal fiscal intermediary -- an activity identical to that performed by non-exempt organizations such as Mutual of Omaha, Aetna, Occidental Insurance Co., etc. -- may be in conflict with the CPS tax exempt

status. We don't know whether the shift in CPS' business activity from an organization devoted primarily to the promotion of social welfare to its present position which appears to be similar to organizations which are operated for profit constitutes a change of sufficient magnitude to place it in conflict with its tax exempt status.[1]

The Knox-Keene Act of 1975 (State of California) transferred the regulatory control of health care service plans from the Attorney General to the Corporation Commissioner effective July 1, 1976. This Act allows CPS three years from the date it is licensed by the Department of Corporations to reduce indemnification payments (benefit payments to non-member physicians and other non-participating providers) to a level which does not place the company in the position of "substantially indemnifying" subscribers or enrollers. The phrase "substantially indemnifying" has not yet been officially defined. As of June 15, 1977, CPS has not been licensed by the Department of Corporations. Apparently the Department has been inundated by applications from health care providers and is lagging in issuing licenses.[2] Only one of over 100 plans that had applied had been licensed by June 15, 1977.

In order to increase provider membership CPS is actively engaged in recruiting allied groups and providers. For example, participating agreements

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1 In 1978, I.R.S. initiated a review of whether CBS' income from Government Programs is "unrelated business income."

2 People vs. California Mutual Association cite as 68 Cal. Rpts. 585. The California Supreme Court ruled that where indemnity constitutes a significant financial proportion of the total business, the organization must be classified as an "insurer" and not a service plan. Insurers (insurance companies) are subject to all taxes imposed by the State of California and United States.

have already been executed with licensed clinical social workers, psychologists, out-of-state physicians, podiatrists, and pharmacies. In addition, CPS is in the process of negotiating participating agreements with optometrist, opticians, audiologists, hearing aid dealers, independent laboratories, hospitals, etc.

Affiliated Subsidiary Corporation

In 1954, the CMA House of Delegates by resolution instructed the CPS Board of Trustees to form and finance a subsidiary but separate insurance corporation, qualified under the insurance laws of California to write indemnity-type coverage. Consequently, California Physicians' Insurance Corporation (CPIC) was created and received its Certificate of Authority to conduct insurance business in California from the California Department of Insurance in 1954. Like any other insurance company licensed in the State, CPIC is subject to all taxes and regulations imposed by California law. CPIC is a stock company with 2,500 shares (with a par value of $200, total $500,000) issued, all owned by California Physicians Service. The operation of CPIC is guided by its own Board of Directors which consists of five members.[1]

In 1975, primarily as a result of an unfavorable claims experience, CPS lost $2.5 million, its entire equity in CPIC. To make up the CPIC deficit, several contingency plans were considered by the CPS Board of Trustees, including a plan which provided for negotiations with EDS as a secondary source of capital to CPIC. Although numerous discussions were held with EDS officials regarding funding of CPIC, no actual funds were provided by EDS. The CPIC financial problems were solved through the infusion of $2,215,000 additional capital by CPS in December 1975. Total additional capital contributed by CPS, excluding initial investment of $500,000, amounts to $3,910,000 as of the date of this writing.

CPIC sells group indemnity, surgical-medical-hospital coverage, group major

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1/ The current Board consists of the Chairman and another member of the CPS Board of Trustees, the CPS President, Executive Vice President and General Counsel.

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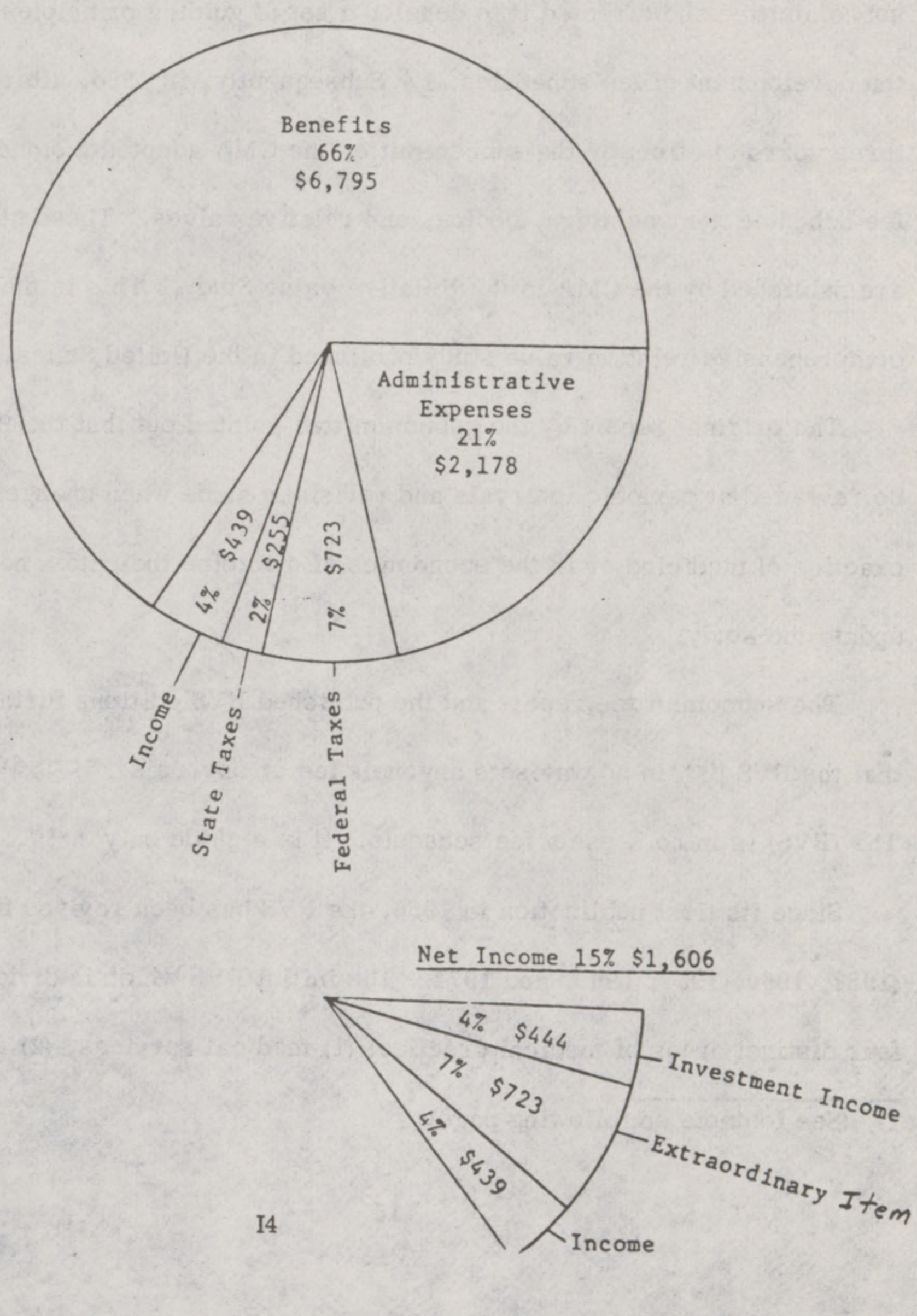
medical benefits, and group life and accidental death and dismemberment policies. Major medical policies, written in combination with regular California Physicians Service programs, account for most of CPIC business at the present. For competitive reasons, group life and accidental death policies are included in "package plans" along with other group program coverages. The following chart shows CPIC operating highlights for 1976.

CALIFORNIA PHYSICIANS' INSURANCE CORPORATION

Year Ended December 31, 1976
($ in Thousands)



THE CALIFORNIA MEDICAL ASSOCIATION (CMA) AND THE CALIFORNIA RELATIVE VALUE STUDIES (RVS)

The CMA is an association of physicians licensed to practice medicine in California. The CMA is comparable, at the State level, to the American Medical Association (AMA) at the national level.

In 1952 the Commission on Medical Services of the CMA appointed a subcommittee and directed it to develop a set of guiding principles to govern the development of fee schedules. 1/ Subsequently, in 1956, after nearly three years of effort by the subcommitte, the CMA adopted a standard for fee schedule nomenclature, coding, and relative values. These standards are published by the CMA in the Relative Value Study. This is the first comprehensive relative value study published in the United States.

The original report by the subcommittee pointed out that the RVS should be reviewed at periodic intervals and revisions made when changes in the practice of medicine or in the economics of medicine indicate a necessity to update the study.

The subcommittee report and the published RVS editions further state that the RVS "***in no way sets anyone's fee or anyone's schedule of fees. The (RVS) is in no sense a fee schedule. It is a guide only ***".

Since its first publication in 1956, the RVS has been revised five times, (1957, 1960, 1964, 1969, and 1974. The initial RVS which is divided into four distinct areas of medical practice: (1) medical services, (2) surgery

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1/ (See footnote on following page)

(3) radiology, and (4) pathology included about 1,000 medical procedure numbers.

1/ (Extract from RVS)
For many years, the medical profession has recognized the need for a guide or "rule of thumb" measurement which could be used to improve fee schedules. In 1952 the Commission on Medical Services of the California Medical Association appointed a sub-committee (Committee on Fees) and directed it to develop a set of guiding principles which should govern the development of fee schedules.

The Committee on Fees had many reasons for expressing relative value standards for fee schedules in units rather than in dollars:

1. The standards for relative values of fees were established by survey of the membership of the California Medical Association. The level of fees varies throughout the state under the influence of many factors. But analysis of the survey results reveals that the relationship between fees for most procedures remains almost the same, even in widely separated geographical areas. Expressed in dollars, these relationships would have been misleading and incorrect for many areas. Expressed in units, they are accurate and useful.

2. Health insurance in California today requires fee schedules and indemnity schedules at many different dollar levels. California Physicians' Service needs different fee schedules for different income ceiling plans. Many groups want to buy indemnity insurance that pays benefits approximating the usual fees charged by physicians. Others want adequate protection at a low premium and will accept an element of co-insurance. The relative value study, expressed in units, may be used as a guide in setting any and all of these schedules with widely varying dollar levels but retaining a constant relationship between fees.

3. The Relative Value Study will require change to keep abreast of the changes in medicine. As procedures are introduced, others become obsolete. New methods of doing the same procedure increase or decrease the amount of time or skill required, with a resulting change in the compensation the physician should receive for the service. Changing a fee schedule expressed in dollars is difficult and often requires years of work and negotiation. The Relative Value Study, expressed in units, can readily be changed by the results of new surveys from time to time, which are recommended by the Committee on Fees. Thus the standards can be changed to reflect new facts of medical practice. Changes in the dollar schedules can follow one by one.

The 1964 RVS included about 2,050 physician services and procedures; and the 1974 RVS which included procedures for five medical fields: (1) medicine, (2) anesthesia, (3) surgery, (4) radiology/nuclear medicine, and (5) pathology, includes about 5,500 medical procedure numbers.

The following analysis indicates the magnitude of change from the 1969 to the 1974 CRVS:

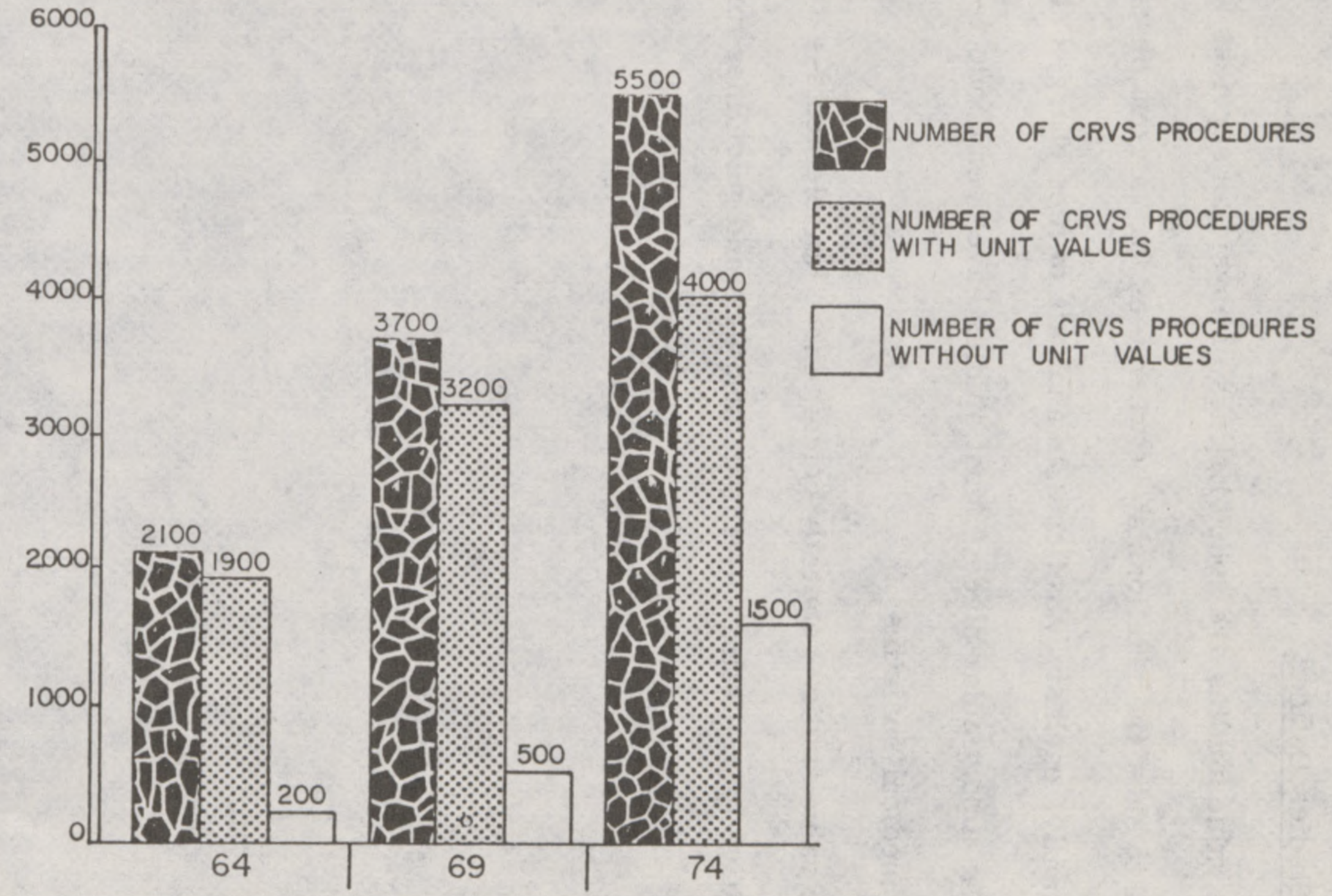
	Procedures in 1974 RVS	Procedures in 1969 RVS	No. Procedure Changes
Medical Section	550	268	518
Surgical Section 1/	3,759	2,517	2,028
Pathology	823	638	917
Radiology	410	259	291
Total	5,542	3,682	3,754

The total number of changes (elimination of a 1969 or addition of a new 1974 number) is greater than the total of the 1969 RVS.

The following chart shows the changes in number of procedures from the 1964-1969, 1969-1974, and 1964-1974 CRVSs:

1/ Anesthesia was not analyzed separately from surgery.

CHANGES IN NUMBER OF PROCEDURES
64-69 CRVS / 69-74 CRVS / 64-74 CRVS
(FIGURES ROUNDED)



NUMBER OF PROCEDURES ELIMINATED & ADDED BETWEEN UPDATING MAY BE GREATER THAN THE TOTAL NUMBER OF PROCEDURE INCREASE SHOWN. (I.E. 69 CRVS CONTAINED 3700 PROCEDURES WHEREAS 74 CRVS HAD 5500 OR AN INCREASE OF 1800, HOWEVER BECAUSE OF ELIMINATION OF SOME PROCEDURES IN 69 CRVS & OTHER CHANGES THE TOTAL NUMBER OF CHANGES MAY BE GREATER THAN 1800.)

Relative Value Studies Defined

Relative value studies are coded listings of physician services with unit values designed to show the relationship between fees for various physician services. Normally, each study reflects an analysis of fees charged at a particular time in a particular place. Most studies have been conducted by county or State medical societies.

Relative value studies generally contain three key elements---terminology, codes, and relative value listings---plus instructions and guidelines for using

the studies to evaluate or establish fees. The most important element is the terminology--the words used to describe a particular procedure and to distinguish it from all others. The second element is a unique, usually numeric, code prefaced to each terminology set. It is often used by the doctor in billing patients and completing health insurance claims, and it is normally used by the health insurance carriers in processing claims. The third key element is the relative value published for each procedure. Relative values are quantitative nonmonetary expressions of the worth or usual charge that one procedure commands as compared to all others.

The primary purpose of the RVS is to precisely describe and code the services provided by physicians. The general acceptance of the RVS by insurance carriers and government agencies assures the physician who uses its coding and terminology that the services and procedures he performs are identifiable. With appropriate consideration to individual and local variations in practice, the RVS may also be used:

1. As a guide to physicians in establishing fees;

2. As a guide for insurance carriers and government agencies in determining the extent of their commitment; and

3. As a guide in evaluating individual claims.

As previously indicated the RVS reflects medicine as it is being practiced.

Role of CPS, CMA, and
Others in Revising of CRVS

Data was provided to CMA by CPS for its revision of the 1969 RVS, however, because of the time elapsed it is not practicable to determine CPS' role in updating of the CRVS prior to 1974. We found that CPS provided the CMA at their request data for the 1974 revision of the RVS. 1/ Data provided was based on 6 months' claims filed under the CPS Standard Business Program. (CMA paid the data collection costs.) For each procedure in the then current RVS the data showed the distribution of charges by dollar increments, the relative value of the procedure in units, and the average dollar coefficient for each unit. A sample printout of the data provided by CPS to the CMA follows.

1/ The 1974 CRVS required approximately two and one-half years of the CMA Committee on Relative Value Studies' time equalling over 10,000 hours of physician input and has resulted in an expenditure of approximately $125,000 of CMA funds, excluding printing and distribution cost in the amount of about $30,000. An independent study performed under the auspices of the CMA states each parent committee meeting was typically a weekend affair, commencing on a Friday afternoon, lasting all day Saturday and adjourning after a Sunday morning session. Meeting attendance was good, and all members had travel and hotel expenses reimbursed under the standard (and generous)CMA policy applying to all its regular committees. See page 47 of this report for further information on RVS committee structure.

--------- PROCEDURE 27127 MODIFIER 80 ARTHROPLASTY W ACETABULOPLASTY SECTION SURGERY

FROM - TO	SERVICES	TOTAL BILLED
PROCEDURE 27127-80 TOTALS ----------	1	11.33

1969 CRVS VALUE OF A SINGLE UNIT 1.00 TOTAL RVS UNITS 1.00 CRVS UNIT COEFFICIENT 11.33

TOTAL SERVICES 1 MEAN 11.33 MEDIAN 11.01 TO 11.50 MODE 11.01 TO 11.50

--------- PROCEDURE 27127 MODIFIER 80 ARTHROPLASTY W ACETABULOPLASTY SECTION SURGERY

FROM - TO	SERVICES	TOTAL BILLED
23.01 24.00	1	24.00
163.01 170.00	1	170.00
PROCEDURE 27127-80 TOTALS ----------	2	194.00

1969 CRVS VALUE OF A SINGLE UNIT 34.00 TOTAL RVS UNITS 68.00 CRVS UNIT COEFFICIENT 2.85

TOTAL SERVICES 2 MEAN 97.00 MEDIAN 165.01 TO 170.00 MODE 165.01 TO 170.00

--------- PROCEDURE 27130 MODIFIER 00 ARTHROPLAS W PROSTHET REPLACE SECTION SURGERY

FROM - TO	SERVICES	TOTAL BILLED
775.01 800.00	1	800.00
925.01 950.00	1	950.00
975.01 1000.00	1	1,000.00
1375.01 1400.00	2	2,800.00
1475.01 1500.00	5	7,500.00
1575.01 1600.00	5	8,000.00
PROCEDURE 27130-00 TOTALS ----------	15	21,050.00

1969 CRVS VALUE OF A SINGLE UNIT 40.00 TOTAL RVS UNITS 600.00 CRVS UNIT COEFFICIENT 35.08

TOTAL SERVICES 15 MEAN 1403.33 MEDIAN 1475.01 TO 1500.00 MODE 1575.01 TO 1600.00

--------- PROCEDURE 27130 MODIFIER 22 ARTHROPLAS W PROSTHET REPLACE SECTION SURGERY

FROM - TO	SERVICES	TOTAL BILLED
1475.01 1500.00	1	1,500.00
PROCEDURE 27130-22 TOTALS ----------	1	1,500.00

1969 CRVS VALUE OF A SINGLE UNIT 40.00 TOTAL RVS UNITS 40.00 CRVS UNIT COEFFICIENT 37.50

TOTAL SERVICES 1 MEAN 1500.00 MEDIAN 1475.01 TO 1500.00 MODE 1475.01 TO 1500.00

Additional information, although less detailed than that submitted by CPS, was also obtained from other insurance carriers, health care providers, county medical societies, government agencies (HEW and CHAMPUS) and subdivided specialty groups such as Licensees for Medical Use of Radionuclides in California.

According to CMA records, CPS Standard Program data represented the most comprehensive information available as to charging patterns in California. By way of interest the CMA/RVS Committee felt that no median charge figures could be intrinsically reliable if there was a total frequency of less than twenty-five (25) services per procedure.

The data was compiled, reviewed and analyzed by the CMA Committee on RVS, who has the responsibility to update the RVS on the basis of the proper relativity of all procedures and to assign procedure numbers whenever possible. The Committee on RVS is supported by specialty subcommittees who evaluate each item within their specialty. The Committee on RVS functions on a continuous basis; for example, the work on the 1974 CRVS revision was initiated as early as 1971.

Also data provided by the CMA indicates that close coordination is maintained with the American Medical Association (AMA) during the updating of the CRVS. In part, the AMA's "Current Procedural Terminology" 4th edition (CPT 4) is based largely on the 1974 CRVS. Some committee members of the (1969-1974) CRVS Committee on Relative Value Studies also serve on the Editorial Board of the AMA's CPT and/or as consultants to the AMA's Editorial Board. The Committee has met with representatives of the AMA to discuss the development of the CPT. 1/

The recommendations of the Committee on RVS are submitted to the CMA council for adoption. Subsequent to this adoption, a report entitled "Pre-Publication Copy, for Administrative Use only (-) Not To Be Used for Billing

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1/ Discussions with representatives from AMA on following pages.

Purposes until Date is Announced," is published and distributed on a very limited

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"Doctor Max Parrott and Mr. Vaughn Alexander attended the Sunday portion of the meeting in order to discuss AMA's Current Procedural Terminology and, particularly, its bearing on the RVS. Also in attendance at this portion of the meeting were Doctors Elmendorf and Rose.

Doctor Parrott led off the discussions by providing the committee with a brief background on the development of CPT and the pressures extant to achieve a single unified system for reporting procedures. He urged communication between the persons involved in the RVS and the CPT. He expressed concern that if the proposed RVS were too different from the CPT or if changes in the RVS forced AMA to immediately update CPT, there would be less willingness on the part of governmental agencies to accept CPT. He noted the fears of the government about escalation when descriptors are revised, while commenting that the purported "inflation" really represented justified charges that physicians could not make if they didn't have adequate descriptors to use.

Mr. Alexander also emphasized that a uniform language was needed throughout the nation and expressed the hope that CPT could serve in this capacity. Nevertheless, he agreed that there had to be agreement among physicians on what the language should be.

Doctor Elmendorf summed up the alternatives that the RVS Committee is faced with, in terms of the recommendations it might make about further direction it should take:

1. Abandon the RVS entirely in favor of the CPT.

2. Merge the RVS and the CPT to arrive at one universal language.

3. Attempt to persuade AMA to accept the RVS as that single language.

Doctor Hoskins outlined problems the AMA had in working at the national level in developing the CPT. Among them he enumerated:

1. Difficulties the AMA has in coping with specialty society interests, which CMA has usually been successful in neutralizing through intensive discussion. He commented that AMA has no policy on how the Editorial Board should deal with political thrusts such as can come from specialty interests.

Continued

basis. For example, the 1974 CRVS Pre-Publication Copy dated November 8, 1974,

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2. Some sections of the CPT are particularly limited, due to lack of participation by particular groups. The best sections are those where there was strong linkage with California physicians who were also working on the RVS.

3. He suggested that the AMA must immediately begin revising CPT3, to correct obvious errors and omissions. He felt it important to know the current stage of discussions with the Federal Government, as well as how the private insurance industry views the CPT.

He also suggested that practicing physicians be a more heavily represented factor on the Editorial Board, commenting that they were neither numerous nor influential on the last Board.

Lastly, he noted that CPT users would need to be informed that there will be constant change -- and that this is necessary.

Doctor Gerrie observed that the CPT lacks continuity among various sections, indicating that often single individuals who may or may not have represented specialties were given free rein to design 'their' sections. He suggested that during the next revision more direction come from AMA itself.

In response to a question posed by Doctor Elliott about when the AMA would start the next revision, Mr. Alexander suggested that government would be reluctant to consider adopting CPT3 if they knew another edition was being developed.

Doctor Bell noted the Committee's feeling that they must necessarily complete the task of revising the 1969 RVS, and agreed that while carriers will inevitably convert the document to earlier, simpler systems, the updating still needed to be done. (sic) He, too, observed that medical practice must be recognized as dynamic, and that retention of a static reporting system is essentially erroneous.

Committee members agreed to the importance that there be no conflicting number in the two systems so that they can co-exist, and promised that they would provide RVS Committee input to AMA for inclusion in its CPT4. There was agreement, furthermore, that the Committee must continue work on its revision, but that the task would not be necessarily publicized. No specific recommendation from the Committee was elicited by Doctors Rose and Elmendorf, since bringing up the subject again at a Council meeting would merely tend to put the entire subject in the spotlight ***." (Note: The CMA's CPT4 was issued in the spring of 1977.)

was mailed to the AMA, various insurance carriers, State and Federal agencies, State medical associations, hospitals, medical foundations, schools of medicine, etc. About 60 copies were mailed.

Distribution of CRVS

The 1974 Official CRVS revision was initially printed in April 1975. As of June 1977, a total of 85,600 copies of the 74 CRVS[1/] were distributed, of which 24,000 were distributed to CMA members, and the balance of 61,600 were distributed to all others.[2/]

To provide some insight into the distribution of the CRVS, the CMA has developed information taken from sales records for one week, September 22-26, 1975. Sales by type of purchaser are on the next page.

1/ Estimated number of copies of CRVS distributed 1957-1974.
Distribution to:

RVS Edition	Total Distribution	Distribution to CMA members	All Others
1957	16,000+	16,000	Unknown
1960	67,500	17,500	50,000
1964	171,500	21,500	150,000
1969	134,500	24,500	110,000

2/ All others include additional copies purchased by CMA members.

Type of Purchaser	Number	Percent
Physicians (M.D.)	448	50.9
In California	210	23.8
Outside California	223	25.3
county medical societies	15	1.7
Other Providers	141	16.0
Podiatrists	14	1.6
Laboratories (not MDs)	4	0.5
HMO-type organizations	6	0.7
Hospitals	77	8.7
Medical Assistant Students	23	2.6
All other providers	17	1.9
"Payors"	187	21.2
Insurance Carriers	99	11.2
Corporations	86	9.8
Governmental Agencies	2	0.2
Teachers/educational institutions/libraries	80	9.1
Individuals not otherwise identifiable	25	2.8
TOTAL	881	100.0

The CRVS is used as a model because of its wide circulation and acceptance within and outside California. For example, 1/ 2/ , the CRVS was adopted with very little modification by several State governments and State medical societies including Massachusetts and Florida. Also, the 1971 Massachusetts Relative Value Study, Fifth edition, and the 1975 Florida Relative Value Studies are based on the 1969 CRVS. Further, the third edition of the American Medical Association's Current Procedural Terminology (CPT-3) was heavily based upon the 1969 CRVS coding and terminology. Shortly after the 1969 CRVS introduction, a number of Medicare carriers petitioned the Social Security

1/ 2/ (see page 26 for footnotes)

Administration to be allowed to use the CRVS coding and terminology, or CPT-2, for their Medicare Part B activities.

However, not all users of the CRVS graduate to the most recent CRVS, nor do all users adopt the entire CRVS. For example, we were informed that

> * * *the 1964 and 1969 editions CRVS are still in widespread use, and that some states adopted the CRVS intact while others made minor revisions in the preface and explanatory pages. Other states adopted the CRVS format but made changes in nomenclature and coding and/or developed new unit values based on a survey of local physicians. Still other state societies adopted the CRVS but substituted or used the CRVS on a temporary basis until independent studies were completed and distributed.

1/ The 1974 Revision of the 1969 CRVS was adopted by the State of California Division of Industrial Accidents (DIA), Worker's Compensation on May 1, 1976. DIA also adopted the CMA recommended minimum dollar conversion factors as follows to be used in conjunction with 1974 CRVS unit values:

Medicine Section	$ 3.50
Surgery Section	80.00
Radiology Section:	
Total Service	7.00
Professional Component	0.85
Pathology Section	0.65
Anesthesia Section	18.00

2/ Also, CMA granted permission to the Union of American Physicians in response to a September 12, 1974, request to reproduce pages 33 to 69 of the 1969 CRVS to be used in the preparation of "* * *a number of instructional aides of a socio-economic nature, to assist our members in receiving their just compensation for their services from insurance companies and fiscal intermediaries." Pages 33 to 69 are from the Surgery Section of the CRVS.

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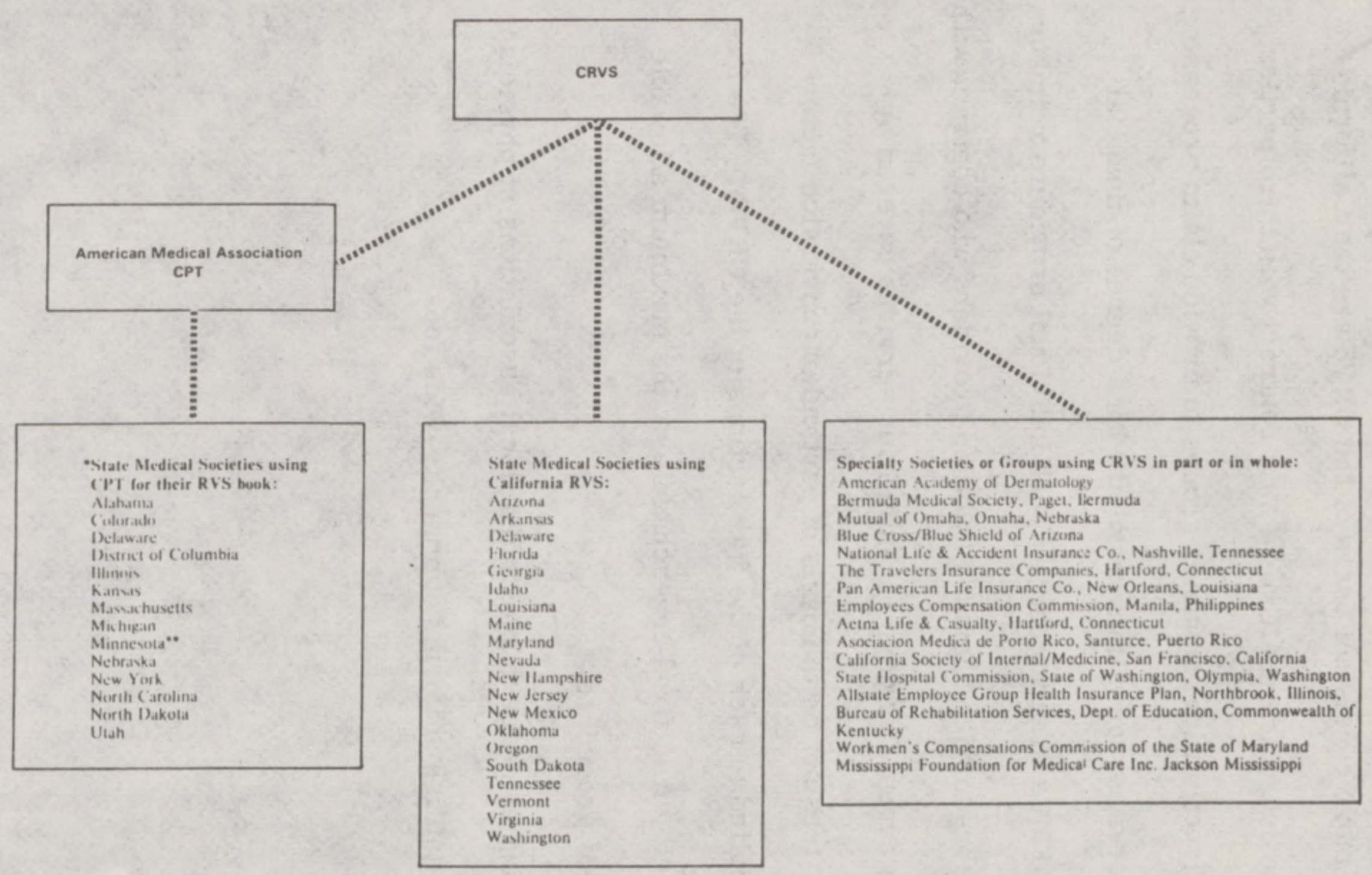
This same source states that

> "* * *It has been commonplace for specialty societies to extract portions of the CRVS and publish separately only those lists of procedures used by specialist members. Only rarely will the makers of the CRVS borrow ideas from other states' relative value guides. In one such instance, an essential element of the description of laceration repairs in the 1974 CRVS was drawn from the Michigan relative value guide * * *."

Further, in many States, the prevailing nomenclature is the one developed and promoted by the AMA. See following chart for a more detailed overview of CRVS impact nationwide.

Chart Showing Use of CRVS and CPT by Other State Medical Societies, Specialty Societies, and Other Groups*



*Based on data obtained from the AMA, CMA, & FTC. This information has not been verified by us in any way and we have not ascertained which revision is being used.

**The Federal Trade Commission has accepted from the Minnesota State Medical Association and its 34 local components a consent order agreement to cease the use of the Minnesota Relative Value Index and to withdraw such publications already in circulation. According to the FTC's proposed complaint, relative value scale activities "have established, maintained, or otherwise influenced fees charged health care consumers in violation of the FTC Act." The consent agreement states that it does not constitute an admission by MSMA or any component society that the law has been violated, and that it is for settlement purposes only.

Among the more consistent users of the CRVS are the California Foundations for Medical Care (FMCs). FMCs contract with third parties, such as CPS, or directly with consumer groups to provide claim processing and peer review services sometimes coupled with a degree of financial risk assumption. FMCs in turn contract with individual providers reimbursing them on a fee-for-service basis. Physician providers who contract with the FMCs agree to accept, as payment in full for services covered by endorsed policies, fees set on the basis of particular conversion factors (dollar amounts applied to each of the five sections of the CRVS). The fees established serve either as fixed-fee-schedule or the maximum allowable fee for each medical procedure.

The following evidence suggests that local associations of physicians use the CRVS to establish uniform, community-wide fees:

FOUNDATION FOR MEDICAL CARE
OF ORANGE COUNTY
300 SOUTH FLOWER • ORANGE, CALIFORNIA 92668 • (714) 547-6317

TO: All Orange County Physicians

FROM: The Board of Trustees
Foundation for Medical Care of Orange County

Raise of Conversion Factors

The Foundation for Medical Care of Orange County is undertaking an active role in the guidance and leadership of the provision of medical services in our county. We are working closely with, and have the endorsement and parallel philosophies of the Orange County Medical Association.

Recently the Board of Trustees of the Foundation proposed raising the conversion factors in order to keep pace with these inflationary times and to offer a fair reimbursement to its providers, and the membership was polled for its opinion. The results of this referendum have been tabulated, and commencing with all new and renewed contracts as of January 1, 1978, providers will be reimbursed on a sliding scale (based on the 1974 California Relative Value Studies) as follows:

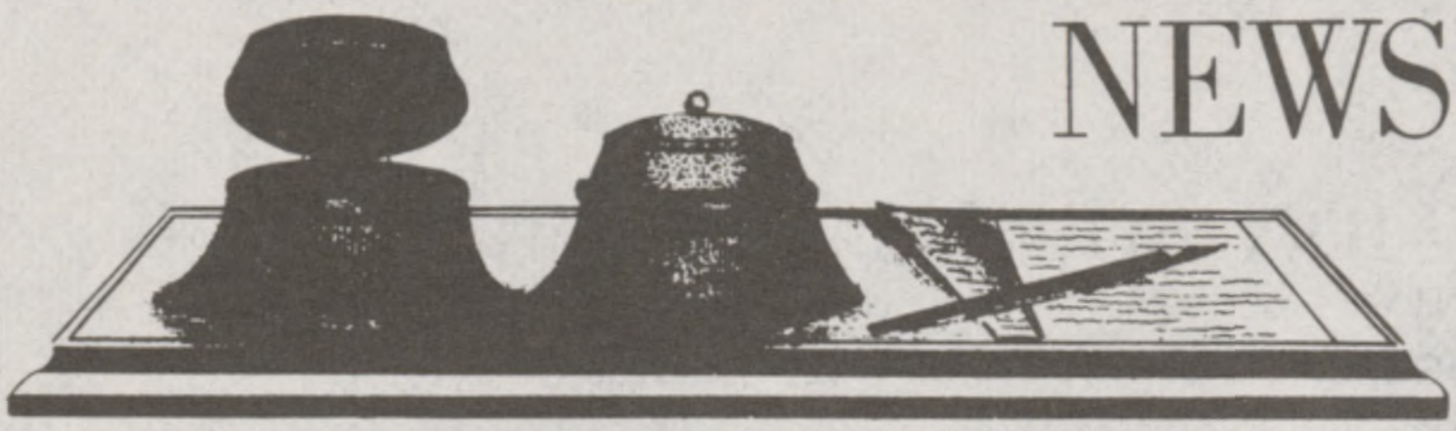
Surgery	$110.00
Medicine	5.39
Anesthesiology	20.90
Radiology	9.13
Pathology	1.30

As the concern for good medical care at a fair fee for service is becoming more of an issue with the government and physicians, foundations for medical care are rapidly becoming increasingly effective throughout the nation. Recent legislation will have a great impact on us all; but hopefully, with additional support and increased membership in the Foundation for Medical Care of Orange County, individual practice will continue to flourish. Let us assure you that our program will consistently orient its design to meet the needs of the physicians in our community, and provide their patients with high quality medical care.

The Foundation welcomes your participation and support.

SAN FRANCISCO MEDICAL SOCIETY HEALTH PLAN
1375 Sutter Street • San Francisco, CA 94109

NEWSLETTER



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no 2

1977
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President
John A. Driscoll, M.D.
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Maurice Eliaser, Jr., M.D.
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Mr. Ransom M. Cook
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January 1, 1975
December 31, 1977
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Terms:
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Terms:
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Rafael A. Solari, M.D.

Executive Director
Mr. Robert Bjorkquist

NOTICE OF THE ANNUAL MEETING OF THE PARTICIPATING MEMBERS

This year's Annual Meeting will be held in conjunction with the meeting of the Board of Trustees. The meeting will convene promptly at 6:00 p.m. on Thursday, December 1, 1977, in the Medical Society Auditorium. The agenda is listed below, and if any Health Plan member wishes to have additional items or resolutions considered, please contact the Health Plan office at least five days before the meeting. We hope that this new format will entice both members and potential members to attend and participate in the meeting.

The reports of the Benefit Standards Committee and Bylaws Committee are included for your review on the reverse side.

AGENDA

I. Report of the Benefit Standards Committee

II. Report of the Bylaws Committee

III. Report of the Nominations Committee

A) Nominations from the floor for Participating Trustees

IV. Report of the Finance Committee

V. Report of the President

VI. Resolutions for consideration: Be it resolved:

A) That the non-recurring enrollment fee for physicians in their first year of practice in the community be reduced to $50.00, and/or

B) That the non-recurring enrollment fee be reduced to $50.00 for all physicians until July 1, 1978.

VII. Physicians Office Employees Health Plan Open-Enrollment

VIII. Federal Employees Health Plan

IX. SFMS Ad Hoc Committee on the Health Plan

X. Other Business

XI. Adjournment 7:00 p.m.

29b

BYLAWS

The Bylaws Committee met on October 13, 1977, and recommends that the following revisions be considered for adoption.

CHAPTER V - BOARD OF TRUSTEES

Section 1. Composition of Board of Trustees:

The Board of Trustees shall be composed of six (6) physicians elected by the statutory members; ~~nine (9)~~ eleven (11) physicians elected by the participating members; ~~three (3) physicians who shall be representatives of the three respective principal communities which are target groups to be served by the Health Plan, said three (3) physicians to be appointed by the elected Trustees; three (3)~~ four (4) public members who shall not be physicians, appointed by the remaining Trustees; and one (1) podiatrist appointed by the San Francisco/San Mateo Counties Podiatry Society; the Immediate Past President of the Health Plan; the President of the San Francisco Medical Society, and the President-Elect of the San Francisco Medical Society, the latter two persons serving ex-officio, with the right to vote.

Section 3. Nomination and Election of Trustees:

Nominations may also be made from the floor at such meeting of members of either class, and positions shall be filled by the person receiving the highest number of votes by secret ballot. The Trustees may, in the same manner, provide for election to fill any other vacancies on the Board existing at the Annual Meeting.

CHAPTER VI - OFFICERS

Section 1. Officers:

The officers of this corporation shall be a President, Immediate Past-President, Vice-President, Secretary, Treasurer, and such other officers as the Board may appoint.

CHAPTER VIII - EXECUTIVE COMMITTEE AND OTHER COMMITTEES

Section 1. Executive Committee:

There is hereby created an Executive Committee to consist of the President, Immediate Past-President, Vice-President, Secretary, and the Treasurer ~~(and the Coordinator)~~.

BENEFIT STANDARDS

The Health Benefit Standards Committee met on October 12, 1977, and recommends that the reimbursement levels for sponsored groups be changed as shown for all contracts renewing or written after January 1, 1978. Further, that the procedure numbers and nomenclature in the 1974 Relative Value Studies be utilized.

Medicine	*$ 4.20*
Surgery	*100.00*
Radiology	*8.00*
Pathology	*1.15*
Anesthesiology	*21.00*

Some FMCs use a combination of CRVS revisions. Manuals for "correlating" 1964 and 1969 codes to the 1974 CRVS are published by a subsidiary of the CMA. Data provided indicate one FMC uses any of three sets of conversion factors applicable to each of those CRVS editions, depending on whichever yields the greatest compensation for a procedure.

Thus, this FMC appears to ignore the argument by the CMA that while the relativities of some CRVS procedures are elevated, these increases are canceled out in the final balance of downward shifts in the relativities of other procedures.

Finally, the CRVS is used by CPS in its management and administration of the "usual, customary or reasonable" fee payment system. For example,

1) The Medi-Cal program utilizes a statewide uniform reimbursement system. The State sets specific conversion amounts, by type of service and procedure for physicians and podiatrists, which are multiplied by the 1969 CRVS relative value units for each procedure to determine the allowable amount. 1/ The dollar conversion factors are:

Section	Conversion Factor
Medicine:	
Procedure Codes 90000 through 90470	$ .69
Procedure Codes 90751 through 90776	.69
All other medicine procedures	.64
Anesthesia:	
M. D.	11.00
CRNA	8.25
Surgery:	
Procedure Codes 59400 through 59561	37.50
All other surgery procedures	29.25
Radiology (Nuclear Medicine)	3.00
Pathology (Individual Tests)	.28

2) Each year CPS establishes high-low dollar coefficients per unit value for each type of service charged under the Medicare, CHAMPUS and Standard programs. These parameters are used in refining the charge data used in building fee profiles for physicians. The parameters are setup in the form of payment screens, or computer

1/ On January 1, 1978, Medi-Cal began accepting 1974 CRVS procedure numbers in addition to 1969 CRVS numbers. The adoption of 1974 CRVS procedure numbers will become mandatory on July 1, 1978. Medi-Cal's reimbursement will continue to be based on the statewide fee schedule as applied to 1969 CRVS unit values.

edits, which eliminate the extremely high or extremely low charge data entered into the claims processing system. For example, the payment screen would reject a claim from further processing if the claim was incorrectly coded or the amount charged was unrealistic in relation to the services provided. The high-low coefficients are based on the 1969 CRVS actual or derived unit values.[1/] For example, the high-low parameters for medicine procedures in Fee Screen Year 1978 (See page 126) are $.60 and $1.90 respectively. Assuming that a physician submits a charge of $50 for procedure #90060 (Intermediate examination, evaluation and/or treatment same or new illness), the coefficient would be $2.50 ($50 ÷ 20 unit values). Since this $2.50 coefficient exeeds the high parameter of $1.90, the computer rejects the charge for profile building purposes. See page 127 of this report for additional comments on payment screens.

Parameters used for profile building are:

CRVS Section	F.S.Y. 1973 Low	F.S.Y. 1973 High	F.S.Y. 1975 Low	F.S.Y. 1975 High	F.S.Y. 1978 Low	F.S.Y. 1978 High
Medicine	$ .42	$ 1.29	$ .45	$ 1.30	$ .60	$ 1.90
Surgery	20.49	64.64	18.50	65.00	35.00	90.00
Anesthesia	4.99	14.53	6.50	17.70	10.00	35.00
Radiology	2.00	5.16	2.30	5.20	3.00	8.00
Pathology	.21	.67	.15	.50	.25	.85

1/ For 1974 CRVS procedure numbers where the descriptor of service is identical to the 1969 CRVS, CPS uses 1969 unit values. Procedures which are new to the 1974 CRVS, and which have been assigned unit values by the CRVS Committee, are converted by CPS to 1969 CRVS unit values by a conversion factor based on the matched procedures for each RVS section. The conversion factor for medicine procedures is $3.66, surgery procedures $1.66, and radiology $1.63. Thus Procedure #75508 (Angiocardiography) which has a 1974 CRVS unit value of 7.70 is assigned 12.6 1969 CRVS units (7.70 x 1.63 = 12.6)

Professional Societies and Antitrust

The publication of the CRVS by the CMA and its use by physicians, the insurance industry, etc., has resulted in considerable controversy.

Allegations have been made that the CRVS is used as a vehicle to fix fees.

One critic stated:

> "The problem is that--the RVS is produced by the CMA and updated every 3 or 4 years--and it is the administration of prices for health services; it is an administered price monopoly. What the RVS is economically is an agreement to charge at least so much money and no less. But it is not an agreement to prevent the doctor from charging more; all they do in the ethics of medicine is say 'Thou shall not go below of what the CMA says the RVS monetary value is.' It is negotiated instrument for pricing medical services at a floor; and nobody says to anybody you can't go above the floor."

Others have stated that the CRVS is used to establish fees and that its overall effect is no different from the RVS published by specialty groups such as the American Society of Anesthesiologists 1/ 2/ 3/ 4/ 5/. In September 1975, the U.S. Justice Department filed an antitrust suit in U.S. District Court in New York City against the American Society of Anesthesiologists (ASA). The suit contends that the ASA, its component societies and its members have for many years been engaged in a conspiracy in unreasonable restraint of interstate commerce. It accuses

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1/ 2/ 3/ 4/ 5/ (see page 31 for footnotes)

them of violating Section 1 of the Sherman Antitrust Act by their agreeing

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1/ Medical World News, January 26, 1976, pages 27,28

2/ The cornerstone of antitrust legislation in the United States is Section 1 of the Sherman Act which provides: "Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal * * *." a/

Although the above language appears to encompass a wide variety of transactions and agreements, the section includes a number of substantive and jurisdictional limitations. b/ In addition, several statutory exemptions dilute the Act's viability as a method of deterring restraints of trade. c/ Collective fee bargaining between private physicians unions and health insurance carriers raises serious questions concerning the extent to which a number of these limitations and exemptions apply.

a/ 15 U.S.C. 1 (1970)
b/ See Coleman: "The Learned Professions," 33 ABA Antitrust LJ. 48, 51-55 (1967)
c/ See: e.g., 50 U.S.C. 2158 (1970) (government contracts); 15 U.S.C. 521-22 (1970) (fisheries); 7 U.S.C. 291-92 (1970) (agricultural associations); 15 U.S.C. 17 (1971) and 29 U.S.C. 52 (1970) (labor).
See: C. Hills, Antitrust Advisor 2.14 - .22 (1971),
Source: MCLA Law Review June 1973.

3/ On December 14, 1976, the Federal Trade Commission (FTC) and the American College of Obstetricians and Gynecologists, a corporation, entered into an agreement whereby the latter agreed to (1) cease and desist from directly or indirectly, initiating, originating, developing, publishing, or circulating the whole or any part of any proposed or existing relative value scale(s), and (2) permanently cancel, repeal, abrogate, and withdraw any and all relative scales which is heretofore developed, published, circulated or disseminated (Source FTC Docket #2855).

Similar consent agreements were executed between the FTC and the American Academy of Orthopedic Surgeons, a corporation, and the American College of Radiology, a corporation. (Source: FTC Dockets #C-2856 and #2871, respectively).

4/ Agreement by professionals on an actual fee schedule was condemned in Goldfarb vs. Virginia State Bar (421 U.S. 773,1975).

(continued on next page)

to adopt, publish, and circulate relative value guides which are used by members in determining fees charged for anesthesia services. The complaint charges that as a result of these activities:

> --"Fees for the sale of anesthesia services by members of the ASA have been raised, fixed, stabilized, and maintained at artificial and noncompetitive levels;
>
> --Price competition in the provision of anesthesia services by members of the ASA has been restrained; and
>
> --Purchasers of anesthesia services have been denied the right to obtain such services at competitively determined levels."

The suit asks the court to enjoin the ASA and its "agents" from "promulgating, adopting, or disseminating any guide or schedule concerning fees or from making any recommendations regarding the calculation of fees to be charged by members."

After concluding that the Bar Association's fee schedule violates the Sherman Act, the Court then threw in a sort of by-the-way discussion in which it said that it recognized that the States have a compelling interest in the practice of professions and have a broad power to establish standards regulating the practice of professions. It then cited United States v. Oregon State Medical Society, 343 U.S. 326 and quoted an oft-quoted statement contained in that Opinion: "* * *forms of competition usual in the business world may be demoralizing to the ethical standards of a profession." At the very end of its Opinion the Court said:

> "in holding that certain anticompetitive conduct by lawyers is within the reach of the Sherman Act we intend no diminution of the authority of the State to regulate its professions."

5/Recently, a group of California dentists brought a class action antitrust suit against California Dental Service, (CDS) alleging a monopoly and restraint of their practice. A Federal court opinion issued, held that CDS was insulated from the antitrust act by reason of the McCarran Act. The McCarran Act (which was enacted by Congress some years ago) says that the business of insurance is not subject to the Federal antitrust laws.

The ASA in its answer to the complaint asserted that its adoption and publication of its Relative Value Guide were activities protected by the First Amendment to the Constitution. It further asserted that the uses of this guide, "or any other concerted actions respecting fees, if any there were," were activities prescribed and induced by governmental agencies in their official capacity.

U.S. Senate Bill 1470 Section 15 requires the Secretary of DHEW to propose a "procedural terminology" for physicians services, to solicit comments on terminology as well as proposed relative values for the various services, and to establish a "system of terminology," definitions and their relative values.

The legislation assumes that such a system or document is needed in order to administer the Medicare and Medicaid program.

We understand that the FTC has gone on record with the Chairman, Sub-committee on Health Committee on Finance that such a system would have a substantial anti-competitive effect and that consideration be given to deleting this section of the bill. The CMA on the other hand, feels that the FTC never conclusively demonstrated that the CRVS is used as a price fixing tool, and that its development and dissemination should not be vested in the DHEW.

We cannot take a position as to whether the CMA's publication of the CRVS is in violation of any antitrust statutes. We find the whole subject of antitrust extremely complex and believe it can best be addressed by legal specialists in this area.

The Federal Trade Commission (FTC) has for some time and continues to investigate the impact of the CRVS. In November 1977, the CMA Council on advice of legal counsel, directed the CMA to enter into an agreement with the FTC whereby the CMA would:

a. Cease publishing and circulating all editions of the RVS.

b. Cease suggesting that conversion factors can be calculated for use within existing editions of the RVS.

c. Cease advising government or third parties to use any existing RVS. (This does not preclude submission of historical data to support recommended changes in reimbursement levels under various programs.)

d. Cancel and seek to withdraw all editions of the RVS.

e. Request that outstanding copies of RVS be returned to the CMA.

Counsel for the CMA obtained the opinion of an outside consultant, specializing in antitrust matters.

> "I should point out that the legal advice given to the CMA Council was not solely mine. At the outset, I requested and received permission to bring in an outside consultant, the antitrust department of the San Francisco law firm of Pillsbury, Madison & Sutro. It was that firm's advice that CMA had little or no chance of winning in the Federal Courts, and that, accordingly, the agreement should be accepted." (See Appendix D for the full text of the letter.)

Defenders and Other Critics

Defenders of the RVS have argued that the RVS is not a fixed fee schedule because the factors---the unit value and the dollar conversion factor--- are subject to change; however, critics of the RVS point out that flexibility in the factors does not prevent the fee from being fixed, a fee scale derived from

accepted factors becomes a fixed schedule. Physicians may use personal conversion factors or factors developed in conjunction with other physicians and the RVS unit value to establish a fee schedule.

An Associate Professor of Medicine, University of California, School of Medicine, states that

> "* * *Relative value studies are an attempt to assign specific values to procedures and services which, theoretically, correspond to their true cost or worth. RVS are simply a listing of various medical services and their theoretical value (or true cost) in relationship to each other. If one procedure, such as a tonsillectomy, is given an arbitrary value of one unit and another procedure has a true value twice that of a tonsillectomy, then this second procedure should be given a relative value of two units. It is intended to be an approximation of the true absolute point-in-time value of one procedure versus another. An RVS is not <u>necessarily</u> a fee schedule, but can be converted to one by using appropriate "conversion factors". For instance, if a tonsillectomy is worth one unit, and if the conversion factor per unit is $100, then a fee of $100 per tonsillectomy could be charged. In the same way, a procedure worth two units could have a fee of $200 charged (2 units x the conversion factor of $100).

Since the way procedures and services are performed changes over time, as does the true cost or value of particular procedures and services, it is essential that RVS be updated regularly, with a constant reassessment of the changes in the value relationships between procedures. Once these relative values are incorporated into the structure of medical care reimbursement, a whole new set of unforeseen problems arise, particularly in the effect these relative values have on the pattern of delivery of medical services* * *". "* * *An RVS not only creates set value relationships, but also tends to rigidify the pattern of delivery of medical services, as well as providing incentives to perform overvalued (high charges in relation to cost) services. A further problem is created when a unit value has to be assigned to a new or rarely performed service.

Since the easiest approximation of the true cost or value of a service is what is actually charged for it, the most common means of obtaining a set of relative values is to collect data on what is commonly charged for various services. The relationship between <u>charges</u> for different services can then be established. Charges are thus used as a proxy in the absence of real data. Even with these data, arbitrary decisions must be made concerning the relative values of rarely performed or new procedures.* * *"

Briefly, the arguments for and against the use of RVS unit values are:

	For		Against
1.	Provides equity of payment for various services.	1.	Lends itself to conversion into a fee schedule.
2.	Can simplify MD's problem of determining appropriate fees.	2.	Subjects profession to criticism re: establishing charges.
3.	Provides flexibility for making changes in charges when circumstances warrant.	3.	Revisions create escalation in charges.
4.	Useful in claims review.	4.	Current system of unit values is difficult to understand and use.
5.	Established within the profession, not from the outside.	5.	Is used to justify charges that may be totally unwarranted ("I just used the <u>RVS</u> and that's how it came out!")

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For	Against
6. Unit values reflect actual patterns of charges.	6. Unit values tend to artificially establish patterns of charges.
7. Can simplify interaction between computerized billing services and physicians.	7. Effectively undermines the concept of "usual fees".
8. Assists insurance mediation committees in resolving problems.	8. Provides carriers with an easy means of establishing ceilings on physicians' charges.
9. Can minimize unwarranted disparities in levels of fees charged by physicians in different specialties.	9. Lends itself to accusation of collusion among physicians, possibility of legal action.

* * * *

Based on information provided by physicians and by CPS, cost escalation due to revision of the CRVS can result because of the change from one system of terminology to another - from an excessive increase in the unit value to specific procedures, and/or proliferation of procedure "descriptors".

For example, in his capacity as president of the Association of Foundations, Doctor Kenney wrote on December 30, 1969, a letter to a California Medical Association official expressing his concern with the newly-published 1969 CRVS. Doctor Kenney asked for a delay in implementation of the CRVS pending further study. In addition, he said,

> "I have very carefully assessed the surgical section of the 1969 RVS and I find in it absolutely nothing to which one can apply the term relative. Basically, it is a median fee schedule....Many of the procedures are outrageously over-priced in terms of relativity."

> "If I were a government official eager to pick up on the medical profession and point out its cupidity, I would eagerly await the issuance and acceptance of this schedule as a prime opportunity to really splatter our profession with mud."

In a letter dated August 14, 1972, the Chairman (a physician in private practice) of the Medical Policy Committee of CPS expressed his concern to the Chairman of the CRVS Committee that the 1969 CRVS contained errors in evaluation of surgical procedures. He felt that certain surgical procedures had been given

"too great a value" to be considered reasonable. In this letter, the Chairman stated that a new revision of the CRVS might further magnify those errors and said:

> "Procedures which were given arbitrarily, or even with scanty data, a relative value which is in error have lead the physicians to use this as a means of determining fees when indeed the resulting fee charged is well beyond the level of reasonableness. For example: A procedure which is listed in the surgical section at 40 surgical units, when the book was originally being put together, resulted in a fee of $1,000.00. However, when you change the conversion factor to $45.00 from $25.00, you suddenly come up with a fee of $1,800.00, magnifying this even further as we increase the number of units available for procedures....This has necessitated action by the Medical Policy Committee in that we are now using a philosophy of 'Maximum Fee Schedules' in these instances attaching maximum fees without reference to the RVS in order to prevent a runaway escalation of fees in new procedures...."

Likewise, the current Chairman of the Board of Trustees of CPS (also a physician in private practice) provided comments to Subcommittee staff on March 17, 1978. The Chairman of the Board not only concurred with the comments made by the Chairman of the CPS Medical Policy Committee concerning the 1969 CRVS but stated that the defects discussed not only apply to the 1974 CRVS but are probably magnified in the latter document. The Chairman further stated:

> "...Between 1969 and 1974 many new surgical procedures were introduced. The limited charge data for these procedures represented justifiably high fees in that those few physicians who were doing the new procedures were 'feeling the way' and were exposed to very significant risks both in terms of their feeling of responsibility to their patients and to possible subsequent malpractice actions. However, most of these procedures soon became quite routine. The extraordinary strain on those who introduced the new techniques was no longer there and the very high fees were no longer justified. However, the level of charges which had been introduced into the CRVS had become standard. They still are. There may have been a few instances where such fees have been slightly reduced but generally speaking they have been maintained at their original high levels.
>
> By 1974 a great many new diagnostic procedures were included with the same distortions. Cardiac angiography, fibroptic endoscopy, ultrasound, radionuclide studies, CT scanning are all examples.

While some of these were not given relativity numbers in the 1974 CRVS, the methodology has remained unchanged and if the CRVS were to continue the results could be predicted.

Another defect in the 1974 CRVS was the introduction of multiple levels of patient visits which introduced a new possibility for abuse. There is considerable evidence that few visits are billed at the lower levels so that the more or less extended visit has become the standard minimum."

Also, the Medical Director (also a practicing physician) of CPS explained the changes in the practice of medicine in the past 20 years, as reflected in the proliferation of office descriptors and procedure numbers in the CRVS from 1956 to 1974:

> "...In my opinion there has been no basic change in the actual medical services provided in typical medical office visits, but there obviously has been a marked change in pattern for billing of these services. ***It is my belief that the 1960 and 1964 editions truly and equitably described the range of services provided in office visits. ***In the 1969 CRVS, however, several significant changes were made. First the system of unit values was altered; so that a major section (medical, surgical, anesthesia and laboratory) could no longer be interrelated. Second the descriptors in the medicine section were rewritten in such a way that there was a subtle but definite shift to the higher-valued numbers."

"The word 'routine' was no longer used and, according to the wording of the descriptors, physicians felt that 90050 would more properly than 9004 describe the 'routine' visit. At that time CSIM urged its membership to disregard the wording in the 1969 CRVS and to use the numbers which really correlated with the 1964 edition. By this time, more internists were using 9005 for the visits characteristic of internal medicine; whereas generalists most frequently used the 9004."

"Also, of course, the 1969 CRVS introduced 'modifiers' and shifted from four- to five-digit coding; and 'comprehensive' examinations were subdivided by age groups."

"In summary, the 1969 CRVS introduced mechanisms with inflationary forces built in. These inflationary factors were, in my opinion, even greater in the 1974 Revision. Such procedures as 90026 and 90085 were added to the list to permit billing for 'unusually complex medical problems' and '***complicated by chronically disabling condition.' which situations comfortably could be described by the previously extablished 90020 and 90080. Also, of course, the 1974 Revision added the category of "Diagnostic Problem or Challenge', which also could have been accommodated by the old 90020 or 90080."

The following charts (pages 36 and 36a)show the proliferation of procedure "descriptors" for hospital and office visits during the period 1956-1974. The chart on page 36b shows the dollars allowed for hospital and office visits as a percent of the total dollars allowed for the Medicare and Medicaid programs.

OFFICE VISIT DESCRIPTOR PROLIFERATION
CALIFORNIA RELATIVE VALUE STUDIES
1956 — 1974

RVS CODE	1956 DESCRIPTION	*** Unit Value
001	Office visit (first call—routine history and necessary examination)	2.0
006	Follow-up office visit	1.0

RVS CODE	1960 DESCRIPTION	*** Unit Value
9001	INITIAL office visit, ROUTINE, new patient or new illness, history and examination	2.0
9002	INITIAL office visit, COMPLETE diagnostic history and physical examination	5.0
9003	FOLLOW-UP office visit, BRIEF; e.g., routine injection, minimal dressing, etc.	0.8
9004	FOLLOW-UP office visit, ROUTINE	1.0
9005	FOLLOW-UP office visit necessitating professional care OVER AND ABOVE routine office visit	1.5
9006	FOLLOW-UP office visit, PROLONGED, over and above 9005	2.0
9007	FOLLOW-UP office visit necessitating complete re-examination and re-evaluation of patient as a whole, SAME ILLNESS	2.5
9008	FOLLOW-UP office visit necessitating complete re-examination and re-evaluation of patient as a whole, NEW ILLNESS	3.0
9009	Periodic complete re-examination (annual type)	4.0

RVS CODE	1964 DESCRIPTION	*** Unit Value
9000	INITIAL office visit, ROUTINE, new patient or new illness, history and examination	2.0
9001	INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs	3.5
9002	INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs	6.0
9003	FOLLOW-UP office visit, BRIEF; e.g., routine injection, minimal dressing, etc.	0.8
9004	FOLLOW-UP office visit, ROUTINE	1.0
9005	FOLLOW-UP office visit necessitating professional care OVER AND ABOVE routine visit	1.5
9006	FOLLOW-UP office visit, PROLONGED, over and above 9005	2.0
9007	FOLLOW-UP office visit necessitating COMPLETE re-examination and re-evaluation of patient as a whole (continuing illness)	3.0
9008	RE-EXAMINATION, comprehensive diagnostic history and re-evaluation, established patient, (annual type)	4.0

RVS CODE	1969 DESCRIPTION	*** Unit Value
	NEW PATIENT	
90000	Brief evaluation, history, examination and/or treatment	20.0
90010	Initial limited history and physical examination, including initiation of diagnostic and treatment program	30.0
90015	Initial intermediate history and physical examination, including initiation of diagnostic and treatment program	50.0
90020	Initial comprehensive history and physical examination, including initiation of diagnostic and treatment program, adult	70.0
90021	adolescent	50.0
90022	late childhood	40.0
90023	early childhood	30.0
90024	infant	25.0
	ESTABLISHED PATIENT	
90030	Minimal service (e.g., injection, immunization, minimal dressing) (independent procedure) (See also 90700, 90705)	8.0
90040	Brief examination, evaluation and/or treatment, same or new illness	12.0
90050	Limited examination, evaluation and/or treatment, same or new illness	16.0
90060	Intermediate examination, evaluation and/or treatment, same or new illness	20.0
90070	Extended re-examination or re-evaluation	30.0
90080	Comprehensive re-examination or re-evaluation, adult	50.0
90081	adolescent	40.0
90082	late childhood	30.0
90083	early childhood	25.0
90084	infant	20.0
90088	Periodic or annual type examination, adult	40.0

RVS CODE	1974 DESCRIPTION	*** Unit Value
	NEW PATIENT	
	(For visits that include provision of an astrisked surgical procedure, see Surgery ground rule 8.)	
90000	Brief evaluation, history, examination and/or treatment	5.9
90010	Initial limited history and examination, including initiation of diagnostic and treatment program	7.6
90015	Initial intermediate history and examination, including initiation of diagnostic and treatment program	10.5
90020	Initial comprehensive history and examination, including initiation of diagnostic and treatment program	17.5
90026	An unusually complex medical problem, necessitating a comprehensive history and complete examination, extensive review of prior medical records, compilation and assessment of data, any age	BR**
	(For established patient, see 90086, 90087)	
	ESTABLISHED PATIENT	
90030	Minimal service, e.g., injection, minimal dressing, blood pressure or weight check (independent procedure)	2.4
	(For immunizations, see 90720-90729)	
90040	Brief examination, evaluation and/or treatment, same or new illness	3.5
90050	Limited examination, evaluation and/or treatment, same or new illness	5.2
90060	Intermediate examination, evaluation and/or treatment, same or new illness	6.5
90070	Extended re-examination and/or re-evaluation	8.7
90080	Comprehensive re-examination and/or re-evaluation	13.0
	(For well child care, see 90751-90776)	
90085	Comprehensive re-examination or re-evaluation when complicated by chronically disabling condition	16.0
	DIAGNOSTIC PROBLEM OR CHALLENGE	
90086	Comprehensive: requiring a complete history, examination and/or evaluation of the patient as a whole, necessitating an unusual amount of time, skill and judgment (e.g., metabolic disease, cardiovascular problem, convulsive disorder)	RNE*
90087	Complex: requiring a thorough evaluation of all systems, review of an extensive history and/or involving a problem requiring great skill, diagnstic acumen and a prolonged period of evaluation and time (obscure infection, genetic problem, psychosocial problem associated with organic disease, tumor).	BR**
	PERIODIC EXAMINATION	
90088	Periodic or annual type examination, adult	11.0
	(For infant, child or adolescent services, see 90751-90764)	

* RNE — RELATIVITY NOT ESTABLISHED
** BR — BY REPORT ONLY
*** There is no correlation between the relative unit values and the relative value studies. There is a relationship between the unit values in each of the major sections of the relative value studies.

HOSPITAL VISIT DESCRIPTOR PROLIFERATION
CALIFORNIA RELATIVE VALUE STUDIES
1956–1974

RVS CODE	1956 DESCRIPTION	UNIT VALUE
002	Hospital visit	1.0
009	Hospital care of premature infant— first week	10.0
	each week thereafter	8.0

RVS CODE	1960 DESCRIPTION	UNIT VALUE
9020	INITIAL hospital visit, ROUTINE, history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records	8.0
19021	INITIAL hospital visit, COMPLETE diagnostic history and physical examination, KNOWN PATIENT OF CHRONIC CONDITION, including initiation of diagnostic and treatment programs and preparation of hospital records	8.0
19022	INITIAL hospital visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OF MAJOR ACUTE ILLNESS, including initiation of diagnostic and treatment programs and preparation of hospital records	7.0
9023	FOLLOW-UP hospital visit, ROUTINE	1.0
19024	FOLLOW-UP hospital visit necessitating care OVER AND ABOVE routine visit	2.0
19025	FOLLOW-UP hospital visit necessitating complete re-examination and re-evaluation of patient as a whole, SAME ILLNESS	2.5
19026	FOLLOW-UP hospital visit necessitating complete re-examination and re-evaluation of patient as a whole, NEW ILLNESS	5.0
9035	Hospital care of premature infant (see values for specific services rendered under "Hospital Visits," etc.).	

RVS CODE	1964 DESCRIPTION	UNIT VALUE
9020	INITIAL hospital visit, ROUTINE history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records	8.0
19021	INITIAL hospital visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs and preparation of hospital records	5.0
19022	INITIAL hospital visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs and preparation of hospital records	8.0
9024	FOLLOW-UP hospital visit, ROUTINE	1.0
19025	FOLLOW-UP hospital visit necessitating care OVER AND ABOVE routine visit	2.0
19027	FOLLOW-UP hospital visit necessitating COMPLETE re-examination and re-evaluation of patient as a whole	5.0
9035	Routine newborn care in hospital (including physical examinations of the baby and discussions with the mother during the hospital stay)	5.0

RVS CODE	1969 DESCRIPTION	UNIT VALUE
99200	Initial hospital care. *brief or limited* history and physical examination. including the initiation of diagnostic and treatment program and preparation of hospital records	30.0
99215	Initial hospital care. *intermediate* history and physical examination. including initiation of diagnostic and treatment program and preparation of hospital records	50.0
99230	Initial hospital care. *comprehensive* history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records	70.0
99240	*Brief* examination, evaluation and/or treatment. same illness	12.0
99250	*Limited* examination. evaluation and/or treatment. same or new illness	20.0
99260	*Intermediate* examination. evaluation and/or treatment. same or new illness	30.0
99270	*Extended* re-examination or re-evaluation	40.0
99285	Routine newborn care in hospital (including physical examination of the baby and discussions with the mother during the hospital stay) (For illness. immature or premature care, see appropriate hospital visits or other services.)	60.0

RVS CODE	1974 DESCRIPTION	UNIT VALUE
99200	Initial hospital care, *brief or limited* history and examination, including the initiation of diagnostic and treatment program and preparation of hospital records	30.5
99215	Initial hospital care, *intermediate* history and examination including initiation of diagnostic and treatment program and preparation of hospital records	15.5
99230	Initial hospital care, *comprehensive* history and examination including initiation of diagnostic and treatment program and preparation of hospital records	18.5
*99230	Initial hospital care, *unusually complex* medical problem, necessitating a comprehensive history and examination, extensive review of prior medical records, assessment of data and preparation of hospital records	BR†
	ESTABLISHED PATIENT, FOLLOW-UP CARE	
99240	*Brief* examination, evaluation, and/or treatment, *same illness*	3.9
99200	*Limited* examination, evaluation and/or treatment, *same or new illness* (characteristic of the usual hospital visit)	5.2
99260	*Intermediate* examination, evaluation and/or treatment, same or new illness	6.5
99270	*Extended* re-examination or re-evaluation	8.7
*99275	Final hospital care for discharge of a patient including final examination of the patient, discussion of the hospital stay, prognosis, instructions to the patient for continuing care, and preparation of discharge records (For transfer to extended care facility, see 90301)	8.7
99285	Routine newborn care in the hospital (including physical examination of the baby and discussions with the mother during the hospital stay) (For illness, complicated or premature care, use appropriate hospital or critical care visits or other services.)	11.5
*99290	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician, per hour This descriptor is intended to include cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate charges for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, etc., are excluded when utilizing this descriptor per hour. (The physician may list his services separately if he desires.)	BR†

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HOSPITAL AND OFFICE VISITS AS
PERCENT OF TOTAL DOLLARS ALLOWED
OCTOBER 1978

	MEDICARE				MEDICAID			
	Hospital Visits		Office Visits		Hospital Visits		Office Visits	
	Services	$ Allowed	Services	$ Allowed	Services	$ Allowed	Services	$ Allowed
	305,116	6,648,883	472,477	8,031,674	209,333	2,419,199	848,156	10,171,287
Total for Program	2,611,462	50,864,934	2,611,462	50,864,934	4,057,141	48,287,703	4,057,141	48,287,703
Percent		13%		15.8%		5%		21%

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It is difficult to demonstrate that CRVS revisions cause cost escalation. CPS finds it difficult to quantify the impact of a variety of events which occurred during the period 1966-1977. These events include the impact of the malpractice crisis, wage and price controls during the previous administration, increased physician specialization, etc. However, the following brief examples provided by CPS demonstrate, and may provide a measurement of, the cost escalation resulting from the CRVS revisions in 1969 and 1974.

Conversion by physicians from the 1964 to the 1969 CRVS resulted in an estimated cost escalation of 8.7 percent for hospital visits and 5.5 percent for office visits for Medicare. About 27.5 percent of the professional dollars paid in April 1977 were for hospital and physicians office visits for Medi-Cal (18.9 percent for office visits and 8.6 percent for hospital visits). The monthly variance for these figures would be not greater than plus or minus 5 percent.[1/]

1/ As a matter of interest the following statement was extracted from the minutes of the CPS Board of Trustees:

"***IX. CMA HOUSE OF DELEGATES

Copies of the Blue Shield Supplemental Report to the CMA House of Delegates were distributed to the Trustees for their review and comments. Doctor Anderson (Chairman, CPS Board of Trustees) stated that he planned to augment this report verbally by reassuring the House that the transition to the 1969 RVS will not result in a reduction of physicians' charges from the present system of payment ***".

Task Force Reports also prepared by CPS provide the following information:

> "* * * The preliminary draft of the 1974 Relative Value Study was received by Blue Shield in late March. Since that time we have reviewed section by section the proposed changes from the 1969 RVS presently in use. It is our conclusion that the new RVS, if published without major revisions from the preliminary draft, [it was] will have a greater impact on Blue Shield in terms of both benefit costs and administrative change than was experienced in transferring from the 1964 RVS to the 1969 RVS. The 1964 to 1969 change produced near chaos in program administration and must be considered as one of the key factors leading to the $20 million loss experienced in the 2 years subsequent to the release of the 1969 RVS * * *."

(CPS incurred this loss in spite of a 5 percent escalation of the standard program premiums in February of 1970 to cover possible increases in benefit payments resulting from the implementation of the 1969 RVS.)

> "* * * The latest revision to the 1969 Relative Value Study, commonly referred to as the 1974 RVS, appears to reflect a new attitude toward the function of a relative value study. Rather than reflecting medical economics as practiced, it is our opinion that the document reflects medical economics as the Committee would like it to be practiced * * *.
>
> * * * The number of changes (1974 CRVS Revision) to basic concepts and principles is too exhaustive for this preliminary report, but we are compelled to raise a basic issue of RVS concept. The following examples illustrate what we find to be a new attitude.
>
> 1. The concept of office visits being related in value to a combination of time and skill appears to have been abandoned. We find descriptions for the following factors.
>
>   a. Diagnostic problem or challenge.
>   b. Critical care services.
>   c. Medico-legal on forensic procedures.
>   d. Preventive health care.
>
> This new description system defies evaluation. Take only the first new category: how can any physician visit not deal with a diagnostic problem? Who defines a 'special challenge' or a difficult diagnosis? Are not these factors related primarily to the individual physician's ability rather than the patient's problem, and is the RVS Committee

suggesting that compensation should be based on the physician's inabilities rather than his skills?

2. The underlying principle of the 'average case' being the basis for surgical fees seems to have been discarded. Note the following examples.
   a. An incidental appendectomy is now a recognized procedure.
   b. Vaginal delivery has been expanded to seven separate procedures to permit description of the technique employed.
   c. Repair of incarcerated hernias are valued greater than the non-incarcerated.
   d. The fee for simple lacerations will be variable dependent upon the 'cooperative ability of the patient.'

3. The 'consultant role' is redefined by the addition of followup visits, yet there is an addition of two new categories of even more subjective consultations. These are complex (to be differentiated from comprehensive) and very complex.

4. The wording of therapeutic injections has been changed from 'may be warranted' to a positive statement that therapeutic injections are billed in addition to the other services provided.

The above examples are representative of what we see as an apparent shift in function of the RVS Committee. Rather than reflecting medical economics as practiced, it is our opinion that the Committee reflects medical economics as they would like it to be practiced. This new view is escalatory and will produce absolute chaos for any carrier that accepts all the concepts proposed."

* * * *

Blue Cross of Southern California states:

"* * * The draft of the new 1974 RVS has been reviewed section-by-section. * * * As a result of this review, it was found that there were approximately 3,740 changes from the 1969 RVS."

"* * * Certainly, the change has been needed since many new procedures have come into common use since the 1969 RVS was published. These changes are primarily in the area of dialysis. However, it does appear that the basic reasoning for increasing so drastically the number of items included in the RVS is to provide the physician with a means of charging more for the services that he is providing the patient * * *."

The following extract from a memorandum by the Sr. Vice President Medical Director--CPS provides some insight on CPS' Board of Trustees and the Director's position on the adoption of the 1974 RVS:

> "* * *I have substantial concern over the impact Blue Shield will experience in early 1975 as the new CRVS is distributed and physicians begin billing. I seek guidance in this area and present for your consideration our current status and possible alternatives available to us.
>
> The Board adopted the following policy toward the 1974 CRVS on November 20, 1974:
>
> That we implement only those sections of the 1974 RVS in which we find a specific need, and that we not implement those sections that would cause communication problems with providers, an abnormal amount of administrative expense or that would appear to be inflationary* * *.
>
> It was my understanding that the prime purpose of this position was to aid in negotiating revisions or possibly defeat the 1974 RVS at CMA Council. We now know there will be a new CRVS, and it will not be significantly different from the original draft. Our best sources indicate the printed editions will be available in January or early February 1975. Therefore, our concern must be towards operations rather than revision or recession of the 1974 RVS.
>
> The 1969 RVS was the basis of reporting for more than 50 percent of billed services within 3 months of release by CMA. Since the physician office changes necessary to adopt the 1974 RVS are less than those required to change from 1964 to 1969, I think we can expect at least 50 percent of the billings to be based on the 1974 book no later than April 1975. This makes the need for definitive operating policies critical if we are to avoid a major processing crisis.
>
> The present Board policy indicates adoption and acceptance by Blue Shield of certain sections of the 1974 RVS. I assume this be done by specialty with cardiovascular surgery, hemodialysis, radiation therapy, and the other exotic medical specialties, where rapid changes have been made, being the benefactors of the new members. If this was the

intent, then your Medical Director must file a protest on the basis that Blue Shield will be acting to favor the high paid super-specialist at the expense of the primary care physician.

If we do accept the specialty concept, who will make the selection? Certainly the tenor of the Medical Policy Committee in Palm Springs did not indicate positive feelings toward the super-specialist, and I personally doubt the Committee's ability to act responsibly within the present Board policy.

Interpretation of the Board policy as a process of selecting individual procedures that meet the criteria for acceptance seems more difficult than selecting specialties. Who is to say follow-up visits for consultations are not 'needed'? Certainly they have been performed, as have visits for 'Diagnostic Problems or Challenges.' Is the need for new specific terminology greater in surgery merely because the specificity is greater? Also, I find no way to determine the inflationary impact of adding a new number, regardless of area of medicine, nor do I know how to measure 'an abnormal amount of administrative expense'. Both factors are basic to implementation of existing policy.

Personally, I feel we are compelled to move from a policy that attempts to straddle the fence to a definitive position. Either we must adopt the new RVS as it is or reject the document entirely and remain with the 1969 RVS.

Refusal to adopt the new RVS would certainly produce a confrontation at the House of Delegates, reduce or destroy the remaining support we received from local peer review committees, and might lead to the separation of Blue Shield from organized medicine. The reaction from the practicing physician is difficult to predict. It could lead to mass resignations among our members, but I am more inclined to think they would accept our decision, with minor grumbling."

* * * *

The position of the CPS Board of Trustees was communicated to the CMA Council in January 1975. The Board stated that:

"1974 Relative Value Studies

* * * After a thorough analysis of the new 1974 Relative Value Studies, Blue Shield finds it will not be possible to implement it in its present form. The Board voted this position because of the problems the 1974 RVS would cause in communications with physicians, the huge amount of administrative expense to implement it, and sections of it which appear to be inflationary without proper justification.

Another major consideration in taking this action was the realization that any attempt to fully implement the 1974 RVS at this time would substantially increase the need for Blue Shield and all other carriers to change RVS numbers from those originally reported by physicians. It is widely recognized that the changing of procedure numbers, regardless of the justification, has been a constant source of concern to the physicians as well as to Blue Shield. The new RVS has over 2,000 additional procedure codes for which there are no established fee profiles. The absence of such profiles would require Blue Shield to force the new codes into the profiles of existing 1969 coding in order to make payment. The opportunity for erroneous correlation to the 1969 RVS would be immense. Furthermore, there can be no way devised to go through this massive code changing and expect to give physicians advance notice about the changes prior to payment, unless substantial delays in making payment would be tolerated. If so, it would have to be recognized that this would be a condition that would exist for 18 to 24 months.

It is our conclusion that the 1974 RVS is not in the best interest of the profession at this time--nor would it be in the best interest of their patients who will also be affected by such a major disturbance in getting claims paid properly and promptly. In addition, Blue Shield feels certain that Government Programs are not likely to accept the 1974 RVS. If the new RVS were used for Standard Business, everyone would be faced with having to continually deal with more than one RVS, which would be especially burdensome to physicians' office personnel * * *."

The CPS position was considered by the CMA Council in its January 1975 meeting. In April 1975 the Council voted to reaffirm the action taken in November 1974

which provided for the approval of the 1974 CRVS for publication at the earliest feasible time.

* * * * * * * * * * *

The CRVS Committee at its May 1973 meeting discussed the use of computer data versus the use of questionaires.

Both have limitations, however, with the latter type of data probably being more limited in that some physicians may merely indicate their wishful thinking rather than what they actually charge. Computer data may show lower charges than usual fees, however, since some physicians may adjust their charges in line with what they know will be allowed by third parties. One member of the Committee observed that the early editions of the RVS considered time, risk and skills, not just charges.

Legal Counsel for the CMA and CPS[1] expressed concern that the proposed (subsequently eliminated) "Medico-Legal and Forensic Procedures" listed in the pre-publication copy of the 1974 CRVS should be removed on the basis that

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[1] In March 1973, two physicians introduced a resolution (No. 171-73) to the C.M.A. requesting that the same law firm no longer represent both the C.M.A., and C.P.S. because they felt it constituted a conflict of interest. Blue Shield was opposed to this resolution. "We are not aware of any conflict and believe there is a definite advantage to having the same legal counsel due to the close legal relationship between the two organizations. Also, by the very nature of having the same legal counsel, any potential differences are prevented from occurring."

The resolution was not adopted.

they represent a fee schedule by any test. The following two memoranda by Legal Counsel exemplify his overall position.

"July 25, 1973

Mr. Michael W. Jones[1/]
California Medical Association
693 Sutter Street
San Francisco, California 94102

Re: California Relative Value Studies -
Medico-Legal and Forensic Procedures

Dear Mike:

On July 10, 1973, I received from you your letter of July 5 and attached proposed Medico-Legal and Forensic Procedures for the RVS. I immediately wrote you that the proposals raise extremely serious legal problems in the antitrust field and that I would respond as soon as possible.

I have shared the proposed medico-legal procedures with Mr. Karl F. Nygren of Kirkland & Ellis, who is consulting legal counsel to the American Medical Association and who is a specialist in antitrust law. I also shared the proposals with Mr. Paul Gebhard of Vedder, Price, Kaufman & Kammholz, who is general counsel to the College of American Pathologists and the American College of Surgeons, and who also is an antitrust law specialist.

I consulted Messrs. Nygren and Gebhard because they were both involved with me in the defense of the United Medical Laboratories litigation and because both are intimately familiar with all antitrust litigation and threatened litigation in the Country involving medical organizations.

Each has responded and I enclose herewith the following:

1. Copy of a letter dated April 4, 1973, addressee not identified, from Mr. Paul Gebhard. I can tell you that the addressee on Mr. Gebhard's letter was a local surgical society.

2. Copy of a letter to me from Karl F. Nygren, dated July 18, 1973.

Both of these enclosures cover legal aspects of professional fee shedules that I discussed in detail with the Executive Committee of the Association several months ago, at which time Dr. Wallace Gerrie was present representing Dr. Brignoli who was ill.

When the RVS was first envisioned and developed, I was of the opinion that the antitrust laws did not apply to the practice of either medicine or law. In recent

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1/ From Howard Hassard

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"July 25, 1973

Mr. Michael W. Jones [1/]
California Medical Association
San Francisco, California 94102

Re: California Relative Value Studies -
Medico-Legal and Forensic Procedures

years, however, as both Messrs. Nygren and Gebhard point out, the Antitrust Division of the Department of Justice has maintained antitrust cases against pathologists, civil engineers, certified public accountants, professional engineers, and real estate boards. Gradually a change in the law is developing and in time it is likely that the antitrust laws will be held applicable to the professions of medicine and law. If this occurs, the RVS can only be legally justified if it is not either a direct fee schedule or a coded fee schedule.

The proposed Medico-Legal and Foresenic Procedures are a fee schedule by any test. In addition, they propose a fee schedule in an area outside the practice of medicine.

Testifying in a legal action undoubtedly requires preparation and skill and definitely is time consuming, but it is not the practice of medicine. For these reasons, I must express my concern that the proposed medico-legal procedures would likely be held unlawful and could well jeopardize the legality of the entire Relative Value Studies.

* * *

1/ From Howard Hassard (continued)

"September 23, 1974

E. Kash Rose, M.D. [1/]
Chairman of the Council
California Medical Association
P. O. Box 2038
Napa, California 94558

Re: Relative Value Studies -
Proposed 1974 Revision

Dear Kash:

As you requested, I am reporting herein my current state of mind and recommendations concerning the proposed 1974 revision of the RVS.

I received a copy of the finished document from Mike Jones on September 10, 1974 and immediately commenced review of the hundreds of pages of material (by weight 3 pounds).

Since then I have had correspondence with Mike Jones (as per list and copies attached) and telephone conversations with Dr. Leo Bell and Mr. Jack Light on various aspects of the proposed revision. The attachments identify the areas studied and the recommendations relating thereto.

Of course, my overall concern is with the antitrust laws as I have previously reported to the Council, Executive Committee and the RVS Committee itself. To attempt either a review or an evaluation of the numerous court decisions and relevant legal literature on the questions of law pertinent to the RVS would lengthen this letter beyond reason. Suffice it to say case law to date fixes the concept that the learned professions are outside the ambit of the antitrust laws. But, most significantly, the U.S. Department of Justice is currently suing the Oregon State Bar Society alleging that its minimum fee schedule is a price list and, hence, a per se violation of the antitrust laws.

Directly in the face of the decisions above-mentioned, a high official in the Department of Justice has said: "We disagree with the court decisions and we are confident that we can convince the Supreme Court of the United States that the professions are subject to the antitrust laws."

Another high official in the U.S. Department of Justice in the fall of 1973 stated that "relative value schedules" raise serious antitrust problems. He stated: "Agreement upon the relative value between one type of ... service and another is similar to an agreement among tradesman upon a formula to be used for computing the price of a custom made product. Their prices may differ if in employing the formula they use different prices for the basic element. But if they use an identical basic price element

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1/ From Howard Hassard

"September 23, 1974

E. Kash Rose, M.D. 1/
Chairman of the Council
California Medical Association
P. O. Box 2038
Napa, California 94558

Re: Relative Value Studies -
Proposed 1974 Revision

then the use of the formula insures that the end price will be identical. Consequently, agreements upon the method by which the end price will be determined may be a form of per se illegal price fixing.

Many lawyers, including the writer, do not agree with the above quoted appraisal of relative values studies. Nevertheless, it is crystal clear that there is a difference of opinion between the law enforcement officials and the Department of Justice and some courts and some practicing attorneys, and no one knows what the end result will be.

Along this line, I enclose a copy of an article appearing in a current issue of MEDICAL WORLD NEWS, entitled "Medicine faces antitrust threat".

The combination of the uncertainty of the law and the vast size of a new proposed RVS causes me to state that my associates and I need a reasonable length of time to continue and complete our research and evaluation. We cannot be ready by September 27.

In addition to our problem, I strongly recommend that the members of the Council need to take the time to read, review and evaluate the proposed new RVS in its entirety. If the RVS should be adopted without thorough Council consideration, individual Councilors will be hard put to defend their actions at some future date from a witness stand.

It may well be that the 1974 revision will be enthusiastically approved after it has been fully studied, but if it is "rubber stamped" without adequate study and it is later challenged, the Councilors will be hard put to explain.

Finally, I strongly recommend that the Council authorize the appointment of a special Council committee to evaluate the proposed new RVS in depth and to report back to the Council as soon as possible with its recommendations.

1/ From Howard Hassard (continued)

"September 23, 1974

E. Kash Rose, M.D.
Chairman of the Council
California Medical Association
P. O. Box 2038
Napa, California 94558

Re: Relative Value Studies -
Proposed 1974 Revision

I would expect that our office would be able to complete our legal evaluation and submit same to such special committee before it completed its medical evaluation of the RVS.

1/ From Howard Hassard (continued)

The 1974 CRVS was also reviewed by an official of BHI/SSA who expressed grave concern that the use of the CRVS will impact heavily on the cost of the Medicare Program in California. The representative of SSA stated in a letter to CPS and the CMA that this fear was based in part on the prediction of fee escalation resulting from elaboration in the nomenclature or descriptor. The official further stated that a strong possibility of fee escalation was said to result also from an increase in certain relativities. The official stated that if there is an increase in the relativity for one level of hospital visits, for example, it is found that physicians will tend to escalate all their other fees for visits in accordance with the favorably valued procedure.

The following is an excerpt from the official's letter:

> "There is a strong inducement provided in the new terminology to charge above-usual fees for the discharge day of a medical admission, to charge relatively higher fees for care provided to patients in critical care areas, to consider some visits as 'Unusually Complex' and/or complicated by a chronic disabling condition."

To address the views expressed by critics of the CRVS we conducted a limited review of the processes and methodologies used by CMA to write the CRVS. In this review we attempted to test the validity of CMA's position that the CRVS reflects medical practice.

We believe this additional effort was warranted due to the concern expressed by critics of the CRVS and the Attorney for CMA and CPS and the CPS Medical Director as indicated in the following correspondence on pages 45 and 46.

"September 30, 1975

William C. Miller, Esq. 1/
Pillsbury, Madison and Sutro
225 Bush Street
San Francisco, CA 94104

Dear Bill:

Thanks for your letter of September 23, 1975, and the excerpt from the Wall Street Journal. As you guessed, I was aware of the action commenced against the anesthesiologists.

I have been expecting such a suit ever since Goldfarb v. Virginia. Unfortunately, several specialty societies, including anesthesiologists, have developed 'Relative Value Guides' that for all intents and purposes signal the fee that should be charged. In addition, ever since the removal of price controls new editions have been put out with across-the-board increases in unit values.

When a single specialty utilizes a relative value approach there isn't the wide diversification that exists when a relative value study covers the entire practice of medicine.

As you can readily observe, I am not too optimistic as to the outcome of the anesthesiologists' suit, and hopefully hope that the Department of Justice has re-examined the California file and passed us by. I still think we are perfectly okay here in California. In fact the most recent Relative Value Studies, dated 1974, doesn't even put units alongside new procedures. Instead, it uses the phrase 'relativity not established.' I didn't want a committee to be establishing anything, including relativity for new procedures.

Finally, I don't think the plaintiff Bar had anything to do with the anesthesiology suit, although that particular branch of our profession has been hyperactive of late."

* * *

1/ From Howard Hassard, CMA-CPS attorney to Miller (well-known anti-trust attorney).

"October 3, 1975

Howard Hassard, Esq.[1/]
Hassard, Bonnington, Rogers & Huber
44 Montgomery Street - Suite 3500
San Francisco, CA 94104

Dear Hap:

I just received a copy of your letter to William Miller, Esq., commenting on the Justice Department's suit against the anesthesiologists. Your comment that the California Relative Value Studies Committee did not put units alongside new procedures in the 1974 Revision is not entirely accurate. Procedures 90085, 90275, 90625 and the 11 procedures from 90970 through 90985 are all new to the Medicine Section of the CRVS and carry unit values. It is extremely difficult for me to conceive of a value being established for these services on a basis other than subjective judgment.

There are also numerous diagnostic tests and therapeutic procedures that are new to the 1974 Revision that have established values. These procedures could have been studied from actual charge experience, but I seriously doubt the Committee expended the effort that would have been required. Blue Shield certainly performed no analysis of unlisted procedure billings to serve as a basis for the valuation.

I am also enclosing the first CMA Appeals decision involving the 1974 Revision. The case involves the impact of one of the new procedures with an assigned value, Procedure No. 90275. The Appeals decision seems to cite the 1974 CRVS as a basis to overthrow Blue Shield's medical policy that an increased fee is not appropriate on the day of discharge. We seem to have moved to a position where a decision codified in the CRVS takes precedent over any other consideration. Is this attitude really in the long term best interest of medicine?

I certainly hope your speculation that the Justice Department has already bypassed the 1974 CRVS is accurate."

* * *

1/ CPS Medical Director to CPS-CMA Attorney.

The Anatomy of the RVS Committee

As previously indicated the 1974 and previous editions of the CRVS were the product of the CMA Committee on Relative Value Studies (also referred to as Parent Committee). This committee is supported by advisory committees (subcommittees) and several ad hoc committees representing specialty interests.

The RVS Committee was composed of 14 voting members and 5 non-voting consultants. The advisory committees had specialty members ranging from 2 to 13; in addition each advisory committee was assigned 1 or 2 parent committee members as liaison.

Each of the advisory committees met on the average of three to four times; although some met only twice while others met as many as eight times, depending on how much updating their respective fields required. The parent committee met about 26 times in the 2-year period preceding issuance of the 1974 CRVS.

In response to our request, the CMA provided the following explanation on the formation, background, and selection of committee members.

> "Initially, the Committee on Relative Value Studies established specialty subcommittees who were assigned the task of reviewing the coding and nomenclature contained in the prior (1969) edition of RVS and, based on the current practice of medicine in California, developing suggestions as to additions, deletions, and changes. Subcommittee delineations were based on recognized medical specialties. Names of potential members were elicited from physicians who served as chairmen of the subcommittee during the previous revision, chairmen of CMA specialty sections, and officers of specialty societies with branches in California. An aggregated listing of physicians was presented to the RVS Committee who reviewed the listing and selected particular physicians for this assignment. In total, 27 subcommittees consisting of some 125 individual physicians.
>
> "After all subcommittee members were appointed, an orientation meeting was held to inform them of the task at hand. At this meeting (or shortly thereafter) copies of relevant sections of the 1969 RVS were distributed to subcommittee members for usage as worksheets on which to indicate suggested changes. In many instances, as I explained, more than one subcommittee worked on a specific RVS section. Subcommittees were instructed to hold meetings as necessary and to contact

additional physicians within their specialty for suggestions. Additionally, all correspondence that had been received since publication of the 1969 RVS suggesting various changes in RVS procedures, was reproduced and distributed to appropriate subcommittees. Subcommittees were geographically balanced and each had a liaison physician assigned from the RVS Committee itself whose task it was to coordinate subcommittee activities. In most instances, the committee member assigned also attended any subcommittee meetings held."

The Methodology of Revising the CRVS

Each issue of the CRVS published since inception contains the wording that the prevailing view of the RVS Committee is that its role is to "reflect" rather than "direct" change in the practice and billing pattern of physicians. With respect to the 1969 CRVS which is a revision of the 1964 CRVS, the minutes of the meeting of the CMA Council dated June 14, 1968 state in part:

"... Chairman of the CMA Committee on Fees,[1] discussed the revision of the 1964 RVS, which is currently under way. He pointed out that the time required to complete a revised RVS is about 2 years -- meaning that it will be early next year before the current revision is completed. The revision now in progress, he said, represents by far the most extensive effort ever undertaken by the committee ..."

* * * *

In answer to a frequently asked question, the chairman said that his Committee is applying value judgments in determining unit values, pointing out that sufficient computer data to determine unit values is available for less than 20 percent of the procedures contained in the RVS. The Committee itself, in consultation with its subcommittees, must exercise judgment in the majority of instances ..."

* * * *

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[1] "Committee on Fees" was changed to "Committee on Relative Value Studies" in September 1968.

The 1969 CRVS also introduced variable relative unit values for each section of the CRVS. Variable unit values were introduced to preclude third party users of the CRVS from applying a single constant conversion factor to the entire CRVS. In response to inquiries, a consultant to the CRVS

Committee explained the reasons for variable values:

"... Actually, the value of the units in all sections (except anesthesia) was changed in the 1969 edition for a specific reason. All previous editions of the RVS dating back to 1956 have stated that one cannot use the same conversion factor in more than one section. We found that over the years the conversion factor in orthopaedics, for example, had gradually increased to a level of 7 or 8 dollars in some geographic areas. The tendency was for the orthopaedists to apply this $7 or $8 factor to the other sections of the RVS and when such a conversion factor was applied to radiology, he would arrive at exhorbitant fees for his radiology services. In addition, the tendency of insurance carriers and government agencies was to apply the same factor across the board and this produced severe inequities, particularly when payment was made on the basis of something less than the normal charge... ."

For the above reasons, we elected to determine the units on a different basis for each section. We arrived at the unit values by using a conversion factor of 50¢ in medicine, $25 in surgery, $2.50 in radiology and 25¢ in pathology. The choice of these conversion factors was roughly on the basis of the level of common charges in these various fields. We felt that this change will force physicians, insurance companies, and government agencies, to think in terms of a different conversion factor for each area, and will prevent many of the inequities that have developed in the past by the use of an across the board factor... ."

* * * *

The use of multiple conversion factors was also commented on by others including:

1) The Sacramento County Medical Society who stated in a memorandum to the C. M. A. dated October 8, 1974 that:

"... We believe that the multiple factor concept strongly supports the use of the RVS as a fee schedule and defeats the principle on relativity of all medical procedures regardless of the nature of practice or field of specialization. Additionally, we believe that multiple factors increase possible legal implications found in federal law."

2) An Associate Professor of Medicine, School of Medicine, University of California, in a paper prepared for the 1977 Summer Symposium of the Sun Valley Forum, Inc. stated that:

"... Four guiding principles were set forth in the introduction to the first (1956) CRVS. These were: 1) uniform nomenclature, 2) standardized coding system, 3) relative valuation of procedures and services as opposed to a set dollar fee schedule, and 4) correct segmentation. Principles one and two are fairly straightforward in their implications. They implicitly acknowledge the needs of third-

party payment systems. Principle three was emphasized in the foreward to the original RVS. This stated that, "this study in no way sets anyone's fees or anyone's schedule of fees. The Relative Value Schedule is in no sense a fee schedule." Principle four is based on the theory that different rates of overhead and technological innovation in the four major sections of the RVS (Medical, Surgical, Radiological, and Laboratory) create a need for four different conversion factors to be applied to these sections. The reasons for this division into four sections were probably as much political as any other. This resulted from the need for acceptance of the CRVS by the entire CMA membership and the medical profession in general, and the protection of the interests of various specialty groups. There apparently was a decision to let the various contending groups determine relative values within their own general areas rather than to open up the whole question of parity between these areas. It was felt by the committee on fees that a single conversion factor disadvantaged anesthesiologists the most, while radiologists and pathologists were the most advantaged by this arrangement. This is theoretically because an anesthesiologist is primarily paid for the time worked, while radiologists and pathologists are primarily paid for the technology used. Obviously, technology has the greater chance for movement toward more productivity and efficiency over time..."

* * * *

In the 1974 CRVS, the Committee on Relative Value Studies, assigned the following divisors in order to develop unit values: Medicine $2.50; Surgery $60.00; Radiology $5.50; Pathology $.65. No divisor was used to arrive at unit values for anesthesia because first, only fragmentary charge data was available from insurance carriers and second, experience had shown that some anesthetists tend to use the Society of American Anesthesiologists' Relative Value Guide while others use the CRVS guide. Consequently, a CMA official stated that unit values for the 1974 CRVS anesthesia section are primarily based on judgment of the CRVS Committee and responsible subcommittees who took into consideration the difficulty and complexity of the operation.

The revision of the 1969 CRVS began early in 1972. In a letter requesting recommendations for subcommittee members, the CRVS Committee Chairman explained the requirements and task of the subcommittee members:

> "Particularly important of subcommittee members is conversance with both the science and socioeconomics of medicine, since the task will require reviewing

and developing both the definitions of procedures and the unit value assigned thereto. As appropriate, subcommittees should have a balance which would include private practice and hospital, or university, based physicians. Lastly, we would like to achieve a modicum of geographic balance on each subcommittee.

Uniform and precise instructions were not issued to all subcommittees and ad hoc committees. However, subsequent correspondence between the parent Committee and the subcommittees, worksheets and subcommittee reports indicate that the subcommittees were instructed to revise their respective sections in two steps, 1) revise the coding and nomenclature and after the coding and nomenclature was approved by the parent Committee, 2) revise or otherwise assign unit values. In June 1973, some subcommittee members were instructed to:

"Please focus your review on the coding and nomenclature only, since values are not being considered at this time. However, if there are suggestions about values, they will of course be considered by the committee when that subject comes up."

In July 1973, the Chairman of the Internal Medicine Subcommittee was asked to consider "the recommendations and to focus attention on developing appropriate unit values for the (dialysis) services." The notice and agenda for the September 7 - 9, 1973 meeting of the CRVS Committee notifies members that:

"This coming meeting should be the final one at which coding and nomenclature are discussed. Subsequent meetings should be devoted to development of unit values..."

* * * *

"Protocol to be followed during the second phase of RVS development -- unit values. This should provide more than enough fodder for the time allowed. This meeting, incidentally, appears to be of particular importance and it is important that all members and consultants make every effort to attend."

The minutes of that meeting indicate that:

"Plans were developed for directing subcommittees in how to approach the problem of developing values. A motion was passed that it would be the responsibility of liaison members of the committee to meet with the various subcommittees in advance of the (CRVS) committee meeting at which they are scheduled to

report. Subcommittees should develop dollar recommendations in advance of their meeting with the liaison member, who will bring computer data to the meeting. Based on these discussions, recommendations can be prepared for submission to the full committee..."

Again, no uniform instructions were issued to all subcommittees and ad hoc committees. In accordance with the September motion, CRVS liaison members guided their respective subcommittees in developing unit values. Late in September, the Acting Chairman of the CRVS Committee and liaison to several subcommittees wrote to subcommittee chairmen:

"Since I have the assignment of liaison to your subcommittee, I will be contacting you with information about how to proceed in the development of recommendations with respect to unit values."

The Acting Chairman informed his subcommittees that they would be scheduled to report to the CRVS Committee at the November, or December, 1973 or the January, 1974 meeting.

At the October, 1973 CRVS meeting, it was again affirmed that it was the liaisons' function to assist in developing dollar recommendations for their respective subsections and that charge data obtained from CPS was not to be distributed to the subcommittees in advance. The notes from the meeting read:

"Members of the committee reviewed the content of printouts of CBS data that were distributed to members in attendance. Doctor Bell (the Acting Chairman) reminded them that their function as liaison entailed meeting with the various subcommittees and developing dollar recommendations for the full committee. Charge data were not to be distributed to the subcommittees in advance. He noted that for new procedures, if the subcommittee members felt that the charge levels were fairly well "settled in," and the committee itself could be so convinced, such procedures, would not necessarily have to be indicated on a BR basis."

The CRVS committee, at its February 1974 meeting, passed a resolution requesting subcommittee chairmen to send in information as to how they developed their recommendations about what constitute charging patterns for various services, so that this information can be on file in the CMA office. It was emphasized that charge data could consist not only of computer figures already

supplied to the committee, but also could be based on similar types of procedures for which charging patterns can logically be assumed to be similar and on survey data secured by subcommittees from physicians performing the procedures. If survey data are collected by telephone, a statement from the committee chairman should be submitted for the files, containing information about how, when and by whom the data were collected, and the number of physicians contacted.

Our review of the revision of selected subsections indicates that the subcommittees initially arrived at unit values for procedures and later converted these values to dollar values. The CRVS Committee subsequently evaluated the values recommended by the subcommittee using as a guide the data obtained from CPS and any other fee information available to them.

A CMA official provided the following summary of the entire CRVS revision process:

"In addition to suggesting changes in procedural coding and nomenclature, subcommittees were also asked to provide the committee with charge data for the various listed procedures. This information was generally posted on worksheets, along with data from the computer printouts which you have reviewed. Computer printouts were in all instances the primary source of information concerning charging patterns for the various procedures.

As we have discussed certain subcommittees conducted formalized surveys about charges for various procedures. In other instances, less formal inquiries were conducted by subcommittee members to secure information about special types of procedures. I have maintained data on all surveys that were formally conducted through CMA by various subcommittees.

Unit values contained in the RVS are based on median statewide charge levels for the various listed procedures. All figures were for calendar year 1973. As I have indicated, data purchased from Blue Shield were the most detailed and were generally used for establishing median charge levels. Also considered, however, were data from the Medicare program, the Medi-Cal program, the CHAMPUS program, Occidental Insurance Company, Prudential Insurance Company, Blue Cross of Southern California and Blue Cross of Northern California.

Subcommittee chairmen were requested to attend individual sessions of the second round of committee meetings at which values were discussed. In certain instances subcommittees made recommendations about median charge levels; in other instances, computer data were merely reviewed in the presence of the subcommittee chairmen. In all instances the RVS Committee, which consists of 13 members and 4 consultants from a broad range of medical specialties, made final decisions.

In many cases new procedures for which no data were available were listed as 'relativity not established' (RNE). Certain other procedures, many of which are new, were listed on a 'by report' (BR) basis. Procedures listed as BR are intrinsically variable and cannot be assigned a specific value. In certain other instances, based on comparability to existing procedures or estimated charges developed by inquiry of the subcommittee, estimated charge levels were actually attributed to new procedures.

In no instance was a value attributed to a procedure when all of these factors were absent.

The final step in the RVS revision process was to align data for all sections into one time — calendar year 1973. Since subcommittees reported at various times and data secured from various sources were for differing periods, adjustments were used to bring all figures into this time alignment.

After 1973 median charge levels were all approved by the committee and posted in the master workbook, divisors were determined which would be used to calculate unit values in each of the sections.

For example:

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Procedure #90085 - was established with a unit value 16.0 by the following methodology:

Subcommittee of three pediatricians suggested $35.00* based on 1971 charge data.

Subcommittee of 10 internists suggested $50.00* based on 1973 charge data.

RVS Committee accepted $40.00 / 2.5** = 16.0 units. I have provided you with divisors, which are arbitrary numbers used merely to translate dollar values into units. These numbers are not publicized to the medical community.

After all unit values were calculated and posted, dollar information was obliterated and a limited number of draft copies of the RVS were duplicated for submission to and consideration by the CMA Council. The material was reviewed by the Council of November 1974, at which time approval for publication was given."

* * * *

"* There was no charge data available, consequently, the amount is based on what the members thought would have been developed if thi s descriptor had been in the 1969 RVS and on comparability to other procedures for which data were available."

"** Arbitrarily established divisor by RVS Committee."

THE 1974 CRVS, ITS EFFECT ON FEES

Introduction

We find that relativities (unit values) and changes in descriptors in several of the specialty sections of the 1974 CRVS were not established according to the stated conditions that (1) relative values for established procedures are based on median charge levels in California, (2) relative values for new procedures are based on estimated charge data obtained by the subcommittees, or relativity to established procedures for which charge data was obtained. The RVS Committee of the CMA appears to have approved these sections without the necessary evidence or support that the charge data submitted on which the resulting relativities (unit values) for new and old procedures were based represented the median charge levels that actually existed in medical practice in California. We also find that the procedure descriptors and values in certain specialty sections are, in fact, based on the subjective judgment of a few physicians practicing in the corresponding specialties, rather than historical charge data.

The lack of support for the charge data used to establish relative unit values is confirmed by a CMA letter to the various subcommittee chairmen who supervised specific RVS specialty sections. Dated December 11, 1974, about one month after the approval of the 1974 CRVS, the letter requested that subcommittee chairmen provide evidence to support the charge data they submitted on which the unit values were based. The request (see sample -- Appendix A) was mailed to several of the subcommittee chairmen or subcommittee subsection chairmen, including the following:

Specialty Section	Subcommittee Chairman
Cardiac Surgery	Benson Roe, M.D.
Ophthalmology	Maurice S. Salomon, M.D.

Specialty Section	Subcommittee Chairman
Orthopedics	Kenneth G. Campbell, M.D.
Pediatric Surgery	George Hyde, M.D.
Cardiovascular Surgery	Frederick Binkley, M.D.
Cardio-Pulmonary Physiology	Richard McLaughlin, M.D.
Internal Medicine	Gerald F. Pepper, M.D.
Nephrology	George Kardos, M.D.
Medicine - Dermatology	William Levy, M.D.
Otolaryngology	George C. Wilson, M.D.
Internal Medicine - Cardiology	Edward Caul, M.D.
Proctology - Surgery	Walter Birnbaum, M.D.

We note that despite a follow-up letter dated June 5, 1975, the subcommittee chairmen responsible for the otolaryngology section and ophthalmology section, have not as of this writing responded to the CMA request and several of those responding failed to provide supporting documentation.

The following are responses received from the subcommittee chairmen responsible for updating the 1974 CRVS sections on Cardiology, Pediatric Surgery and Ultrasound:

"This is in response to your letter of December 11, 1974. My recommendations for relative charges were derived from a study which I conducted personally.

This study consisted of a survey by random sampling of physicians who are members of the American College of Cardiology. They were located in both southern and northern California. We specifically eliminated those physicians who were university based or hospital based and not submitting private bills to patients.

Inquiries were sent to 129 physicians. There were 50 responses. This formed the data basis for definitions of charges in effect. The compilations were presented formally at committee meetings. Copies were distributed to members and it was my opinion that they became part of the minutes. Though I continue to have copies of the original work, the actual responses as original documents were not retained.

If there is anything further you need in regards the substantiation of the data, I would be happy to review this more closely and supply you with more specific data as well as copies of the original report."

* * * * * * * * *

"Approximately 30 surgeons are confining their practices to Pediatric Surgery in California. I contacted personally 11 who because of partnership arrangements could give me information about the billing practice of 14 of the above 30. From this information the sub-committee constructed recommendation for a R.V.S. profile in Pediatric Surgery."

* * * * * * * * *

"Please accept my apologies for the delay in forwarding the following information to you.

At the time when the subcommittee on Medical Ultrasound decided on the relativity of the diagnostic procedures, a sample was taken from three different locations in the State of California. Doctor George Leopold sampled the San Diego area, Doctor Sprague reported on the Los Angeles area, and I sampled the San Francisco Bay area. We took care of including all the existing ultrasonic laboratories from the universities to the private practitioners' offices engaged in diagnostic ultrasound. The relative values we decided upon represented, to the best of our ability, a good cross sectional average of all these institutions."

SCOPE

We reviewed the methodology used to arrive at the coding, nomenclature and unit values for several 1974 CRVS subsections: nephrology, cardiac surgery, cardiovascular surgery, general surgery, orthopedic surgery, and ophthalmology. Our review included discussions with responsible subcommittee chairmen, and analysis of the procedures used by the respective subcommittees to arrive at their recommendations to the CRVS Committee. In addition, we reviewed the adjustments made by the CRVS Committee to arrive at the 1974 CRVS unit values. In order to determine the impact of the 1974 CRVS on charges, we requested and were provided by CPS/EDS a computer report showing charges billed CPS under the Medicare and Standard Programs for a six-month period, July - December 1976. The report was for the medicine and surgery sections.

The report included the same information as used by CPS in developing profiles used for Fee Screen Year ended June 1978, except that it was only for one-half of the base period. The same edits were applied to the report as are applied to the information for the development of profiles. Two sets of edits are applied to billed charges prior to their inclusion in profiles. Phase I edits are general edits including numeric checks, date range checks and elimination of non-profile claims such as drug or institutional claims. Phase II edits are more specific. They consist of a number of checks which result in the elimination of invalid data. Included are edits designed to ensure that billed amounts are reasonable. This is accomplished through the use of "high-low" coefficient parameters. (See page 30a for parameters set for Fee Screen Year 1978.) Charges which fall below the low or above the high

parameters are dropped from the profile base. This also applies to the reports used for our review of the impact of the 1974 CRVS. Initially EDS prepared a report for Medicine procedures prior to the application of Phase II edits. Because charges on this report were extremely broad, ranging from extremely low to extremely high amounts, we chose to obtain and use information after application of Phase II edits.

From the Medicare computer report after application of the Phase II edits, we selected the procedures billed most frequently for the previously listed specialty subsections and the most frequent medicine procedures.

These procedures accounted for a substantial portion of the medicine and surgery services billed CPS under the Medicare Program for the six-month period:

	Total services and fees billed for profile building purposes	Services and fees for selected procedures for profile building purposes	Percent of Total
Medicine (except Nephrology)	4,806,052	3,715,844	77
	$98,891,345	$70,173,987	70
Nephrology	5,179	5,098	98
	$ 1,263,983	$ 1,247,647	99
Surgery	259,988	60,897	23
	$52,140,369	$22,326,457	43

For the selected procedures the tables show:

1. The "Median" or 50th percentile represents the dollar charge at the middle of the range of charges. About one-half of the charges are below and one-half are above this amount.
2. The "Mean" -- the arithmetic average, the total dollar amount for all services divided by the total number of services for each procedure.

3. The "Mode" -- the amount billed most often.

4. The "Dollar Basis of 1974 Unit Value at 1973 Levels" -- The 1974 unit value multiplied by a conversion factor resulting in a dollar amount. This dollar amount is what the CRVS committee determined the procedure to be worth in 1973.

   The 1973 dollar value was used as a basis for deriving the 1974 unit value. For example, the CRVS committee determined that procedure No. 90981 was worth $75 in 1973. Seventy-five dollars was divided by $2.50 (an arbitrary divisor) to arrive at 30 1974 unit values. (Page 59b)

5. The "Dollar Basis At 1976 Fee Index Level" -- This represents the 1973 dollar level increased by an economic index (<u>The Medical Fee Index</u>) to bring the 1973 dollars up to 1976 dollars. The Medical Fee Index is similar in concept to the Consumer Price Index. For example, the Medical Fee Index applicable to the Medicine Section (not surgery) of the CRVS shows an increase for the period 1973 to 1976 of .4363, rounded to .44 on our charts. Multiplying procedure No. 90981's 1973 value ($75) by .44 results in a 1976 dollar value of $108. (Page 59b)

6. The "Range"-- The highest and the lowest fees billed for each procedure.

7. The standard deviation is a measure of the dispersion of values about the arithmetic mean; and in particular is the average distance of all values from the arithmetic mean.

8. The coefficient of variation (standard deviation divided by mean) is a measure of spread of the various charges and can also be used to measure the degree of concentration of the charges. The larger the coefficient of variation (V) the larger the spread; the smaller the V, the smaller the spread and the greater the concentration. However, a low coefficient of variation (less than 0.20) may not indicate a high concentration of charges if the distribution is multimodal or the mode represents less than 50 percent of the total units charged.

In preparing the tables we attempted to shed light on the allegations against the CRVS. Primarily, is the CRVS inflationary, and secondly, is it an agreement to charge at least so much money and no less for a procedure.

Is the CRVS inflationary?

We were unable to draw any conclusions. The tables were prepared for the purpose of comparing charge patterns in States using CRVS with charge patterns in States not using CRVS. However, the subcommittee staff was unable to obtain data for any non-CRVS States. HEW, Health Care Finance Administration which accumulates charge data for the Medicare program on a nationwide basis was not able to break out data on a State-by-State basis.

In addition, for those States using CRVS, many are using either the 1969 edition or the 1964 edition. Charge data from these States is not comparable with California data which is based on the 1974 CRVS.

Also, the high fees shown in the tables may represent billings by physicians who recognize that their current charge data will be used to update profiles in the future.

Finally, one should be cautious in stating that the CRVS is inflationary. While the proliferation of descriptors may result in an overall increase in medical costs, the mere publication of unit values may not be inflationary unless used with a dollar conversion factor that doesn't reflect a physicians cost, time, risk, skill and market place.

We did not review the basis for the dollar conversion factors used by specialty groups and foundations for medical care. However, there is a wide range in the conversion factors used. For example, in 1977 the

Foundation for Medical Care of San Diego County published a minimum conversion factor for surgery of $100. For the same period, the minimum conversion factor for surgery in Butte and Glenn Counties was $76. The minimum conversion factors used in San Mateo and Monterey Counties were $60 and $89 respectively. Further, the range may be influenced by physicians in a university setting whose fees may be different from those billed by physicians in group or private practice.

Finally, as indicated in the text, there is some evidence suggesting that medical associations, specialty groups and medical foundations established fee guidelines for their members. While our data does not break out providers in terms of geographic location, it is possible that a grouping of charges in a multimodal distribution represents charges by providers in the same geographic location.

From our data, it does not appear valid to assume that the CRVS establishes a "floor" below which physicians do not bill. The chart on page 59b shows that for the five procedures with assigned unit values, the lowest amount charged in the last six months of 1976 by physicians was equal to 1973 calculated dollar value in four out of five cases. If the 1973 dollar values were adjusted for inflation to 1976 values, probably even more of the physician charges would be below the adjusted 1976 calculated charges.

While the CRVS does not appear to create a floor for physician charges, when the CRVS unit values are used with set dollar factors (as in the Medi-Cal program and in certain Foundation programs in California), a set fee schedule for reimbursement is created.

* * * *

Discussion of the methodology used by the subcommittees to update seven subsections of the CRVS and corresponding charts showing the subsequent fee trends follow. The charts identify the service billed by procedure number only; for a description of the procedure, see Appendix B. Also attached as Appendix C is a DHEW review of the changes in descriptors from the 1969 to 1974 CRVS.

EXAMPLE #1

MEDICINE - NEPHROLOGY

Peritoneal Dialysis - Hemodialysis

The following members were an ad hoc Committee (Subcommittee) on Nephrology of the Internal Medicine Subcommittee.

1974 Nephrology Subcommittee Members

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* * * *

Modifications of Descriptors & Procedure #'s

The dialysis section underwent major changes. New procedure codes and descriptors were added and the majority of the 1969 CRVS procedure descriptors were revised because they failed to differentiate between the various services a physician provides to a patient on dialysis.

The following table compares the procedures listed in the 1969 CRVS and those published in the 1974 CRVS.

	1969 CRVS	1974 CRVS
Total number of procedures	7	20
Total number of procedures designated BR (By Report)	7	1
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS	5
Total number of new 1974 procedure descriptors with relativities (unit values)		14
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which could not be matched to a previous CRVS		14

The change of the old descriptors and the designation of new ones was primarily the work of the Nephrology Subcommittee members who felt that the 1969 CRVS did not adequately reflect the treatment pattern which had evolved. The Subcommittee members felt that the 1969 CRVS descriptors were out of date and did not represent the state of the art. The Subcommittee did not receive any direction or instructions from the CMA requesting that the descriptors be expanded. The Subcommittee Chairman acknowledges that he and the other members of the Committee had discussions with other nephrologists who were involved in the treatment of patients by dialysis. Although a questionnaire was sent to various practitioners, according to the chairman, the "response was not 100 percent of any where near it, the people did not respond fully..." "I think we got a majority approval both written and unwritten by phone of the people who we could reach who said basically they were in agreement with the philosophy of the approach." In summary, the chairman states that the new descriptors in the

1974 CRVS hemodialysis section are primarily based on the subjective judgment of his committee "and all the people we talked to." (Note Data supporting the Subcommittee inquiries was discarded by Doctor Kardos when he moved to a new residence.)

Basis for 1974 CRVS Unit Values

The minutes of the September 8, 1972 Subcommittee on Internal Medicine indicate that 21 replies were returned in response to a survey of 60 neprologists. It is not clear if, or how, this information was used. In addition, the minutes indicate that two nephrologists, the Nephrology Subcommittee Chairman and another member, felt that the entire section (1969) on dialysis should be revised and that in their opinion remuneration (therefore relative value) for dialysis is reflected by the physician time required. Apparently, other members of the Internal Medicine Subcommittee disagreed, noting that time was a poor means to evaluate payment because it does not reflect the skill and knowledge of the various practitioners.

The Nephrology Subcommittee chairman acknowledges that surveys and inquiries did not result in meaningful charge data. There was more than 200 percent variation in the fee structure; and there was simply no hard core fee data available. Data available from insurance companies, including CPS, was uninterpretable. It was invalid data; "it was 'gigo', garbage in, garbage out". The chairman pointed out that since there were no adequate procedure codes in the 1969 CRVS, Blue Shield was lumping data under the few 1969 codes. Because of the lumping of procedures, there was no mathematical way to interpret the historical data in order to arrive at a median charge.

In addition to the inconclusive fee data, the Nephrology Subcommittee considered the physician effort involved. They tried to gather information as to a median time expended for the various procedures. According to the chairman, physicians are presumably"... paid for a composite of time and expertise...", the committee therefore tried"... to get an idea as to what effort was involved, total effort by the physician..." He adds"... we tried to

somehow come to some sort of middle ground as far as the relative values are concerned."

The list of procedures and dollar values recommended to the parent committee were the chairman's conclusion based on limited, and poor charge data, informal polling of other nephrologists and the opinions of the subcommittee members. The dollar values recommended by the subcommittee and the final values accepted by the parent committee are compared with subsequent fees billed under the Medicare Program on page 59.b.

The 1974 CRVS dialysis section including the unit values and descriptors was approved by the CMA RVS Committee in March 1974. Subsequently, on December 11, 1974, the CMA by confidential letter (See Example Appendix A) requested that Doctor Kardos provide evidence to support the charge data submitted on which the resulting relativities (unit values) were based. By letter dated December 17, 1974, Doctor Kardos replied that, (dollar amounts enclosed in parentheses are inserted by us and represent dollar values accepted by the RVS Committee for purposes of computing 1974 CRVS unit values.)

> "It should be understood that I cannot give you hard core data, in spite of working at Blue Shield, because it is impossible to derive differential fee charges because the RVS numbers currently in use have not permitted discrimination between first and subsequent hemodialysis.
>
> The information I am giving you has been called from multiple nephrologists from both the northern and southern portions of the state. This represents contact with about 50 of the 90 plus nephrologists in the state of California practicing adult nephrology. I will give you a range of fees and what I think the median appears to be from the best I can derive. This is in terms of the current RVS.
>
> Under acute renal failure RVS #90962, the average fee appears to be under $200.00 with the range of $100.00 to $300.00 ($200.00). A 90963 is 50 to 100 with an average fee of around $75.00 ($75.00). A 90946 would be the same as 90962 ($200.00). A 90965 I have no data on. A 90970 the range of fee is as much larger with a low of $200.00 to a high of about $700.00 or $750.00. The average fee appears to be somewhere around $350.00 ($325.00). For a 90971 the range of fee appears similar to 90970, but reality would indicate that the average fee appears to be $200.00 to $300.00 with an average of $250.00 ($200.00). Under 90972

($200.00), the same as 90971. Under 90973, the range appears a little bit smaller, somewhere to $100.00 to $300.00 with the average probably being around $150.00 ($100.00). As best as I can tell, 90974 would be a range of $50.00 to $150.00 with the average being close to $100.00 ($50.00).

The RVS beginning under chronic renal failure 90980 is a range that we have seen in acute renal failure. A more realistic figure would be about $250.00

as being closer to the mean ($200.00). The 90981 range of fees would be from $25.00 to greater than $200.00 with a realistic fee average of $100.00 per run ($75.00). The 90982 range of $25.00 to $200.00 with an average of approximately $75.00 ($75.00). A 90983 which is a global fee ranges from a low of $150.00 to a high of around $450.00 with an average fee of $300.00 to $400.00 ($300.00) A 90984 range of fee appears to be somewhere between $250.00 to $700.00 with an average fee being around $500.00 ($450.00). Under 90985 the range is under $25.00 to $150.00 with the average being somewhere around $50.00 ($35.00). For 90990 there is insufficient data but would appear to be worth approximately one hour of detention time upgraded for special skill areas such as in a critical care area (RNE).

Lastly, under home hemodialysis care outpatient per month, there is no available source from which to get hard core data (RNE)."

The aforementioned letter was discussed with Doctor Kardos at a taped interview session. The transcript of the tape was subsequently submitted to Doctor Kardos for review; Doctor Kardos acknowledged the accuracy of the interview statement by signing each page of the transcript. In summary, Doctor Kardos stated that:

1) From a statistician's point of view, the relativities (unit values) in the 1974 CRVS do not represent the median charge pattern. However, the relativities represented median charges based on the information available to his committee.

2) When the committee started to work on the revision, the data that was available was worthless data, and that it was the committee's feeling that if it could structure a different dialysis section which reflected each treatment unit as a function of time, ultimately charge information would be available which would yield statistically valid data.

Finally, to our question, "How do you know the physician who provided the above fee ranges did not tell you what they would like to charge rather than what they are actually charging?" Doctor Kardos replied, "I don't know that." But added that based on their experience he and his colleagues would recognize untruthful responses.

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Comparison of 1974 CRVS Values to Fees

Subsequently Billed CPS

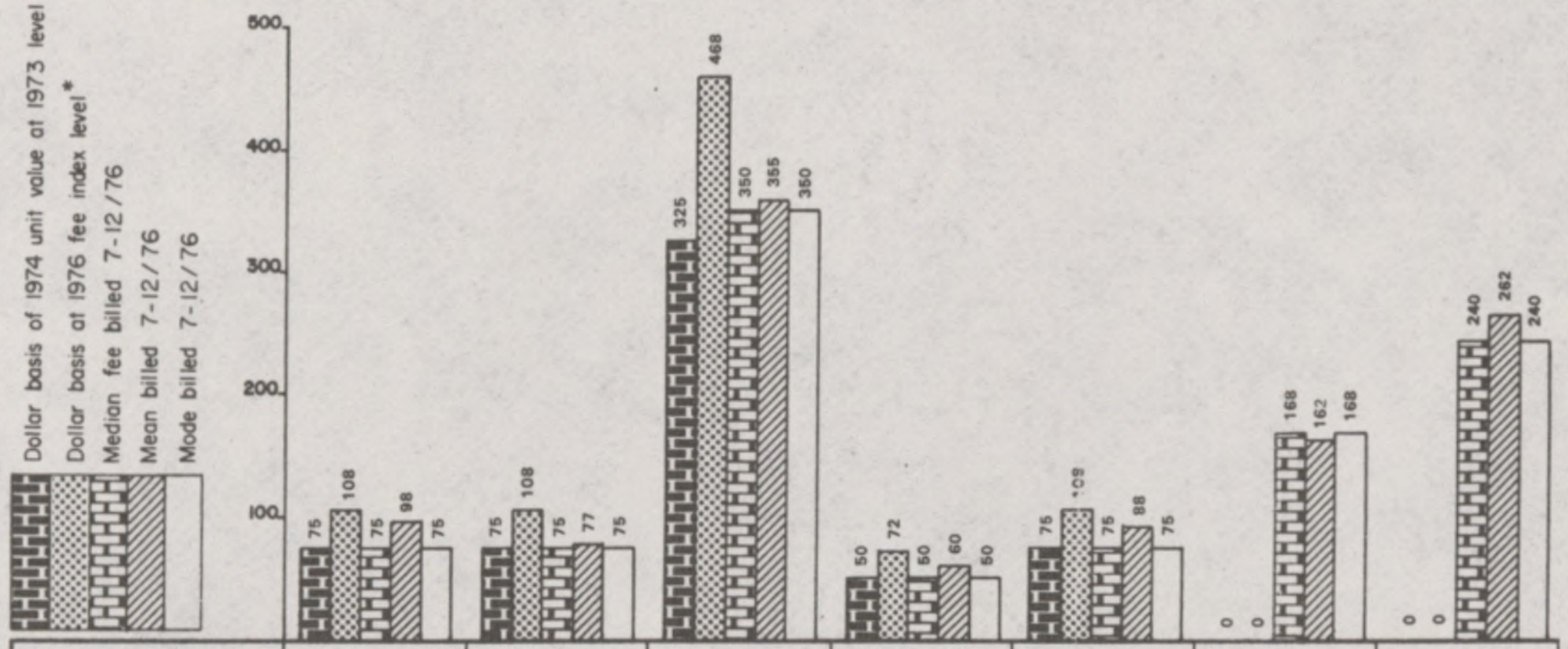
The accompanying chart compares the statistical characteristics of fees billed CPS by nephrologists to the dollar amounts on which CRVS unit values were based. For the comparison, we selected the seven most frequently billed procedures under the Medicare Program during the last six months of 1976. For five procedures, the chart shows the 1973 dollar basis, the comparable value at 1976 fee index level and the median, mean and mode of 1976 charges. We included two frequently billed procedures (#90991 and #90986) which were not assigned relative values. These procedures are listed in the 1974 CRVS as RNE (Relativity Not Established). Procedure #90991 is "Home hemodialysis care, outpatient, per month" and #90986 is "Monthly physician fee for patient dialysis in a facility".

Charges for Procedure #90991, home dialysis, ranged from $100 to $280 and the median charge for 425 services was $168. The CPS Medical Director explained that the median charge results from the application of the Social Security Administration formula for the monthly fee for home dialysis. SSA limits the fee to the lower of the physician's customary charge for a routine office visit multiplied by 14 or the average California prevailing charge by internists not to exceed $12 multiplied by 14. The Director writes,

> "As might be expected, the median was $168.00 which would be identical with the SSA formula of $12.00 x 14. Probably, the high dollar values, up to $280.00, represent billings submitted by nephrologists who know the fees will be reduced to $168.00, but who recognize that the charge data may be used at a future date in updating profiles. It is also possible some patients are affluent enough to pay the difference between the charge and the Medicare allowance. The low charges may represent billings for less than a month."

Similarly, the median charge for Procedure #90986 is equal to the SSA formula for the monthly dialysis of a patient in a facility, (20 x 12 = $240). The CPS Director gave the same explanation for this procedure as for home dialysis.

Dialysis (Procedures No. 90962—90999)
Comparison of 1974 CRVS to Fees subsequently billed CPS
7 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	90981	90963	90970	90974	90982	90991	90986
1974 CRVS unit value	30	30	130	20	30	RNE	RNE
No of procedures billed	20	21	35	49	180	425	4,368
Total dollars billed	1950	1625	12,440	2,930	15,880	68,880	1,143,942
Range	75-150	75-100	300-520	50-75	75-200	100-280	144-455
Standard Deviation	35.26	7.52	34.59	11.32	23.13	27.78	57.54
Coef. of Variation	.36	.098	.097	.19	.26	.17	.22

* Increase in Medical Fee index (3 years 1973-1976) 44%

EXAMPLE #2

SURGERY SECTION

CARDIAC SURGERY

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Modification of Descriptors and Procedure Numbers

The cardiac surgery section underwent major changes because the majority of the 1969 CRVS procedure codes were out of date and did not reflect the practice of medicine. The following schedule shows the changes in the number of descriptors from the 1969 to the 1974 CRVS:

	1969 CRVS	1974 CRVS
Total number of procedures	46	114
Total number of procedures designated BR (By Report)	2	5
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS	0
Total number of new 1974 procedure descriptors with relativities (unit values)		97
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to a previous CRVS		53

According to the chairman of the Cardiac Surgery Subcommittee, revision of the 1969 descriptors and addition of new descriptors was required because 1) there were many new developments in Cardiac Surgery and 2) some 1969 descriptors were not sufficiently explicit causing a variety of procedures to be lumped under one procedure code. The revision of the descriptors was performed primarily by the chairman of the subcommittee. He initiated and planned the changes based on his knowledge of Cardiac Surgery not only in California but nationwide. The other two members of the subcommittee reviewed the proposed list of descriptors and made some amendments, but they basically agreed with the chairman. The chairman points out that,

"... cardiac surgery ... has been a new and burgeoning field and expanding its horizon and its capabilities over the years ... And, these procedures (1974 CRVS) principally represent new developments which warrant operations ... that were not in existence basically at the time the 1969 RVS came out. So, to a large extent, those (additional procedures) simply are the results of new developments."

The chairman points out that the revision of the descriptors was primarily his work.

"... It wasn't even the other members of the committee. I just looked this over and felt that the 69 one was way out of date and nowhere near explicit enough. The 1969 CRVS had the pathway, the potential for abuses by charging for things that were not necessarily as difficult as the previous scale had allowed for ..."

* * * *

"... many times these ... procedures (1969 CRVS) were lumped under one heading ... We felt it was appropriate for these (procedures) to be broken down and clarified because of the variety. Some are much more complicated and difficult to do than others. I think, for example the atrial septal defect - There is one form of atrial septal defect that is simply a matter of stitching up a little hole about the size of a quarter. And, it's a very simple thing to do. It is less than the open heart procedure. Getting the patient on the heart-lung machine which requires some skill, of course, and basic knowledge of heart surgery. But, the actual job that was done inside the heart is relatively simple. Whereas, other types of atrial septal defects require fairly complex techniques, intricate plastic reconstructive procedure. Therefore, it is inappropriate for the person to charge as much for type one as type two, ... So, we broke this down into several categories, different categories. And I think we did that over a fairly wide variety" (of procedures).

The chairman further notes that he classified procedures under anatomical descriptions so that they were more meaningful and easier to locate in the RVS. The descriptors as established represented a national standard of practice. He submitted a list of the descriptors to the American Medical Association; however, the AMA did not incorporate all of the adaptations in its publication, the "Current Procedural Terminology".

Basis for 1974 CRVS Unit Values

Unit values were assigned to most Cardiac Surgery procedures, including new procedures. Unit values were developed based on 1) the committee members' knowledge and informal polling of reputable surgeons in the three communities they represented and 2) the relativity among the various procedures. To determine relativity, the subcommittee deliberated in terms of dollar values arbitrarily attributed to common procedures. The committee used these values as a tool; the values did not represent median charges. Since charges vary geographically, the committee did not attempt to collect charge data and determine median charge levels.

(NOTE: The lack of adequate charge data for the surgery section is also confirmed by the Chairman of the Thoracic Surgery Committee who stated that:

"I might say that I think the so-called "hard data" obtained from various insurance companies is almost completely unusable because of the small number of cases reported. For your information, there are at least 170 surgeons in California confining their practice to thoracic surgery. Obviously, therefore, the sparse number of individual cases reported by the various insurance companies is not valid and either the insurance companies have withheld reports or something, because with this number of people practicing thoracic surgery, there is something obviously wrong with the sparse amount of information from the "Blues" and other sources. I trust this information will be conveyed to the Chairman of the General Committee.")

The Cardiac Surgery' Subcommittee Chairman summarizes how relativities determined

"Basically we knew what reasonable charges were amongst reputable people in the three communities that we represented. We don't speak for the whole specialty, but we do speak for a fairly good sample ... A sample of people who are conscientious and tend to operate by a professional standard ... We realized ... people might charge differently, we attempted to use an arbitrary dollar value ... we will assume that operation X has a standard charge of $1,000 in San Francisco. Now, that may be $2,000 in Los Angeles or $600 in Sacramento. But ... we will assume that it is $1,000 somewhere, San Francisco or anywhere. Now, if operation X is charged (at) $1,000, then what would be the appropriate charge for operation Z, using experience, skill, effort, time, responsibility, all the things that go into making a relative value. So, that if operation X is $1,000, then operation Z is worth $1,200. We agreed on that. If it were somewhere

> where operation X was $2,000 then operation Z would be $2,400. But it is just ratios... we were not able to establish what the proper fees were, and we felt that was geographical matter. We merely attempted to correlate just as the RVS means, a relative value..."

The Subcommittee members informally polled a sample of colleagues in their respective communities to make certain that their recommendations to the RVS Committee did not represent the opinion of the Subcommittee only.

The Cardiac Surgery Subcommittee converted the 1969 unit values to 1973 dollar values changing the unit value for old procedures when necessary and assigning unit values to the new procedures. A list of procedure numbers, descriptors and unit values for established and new procedures was agreed upon by the subcommittee. Upon insistance of the RVS Committee that dollar values (which were to represent median fees in California) were to be submitted, the Subcommittee conceded to convert its unit values to dollar values by multiplying the units by a $30 conversion factor. The Subcommittee agreed that in its judgment the $30 represented the most common rate per 1969 RVS unit in California in 1973.

The RVS Committee used the dollar values resulting by applying the $30 conversion factor to 1969 unit values as the basis for determining 1974 unit values. The dollar value was divided by a common denominator of $60 to arrive at the 1974 unit value. The $60 conversion factor was used for the entire Surgery Section of the RVS. Using five sample procedures, the following table demonstrates the process used to arrive at 1974 unit values:

1	2	3	4	5	6	7	8
1969 Procedure Number	1969 Unit Values	Comparable '1974 Procedure Number	1969 Unit Value or Value as Determined by Subcommittee	Dollar Conversion Factor	Dollar Value	Dollar Conversion Factor	1974 CRVS Unit Value
33040	1.2	33010	1.2	x 30	= 35 [1]	÷ 60	= 0.6
33041	1.0	33011	1.0	x 30	= 30	÷ 60	= 0.5
@	@	33030	35.0	x 30	= 1050	÷ 60	= 17.5
33780	32.0	33502	25.0 [2]	x 30	= 750	÷ 60	= 12.5
33740	50.0	33692	55.0 [3]	x 30	= 1650	÷ 60	= 28.0 [4]

@ Procedure cannot be matched to previous CRVS

[1] Rounded to nearest $5.00

[2] Value decreased by Subcommittee; value in 1969 CRVS is 32.0

[3] Value increased by Subcommittee; value in 1969 CRVS is 50.0

[4] Rounded up by CRVS Committee

Comparison of 1974 CRVS Values To
Fees Subsequently Billed CPS

The accompanying chart compares the statistical characteristics of fees billed CPS by surgeons to the dollar amounts on which CRVS unit values were based. For the comparison, we selected the eight most frequently billed procedures under the Medicare Program during the period July-December 1976. For some procedures two procedure codes are shown, the 1969 and 1974 CRVS procedure codes. Medicare has not adopted all the procedure codes of the 1974 CRVS and also some physicians are still using the 1969 CRVS codes. The procedures selected, however, are homogeneous despite the two different code numbers.

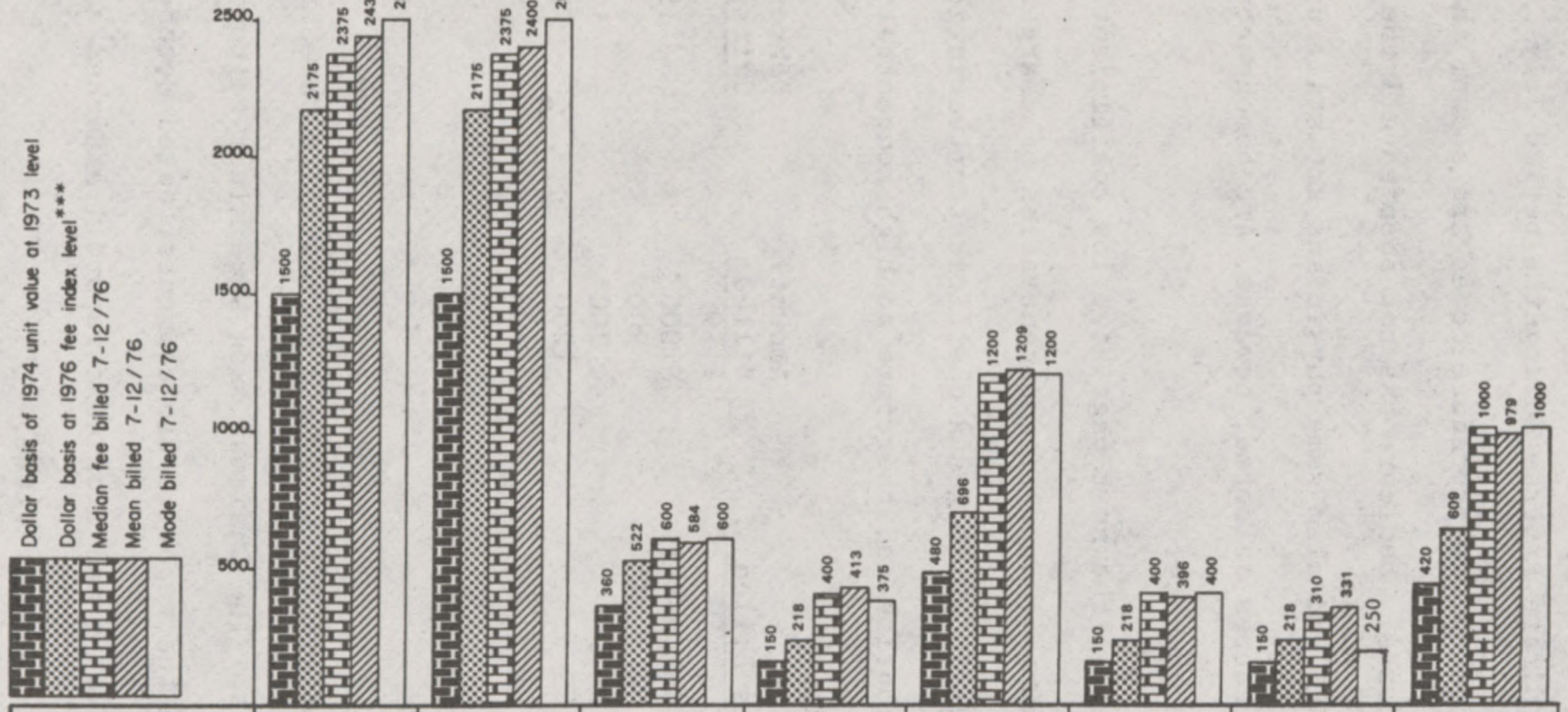
Six of the eight procedures on the next page have low coefficients of variation (below 0.20) suggesting an apparent concentration of charges. However, procedure No. 33205/33220 which has a coefficient of variation of .09 has a multimodal distribution and therefore no high concentration of amounts billed as shown below:

No. of Providers	Units Billed	Amount Billed	Percent of Units Billed
47	166 (Mode)	$1000	19
23	94	800	11
21	86	700	10
21	53	1200	6
16	51	1100	6

Subcommittee Chairman Comments
to Example #2

Pages 60 through 67 of this draft report were submitted to the Sub committee Chairman for comments. The Chairman made some minor editorial changes which are reflected in the report. His comments, dated October 26, 1977, are included as pages 67.a, b and c of this report. Attached as Appendix E is the Chairman's Curriculum Vitae.

Cardiac Surgery (Procedures No. 33010—33999)
Comparison of 1974 CRVS to Fees Subsequently billed CPS
8 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	33430* 33430**	33410* 33405**	33216* 33225**	33212* 33230**	33200* 33200**	33212* 33235**	33240* 33210**	33205* 33220**
1974 CRVS unit value	26	25	6	2.5	8	2.5	2.5	7
No. of procedures billed	67	79	92	127	132	271	736	859
Total dollars billed	163,077	189,584	53,761	52,450	159,571	107,283	243,961	840,799
Range	1820-4250	1820-3500	420-925	280-700	888-2000	280-675	245-600	700-1600
Standard Deviation	61.90	28.46	98.63	80.24	96.60	79.87	68.52	88.52
Coef. of Variation	.025	.012	.17	.19	.08	.20	.21	.09

* 1974 Procedure Code
** 1969 Procedure Code
*** Increase in Surgery Fee index (3 years 1973-1976) 45%

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE
DEPARTMENT OF SURGERY

SAN FRANCISCO, CALIFORNIA 94143

October 26, 1977

Mr. Felix Brunner
514 Avila Road
San Mateo, California 94402

Dear Mr. Brunner:

Thank you for sending me the draft on cardiac surgery and the other background material which I found to be interesting, though not entirely surprising. All of this material is being returned with this letter.

In response to your specific inquiries, I think certain observations are in order, obvious though they may seem.

In my opinion, the confusion and abuses which have arisen from the present system of fee payment were totally predictable. The entire concept of a "usual and customary fee" is unreasonable. As the obvious product of political compromise, it provided a short-term (and still continuing) boondoggle under the guise of avoiding the very governmental interference which it inevitably will bring about.

The doctor is impelled by the same economic forces that affect business. Given a competitive situation, he will not price above the market unless he has an exceptional product which the customer is willing to pay for. However, given the opportunity to charge what he pleases - particularly when it presents no hardship to his customer - he is either a fool or a saint if he does not push to the sky.

It seems ridiculous that the FTC is pursuing the non-competitive aspects of medical ethics (which are basically designed to protect the public from deception) while ignoring the economic facts which have virtually obliterated competitive pricing.

The whole concept of third party payment on the basis of "usual and customary charge" is unworkable and uneconomical; it may also be illegal to pay different prices for the same "product" particularly when identical insurance premiums provide the source.

Sound economics dictate that a competitive marketplace be restored to the system. Without taking into account the political practicalities, I can suggest two of the several pathways through which this objective could be achieved.

1. Through negotiation or bargaining with appropriate professional specialty groups for a global fee payment schedule. If this were derived realistically, there would be ample skilled professional services available to the public at no additional charge. Those physicians who think their services are worth more than the subsidy level, would have to work it out individually with the patient and thus would be in a true marketplace. It is even conceivable that hospital charges could be determined similarly to put them in the marketplace also.

2. Subsidize the public on an individual basis at an established (and published) fee scale, and leave it to them to explore the marketplace for low cost professional services. This system would encourage real competition.

Increasing the competitive aspects of medicine would perhaps increase the need for protecting the public against substandard care and require limitation of payment to certified specialists and hospitals.

You asked for an explanation of motives for variation in charges, but there are clearly so many factors that I find them impossible to analyze. In my opinion,fees are basically capricious when no incentive or limitation exists to control them. Some element of decency and conscience enters into professional behavior, and probably accounts for the fact that the situation is not even further out of hand. It is notable, however, that abuses have a strong tendency to be cumulative. The surgeon who has been quite satisfied with his charges is not likely to stand still when he learns that one of his less experienced and less skillful colleagues has arbitrarily established a higher "profile" and is being paid substantially more. The senior surgeon simply remodels his "profile" by charging similar or higher fees (without necessarily collecting any difference from the patient) and eventually he too gets third party payment at a higher scale. This ridiculous chain of events has no end in sight.

I hope these viewpoints will be of some help to you. I am glad to be of assistance, and I am pleased to report that the Council of The Society of Thoracic Surgeons has given its official sanction to the concept of negotiating for the specialty.

As I have indicated to you, I shall be out of the country until December 4.

Sincerely,

Benson B. Roe, M.D.
Professor

BBR:ew

EXAMPLE #3

SURGERY SECTION

CARDIOVASCULAR SURGERY

1974 Subcommittee Members

Fred Binkley, M.D., Chairman
3838 California Street
San Francisco, Calif. 94118
415/385-9020

Ralph Dilley, M.D.
301 La Canada
La Jolla, Calif. 92037
714/454-7667

Samuel Etheredge, M.D.
30 La Salle Court
Piedmont, Calif. 94611
415/655-5616

Max Gaspar, M.D.
1045 Atlantic Avenue
Long Beach, Calif. 90813
213/436-9645

Liaison Members of CRVS Parent Committee

T. Newlin Hastings, M.D.
1136 West Sixth Street
Los Angeles, Calif. 90017
213/482-8484

Glen S. Harman, M.D.
431 Monterey Avenue
Los Gatos, Calif. 95030
408/354-1424

Modification of Descriptors and Procedure Numbers

The cardiovascular surgery section underwent substantial changes because the 1969 CRVS did not adequately describe the various operative procedures. The subcommittee chairman stated that there were about 100 different operative procedures that needed to be more adequately described and that certain of the existing procedures needed to be subdivided. Another primary goal of the subcommittee was to better define operative procedures with a view towards reducing exaggerated billing by the physicians. With respect to change and expansion of the descriptors, the subcommittee chairman states that:

> "...Well, I would assume that I am primarily responsible for instigating this because of the fact that I had worked with Blue Shield for so many years I would be the recipient of any complaints that vascular surgeons had throughout the State of California. I knew what they were complaining about and had a good idea of what was needed, and I assume that that's how I got appointed by CMA as the subcommittee chairman on this..."

The subcommittee chairman, however, points out that he solicited input from his colleagues on the committee and other physicians specializing in the area of cardiovascular surgery.

The following schedule shows the changes in the number of descriptors from the 1969 to the 1974 CRVS:

	1969 CRVS	1974 CRVS
Total number of procedures	157	183
Total number of procedures designated BR (By Report)	13	44
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS	0

43-113 O - 79 - 9

	1969 CRVS	1974 CRVS
Total number of new 1974 procedure descriptors with relativities (unit values)		62
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to a previous CRVS		38

Basis for 1974 CRVS Unit Values

The chairman of the subcommittee states that good charge data was available for procedures listed in the 1969 CRVS, but that no charge data was available for the new procedures added in the 1974 CRVS. Consequently, the chairman points out that he had to rely on input of his subcommittee members and about 15 other prominent vascular surgeons in California in order to glean a greater mass of information which would reflect the opinions of surgeons in the various communities. Specifically, the chairman points out that:

> "...We were given masses of figures by CMA which I believe they obtained from California Blue Shield as to what kind of bills had been coming in for these various procedures. And we had that information and then we worked off of a basic relativity. We took the four operative procedures which were basic, that the value had been set and established and the billing records been going for ten years, like the carotid and the oartic aneurysm and the aortic bypass graft. ...Those were used as a base line unit values. Now then, we took all of the subdivision procedures under that which had never been identified before and took what information we had on how they had been billed, what information I knew, and then, what was the opinion of these other 15 people as to what it should be. So we had some degree of information. But they didn't have any billing numbers for some of these. You see, there is obviously ... Some of the relativity was established by, I would say, judgment rather than actual figures."

Tentative unit values were determined by the subcommittee based on their familiarity with their specialty and informal surveys of surgeons in their respective communities.[1/] Drafts of the proposed revisions were submitted for evaluation

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1/ In response to a specific question, the subcommittee chairman stated "We knew when we were preparing the CRVS that we were putting together a fee schedule. Of course we knew it. We didn't talk about it, but each of us knew it.

and additions by prominent surgeons around the State. The responses were subsequently considered at the Subcommittee meetings.

An evaluation of the Subcommittee's proposed revision was solicited from about 15 surgeons by a letter dated January 25, 1973. The surgeons were asked to review the proposed revision and submit their own suggested unit values. They were asked to evaluate the proposed values using 1969 relative values for general and thoracic surgical procedures. Eight other surgical procedures with unit values were included as a guideline. The subcommittee chairman wrote:

> "... I am serving as the Chairman of the Vascular Surgery Section for Newlin Hastings who is the Chairman of the Surgery Section for C. M. A. Both of us believe there is some lack of relativity between general surgery and some of the surgical specialties in the present book. Therefore, with regard to the Vascular Surgery Section, we were desirous of obtaining some opinions regarding the relative value of various vascular surgery procedures from prominent surgeons familiar with both vascular and general surgical procedures.
>
> "I am enclosing our suggested revision for this Section and adjacent to each procedure is a new suggested unit value from a small group of Northern California vascular surgeons. We would appreciate your noting beside the suggested values your opinion of the relative unit value for these procedures. Do not hesitate to disagree with any of these suggested values, but we would appreciate your values to be relative in your opinion to the values previously listed for general and thoracic surgical procedures ..."
>
> * * * * *
>
> "... I recognize that this is an imposition on your time, but I do truly need your assistance. I hope you may be able to find 15 to 30 minutes to the job and return the information to me promptly. With everyone's cooperation Newlin and I hope to be able to finish this job with our Committee Meeting in Yosemite in February ..."

Besides the proposed revision listing approximately 114 procedures, unit values and the previously quoted letter of transmittal, the chairman has no other information available. He recently discarded volumes of papers having no further use for them. Concerning the subcommittee's final recommendation to the CRVS Committee,

he states:

> "I submitted unit values for all the procedures including the new procedures to the CMA. The CMA RVS Committee then converted the unit values, to the best of my recollection, which were based on the 1969 values for the existing procedures plus unit values for the new procedures, to dollar values. This was done by the CMA by means of multiplying my values by a dollar conversion factor. I was subsequently provided with a worksheet by the CMA; this worksheet showed the fee values assigned by the RVS Committee or someone else at the CMA. ... We never dealt with dollar values. We recognized that the charge pattern between Northern California and Southern California differed substantially; because you see, an aneurysm in San Francisco was being performed for $1,000 maybe $1,200; an aneurysm in Beverly Hills was going for $2,500. So we realized that charges were running all over the place. We finally decided we did not care about dollar values. We simply assigned unit values and left it to the computer to decide what the conversion factor was in a given geographical area. So we didn't talk dollars - there was no way we could talk dollars."

The CMA has also been unable to provide documentation of the cardiovascular committee's final recommendation. According to the subcommittee chairman, the recommendation should be in unit values. In a memorandum dated September 8, 1977, the CMA representative explains:

> "...I have searched in every file possible to unearth input from Doctor Binkley which is said to have been in terms of unit values, apparently similar to what Doctor Roe submitted for other parts of the cardiovascular system section. My search has been fruitless and this memo will formally advise you that if such a document exists, I am unable to find it for you.
>
> "As I reported to you earlier, I do not recall such a document; nevertheless, among the very large number of papers that I dealt with during the preparation phase for the 1974 RVS it may well be that I have merely forgotten it. In any case, I'm afraid I can only report that this document is nowhere to be found at this point ..."

* * * * *

The 1974 CRVS unit values are the result of dividing a dollar value for each procedure by the constant $60.00 conversion factor. We are unable to ascertain the basis of the dollar values used by the CRVS Parent Committee.

Comparison of 1974 CRVS Value
to Fees Subsequently Billed CPS

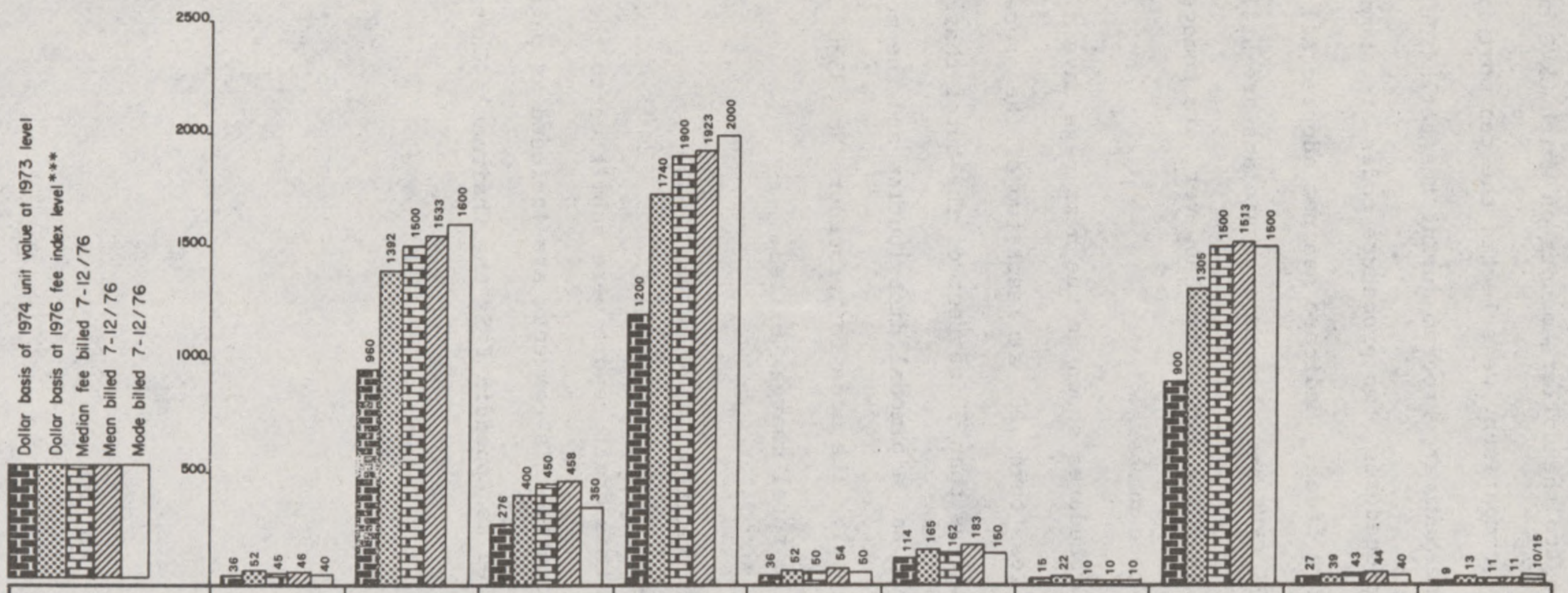
The accompanying chart compares the statistical characteristics of fees billed CPS by surgeons to the dollar amounts on which CRVS unit values are based. For the comparison, we selected the ten most frequently billed procedures under the Medicare Program during the period July-December 1976. For some procedures, two procedure codes are shown, the 1969 and 1974 CRVS procedure codes. Medicare has not adopted all the procedure codes in the 1974 CRVS and also some physicians are still using the 1969 CRVS codes. The selected procedures, however, are homogeneous, despite the two different code numbers.

While six of the ten procedures shown on the next page have a coefficient of variation of less than .20, at least two of the procedures have modes which represent less than 50 percent of the total charges billed. Procedure No. 35610 has a bimodal distribution and the mode is only 11.5 percent of the total. The mode for procedure No. 35300 represents 25 percent of the total charges billed.

Subcommittee Chairman Comments to
Example #3

Pages 68 through 74 of this draft report were submitted to the Subcommittee Chairman for comments. His comments are included as pages 74a - 74k of this report. Attached as Appendix F is the Chairman's Curriculum Vitae.

Cardiovascular Surgery (Procedures no. 34000—37999)
Comparison of 1974 CRVS to Fees Subsequently billed CPS
10 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	36485* 36485**	35610* 35610**	36810* 36810**	35070* 35070**	36620* 36620**	36200* 36200**	36601* 36600**	35300* 35300**	36480* 36480**	36410* 36410**
1974 CRVS unit value	.6	16	4.6	20	.6	1.9	.25	15	.45	.15
No. of procedures billed	221	225	235	239	277	291	470	783	879	885
Total dollars billed	10,236	344,867	107,645	459,579	14,837	53,190	4,885	1,184,44	38,314	9,958
Range	29-72	945-2270	347-800	1400-3500	35-90	140-340	7-18	1050-2250	29-70	7-18
Standard Deviation	8.38	78.00	83.54	32.00	13.16	46.31	2.36	3.64	8.56	3.09
Coef. of Variation	.18	.05	.18	.017	.24	.25	.236	.0024	.19	.28

* 1974 Procedure Code
** 1969 Procedure Code
*** Increase in surgery fee index (3 years 1973-1976) 45%

18 November 1977

Mr. Felix Brunner
U. S. General Accounting Office
1390 Market Street, Room 803
San Francisco, California 94102

Dear Mr. Brunner:

In reply to your request that I dictate to you some of my comments on medical care problems relative to my experience as having served as Surgical Advisor to Blue Shield of California for the past ten or twelve years, I think a great deal has been learned so that many intelligent recommendations could be made for the improvement and the delivery of medical care in the future. In making these changes, I do not believe that the politicians should turn to the medical politicians for the primary source of information but should turn to experienced leaders in the administrative field who have been active in this problem, such as men like Doctor Schaffarzick.

Input should be obtained from outstanding doctors in the various specialty groups, as well as professional organizations representing the specialties such as the American College of Surgeons with reference to general surgery input. The local politicians, representing such organizations as the County Medical Society and the State Medical Society, are medical politicians who are invariably not men of stature in their professional fields and are proving to be reactionary with as much tunnel vision as union labor leaders. We should attempt to develop a system with reasonable compromises which would be to the advantage of the people and totally acceptable to the medical profession. It would certainly take some political courage to make many of the changes which I might suggest but with proper presentation and public relations, I am sure that those changes or suggestions, which would in actuality be to the benefit of the populous, would be readily accepted.

I can remember one of the first meetings which I ever attended in this field of medical economics which was chaired by Doctor Dick Wilbur and held in Los Angeles. This was approximately twelve years ago before the institution of either the Medicare or Medi-Cal Programs. Doctor Wilbur explained to this group of doctors who were to work on this problem that our desire was to establish, in these Programs, the concept that the professional fee should be based on the usual and customary charge of the individual physician. He recognized that some doctors' usual and customary charges might be unreasonable and, therefore, explained that usual and customary was synonymous with reasonable and just. A usual and customary individual profile was to be the primary guide but there would be a geographical regional fee to prevent abuse from individual doctors.

I was the only person at this meeting who objected to this principle, stating that I could think of no better way for the medical profession to commit suicide. I stated that if I were a liberal politician attempting to introduce total government socialized medicine to this country, I could think of no better plan which would aid me in accomplishing this goal, for this type of program would inevitably lead to rampant abuse. I said that in my opinion this was essentially giving the medical profession a blank check which could only lead to continuous, unreasonable escalation of fees in the future. I made it clear that I wanted to express strong opposition to this form of idealism, and favored a basic fee schedule for all third parties. Noting that no physician was bound to be limited in his charges by this fee schedule, I suggested that the fee schedule should then undergo annual arbitration with an appropriate raise in fees based on expenses and inflation. Needless to say, I was condemned for my lack of confidence in the behavior of the medical profession. I believe that we have clearly seen in the past ten years that my anticipated expectations have proven to be realistic.

With the development of the Government Programs, the individual profile system was developed. The fact that an individual profile was being developed by the computers became common knowledge.

As might be anticipated, the older doctors continued to send in their usual and customary charges and developed what proved to be a very low profile. Younger doctors, and the more astute businessmen, promptly escalated their fees to a much higher level than was being paid, anticipating the fact that they would be the benefactor when the regional profile became elevated, which was inevitable. Within a short period of time, we had a system in which there was great discrepancy in the payment being made to individuals performing identical surgical procedures. Obviously when the doctor receiving the lower payment learned that another colleague in the same hospital was being paid 25% more than he for the identical procedure, he became infuriated and immediately raised his fees to the highest level which he had heard was paid to any physician in the community. Once again, we had automatic built-in inflation. This has continued to the present and, in my opinion, this elimination of the free enterprise system with competetive fees has been brought on entirely by the Government's mandatory computer-paid profile system rather than any relative value studies which suggested the unit value of any operative procedure.

I might add that I consider this individual profile system unjust, illogical, inequitable and I cannot see why it is not also illegal as the payments made to doctors in this area are based upon the computer information received in the Blue Shield of California Medicare and Medi-Cal Programs which in actuality may only be 25% of the doctor's practice. If this information is only 25% of his billing, it seems illogical to me that one can say that this is absolutely necessarily his usual and customary fee. These unequal payments have led to a great deal of emotional criticism and many complaints throughout my experience with Blue Shield. In actuality, the majority of my surgical colleagues would prefer to see a definite fee schedule for surgical procedures. This entire concept of usual and customary fees was an idealistic experiment but anyone with any intelligence can recognize that it has been a failure. This should be the first thing abandoned in any revision of the Medicare Program. I believe that the relative value study

should be revised to establish definite relativity among specialties and then a government fee schedule should be set. This fee schedule should obviously vary in geographical locations relative to the cost of living. It should then be adjusted annually on factual economic statistics. Doctors should be bound to accept the fee paid in these Government Programs unless they have clearly informed their patients that they do not accept this fee prior to rendering their services. If the fee schedule were reasonable and just, the vast majority of doctors would accept this and it would put a stop to uncontrolled continuous inflation.

You and I have discussed the CRVS in considerable detail and, as you know, I think that this was a masterful essential undertaking and, generally speaking, an excellent job was done in establishing relativity within the specific sections. If one is to consider any type of fee schedule, it is necessary to have some guidelines establishing the relativity between various procedures. I think those of us who have worked on writing this RVS have been sincere and conscientious in our efforts. I know the surgeons who were picked by Doctor Newlin Hastings for the committees on general surgery and cardiovascular surgery, as well as thoracic surgery, were surgeons of great stature in these fields in the State of California. They were all members of the Pacific Coast Surgical Association which is a select group of surgeons and they did some of their arbitration work at these particular surgical meetings. I was the Chairman of the Cardiovascular Section and Doctor Benson Roe was in charge of the Cardiac Section. Both Doctor Roe and I felt that the fees being paid some specialties were too high relative to the fees being paid in general surgery. We made our effort to downgrade the unit values in the sections relative to general surgery but were not as successful as we desired. We at least felt that we had established excellent relativity within our individual sections. The general surgery section was headed by Doctor Allan Johnson, who is an outstanding surgeon with a long record of unreasonably low surgical charges. I attended many of his committee meetings as a consultant and felt that an outstanding job was being done by this committee in attempting to rewrite the general surgery section. When we completed our revisions, Doctor Johnson, Doctor Roe and I agreed that the RVS was not of the value which it might truly be

unless a sincere effort was made to establish relativity between the sections. As you know, each section was written by a committee which contained only specialists in that particular field. In this way, there might be excellent relativity within the orthopedic section, or neurosurgery section, but there might be no relativity between the orthopedic section and the general surgery section. We, therefore, felt in order to have a true RVS that it was mandatory that a meeting be held among the representatives of each section so that we could argue out the lack of relativity between sections.

For example, a ridiculous surgical fee is being paid today for coronary bypass surgery, or for a hip transplant. Other unreasonably high fees are paid to urologists for a transurethral resection, to ophthalmologists for cataract surgery, or neurosurgeons for herniated disc surgery. The payment received for these procedures is not at all relative to the payments being received by general surgeons for their work in most of our opinions. Therefore, the various specialty surgeons should have to justify the unit value for their particular procedures relative to the unit values being given surgeons in other specialties.

Doctor Johnson and I wrote to the CMA and informed them that we were not going to turn over all of our information unless such a meeting was called to establish interspecialty relationships. They refused to have such a meeting and Doctor Johnson and I were eventually forced to cooperate. Therefore, it is my opinion that the relative value study (RVS) is a marvelous contribution in many ways but could be improved with further arbitration between specialties.

One of the major problems affecting overutilization of medical care and significantly increasing the cost of medical care is the maldistribution of physicians in the specialty distribution of physicians. This is clearly one segment in our private enterprise system where the supply and demand law is not in effect for the cost of medical care where there is a greater supply of specialists which are not truly needed and the cost of medical care is distinctly escalated. Some very definite controls are necessary to prevent the training of specialists which are not necessary. The perfect example of this is seen in the training of cardiovascular surgeons. Every medical school is desirous of having a surgical training program producing cardiovascular surgeons. This results in excessive numbers of cardiovascular surgeons in the larger communities many of whom are not

adequately busy and, therefore, escalate fees in this field to an unreasonable level in order to make an adequate living. Those who are only reasonably busy are capable of making an astounding income which is not reasonable in contrast to other physicians who have a far greater workload. Those who are not busy are encouraged to broaden the indications for surgery. It is of interest that when I initially instituted a ceiling for cardiac surgery procedures, which was approved by the California Blue Shield Policy, we did not hear of a single cardiac surgeon refusing to perform a cardiac procedure including all Medi-Cal cases because the fee was not adequate. However, this policy was overruled as it was against the law relative to usual and customary payments. Immediately after the ceiling was declared illegal, surgical fees in these operative procedures escalated by 200% to 300%. I believe that this criticism of maldistribution is apparent in many other specialties and may well be due to the fact that there is no control over the university medical schools regarding the size or distribution of their residency training programs. Each university department is desirous of improving its reputation and, therefore, attempts to increase the size of its training program. There is no encouragement for the training of physicians appropriate to the needs of society.

One of the major costs to the taxpayers in the State of California is the Medi-Cal Program. No plan could have been devised to offer medical care to the less affluent which could be more costly to the taxpayer. The concept that this segment of society should be cared for in the most expensive manner possible seems illogical. The bulk of these people are in urban communities where a well organized group practice of medical care, such as the Kaiser type organization, could render care to these people in a much more economical manner. The belief that these people are only interested in going to their own private doctors has been proven falacious and the fact is that these people are only desirous of quality medical care for their families.

In San Francisco, it may be accurate to say that the quality of medical care at San Francisco General Hospital is equal or superior to any other hospital in the city. Certainly their trauma center is vastly superior to any other institution in the bay area. It seems obvious that there would be a vast savings of taxpayers' money if the Medi-Cal patients in urban communities were hospitalized at designated medical centers. In San Francisco, such care could be rendered at the University of California Medical Center, the San Francisco General Hospital, and at other private hospitals on specific services if the volume was sufficient that this was necessary. In this manner, there would not be flagrant overutilization, the quality could be readily controlled as could the cost to the taxpayer. It seems to me that our primary desire should be to render quality medical care in the most economical manner. At the present time, in my opinion, a significant percentage of these patients are going to the poorest quality doctors of the community and the overall cost is ridiculous. The present system encourages overutilization in both the doctor's and the patient's standpoint. For, with the fixed fee schedule in this program, it is economically rewarding for the doctor to engage in overutilization and the patient is not going to complain about this apparent personal attention.

I recognize that this would be a political problem to change but with proper presentation and public relations, it could readily be accomplished and, if properly administered, would be accepted by all. The medical profession complained bitterly at the government intervention with the institution of these programs but undoubtedly would complain even more if the program were changed as it has been so economically rewarding to so many physicians. One hardly needs to do little more than view "Sixty Minutes" with Mike Wallace to recognize that this whole program is filled with racketeers.

When I discuss the escalating surgical fees with members of my profession, I have routinely been confronted with the fact that there are also escalating costs to physicians practicing medicine and the

doctor uniformly brings out the cost of malpractice insurance. It is a fact that in many instances, the cost of malpractice for some surgeons has increased from $10,000 to $40,000 per year. I am suggesting that some government controls be introduced affecting the medical profession but certainly the government cannot justify the control of a doctor's income if it is not willing to control the doctor's expense. The malpractice insurance problem is ridiculous and must be faced by legislatures even if practically all of them are attorneys. The most effective method of controlling the cost of malpractice at the present time has been in groups who have used arbitration contracts. This has been used in one of the large closed panel medical groups in Southern California most effectively and the cost of malpractice per physician in this group has been minimal. It has apparently not been unjust or detrimental to the patient for this group has grown in size through the years. I believe that it is essential that the government concern itself in this manner in a realistic and practical manner for the government can certainly not consider encouraging a fee schedule in the Medicare and Medi-Cal Programs which would limit the physicians' incomes if it is not willing to be equally firm in limiting the physicians' overhead.

In recent years, the Government has been interested in developing methods of quality control in the medical profession and the so-called Peer Review system has been put into practice. In the same manner that I criticized the philosophy of the usual and customary fee, I was outspoken in criticism of the Peer Review systems which were instituted. Peer Review at a local hospital level is doomed to failure, in my opinion, as, once again, it is unrealistic idealism. With the advent of the Medicare and Medi-Cal programs, it was the first time that any outsider had any real information about the activities going on in individual hospitals. In my first year as a surgical consultant with Blue Shield of California, I recognized that the Surgical Advisors were not only to be interested in the economic aspect of surgical claims but also take an active part in investigating and evaluating the quality

of surgical care. When we saw questionable claims, we would request copies of the operative notes, pathological reports and hospital records as necessary to clarify the claim. It was obvious that very significant efforts were necessary in the field of quality control. Initially, the committees at the County Medical Society level, on which Doctor Schaffarzick and I served, were sincere and conscientious in their efforts. As time has gone on, these review committees have become increasingly paranoid and bent over backwards to rubberstamp the behaviour of the physician in question.

Early in the game, I contacted many individual doctors who were in charge of services at a local hospital where questionable work was being performed, to discuss some questionable behaviour in some particular individual. It was obvious to all concerned that the doctor at the local hospital, who might be the chief of surgery, was not particularly desirous of being responsible for the discipline in his own hospital.

The reasons for this are obvious and understandable. Many years ago, I requested and obtained an Advisory Committee from the Northern California Chapter of the American College of Surgeons who agreed to serve in an advisory capacity for recommendations regarding surgical behaviour. This proved to be very effective when discussing a problem with an individual surgeon if it was pointed out to him that this was the recommended policy of the Advisory Committee of the American College of Surgeons. It was obvious to me that the review of any quality questions at a local hospital should be reviewed by a peer group from another hospital or another area. Peer Review groups within a small local hospital are entirely too personal, and it is understandable that they might avoid meting out necessary discipline to one with whom they are so closely associated. I can recall some eight or ten years ago, meeting with Doctor Rollo Hanlon, head of the American College of Surgeons, and pointing out to him the necessity of the American College of Surgeons becoming interested in this problem throughout the country. At that time, it was his opinion that the American College of Surgeons was primarily

an educational organization and should not become deeply involved in medical politics. Since then, I believe that he has significantly changed his opinion. It seems obvious to me that Peer Review is essential and that such Peer Review committees should consist of individuals of stature in their particular specialties. These committees should review the quality of work performed in all hospitals when any question arises in a manner in which there is no personal involvement with the doctor in question. There should be a very definite policy concerning the disciplinary powers of Peer Review committees so that hospitals permitting poor quality work to be performed in their institutions would be seriously disciplined.

With such rules and regulations, the quality of work would unquestionably be improved overnight. This is certainly a program which could be undertaken by the Government and would unquestionably promote immediate savings. In spite of the seemingly critical remarks, which I have just made, I should like to state that I believe there is no other profession in our society in which the majority of the members are more sincere and honest in their professional efforts. The vast majority of our profession would welcome strict laws which would permit us to police the offenders who are an absolute minority. At the present time, however, there are practically no laws which permit us to adequately police our own profession.

A perfect example is the surgeon in San Francisco, who was dismissed from the staff of numerous private hospitals because of the questionable quality of his work. This surgeon has dragged this through the courts repeatedly, and with the aid of our judicial system, it has been essentially impossible for our profession to carry out disciplinary measures and, in fact, he even obtained some economic settlement from the County Medical Society. I am bringing this up only to say that additional laws are mandatory to permit us to adequately police our profession.

In spite of my seemingly negative comments, I believe that the medical care in the United States is vastly superior to that which

exists in essentially all other countries in the world. One only needs to go to England, where I have been a visiting professor, to see the results of totally government-controlled medical care. We must develop a system within our private enterprise society which affords the benefits of our system to the vast majority, but yet there must be some government intervention to assure quality control at a reasonable economic level. There is little doubt in my mind that a superior system of medical care can be developed in this country if the advice of intelligent medical leaders is sought rather than medical politicians, and if the legislators will do what is truly for the good of the society rather than utilize medical care programs as a political football to attempt to obtain more votes.

Sincerely,

F. M. Binkley, M. D.

FMB:lg

EXAMPLE #4

SURGERY SECTION

GENERAL SURGERY

1974 Subcommittee Members

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Liaison Members of CRVS Parent Committee

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General Surgery is the broadest of the surgical specialties. The General Surgery Subcommittee was responsible for the revision of several surgery subsections. The Subcommittee considered procedures in the following specialty subsections:

Subsection	RVS Numbers
Integumentary System	13100 - 19499
Varicose Veins	37701 - 37999
Hemic and Lymphatic System	38100 - 38999
Digestive Tract	40100 - 43999
Proctology	44000 - 46999
Liver	47000 - 47399
Biliary Tract	47400 - 47999
Pancreas	48000 - 48999
Abdomen, Peritoneum	49000 - 49999
Endocrine System	60000 - 60699

General Surgery overlaps with other surgical specialties. Certain procedures within the above specialty areas are primarily performed by specialists in that specific area. These specialties were also considered separately by ad hoc or subsection subcommittees. For example, suggested unit values for Integumentary System procedures were also submitted by the Plastic Surgery Subcommittee. An ad hoc committee on gastroenterology under the Internal Medicine Subcommittee also made certain recommendations for digestive surgery. A subsection of digestive surgery was reviewed separately by an ad hoc committee on proctology. Although the General Surgery Subcommittee had final responsibility for the Proctology Subsection, the ad hoc committee, acting in an advisory capacity, made recommendations to the General Surgery Subcommittee. These recommendations are reflected in the final CRVS. We will review separately the revision of the Proctology Subsection (Code numbers 44000 - 46999) in the next example. For this example we reviewed in detail ninety-four (94) procedures,

(#43500 - 43999 and 47000 - 49440, inclusive) revised by the General Surgery Subcommittee.

odification of Descriptors and Procedure Numbers

The General Surgery Subcommittee reviewed the 1969 CRVS and recommended to the CRVS Committee the revision of some descriptors, addition of new procedure descriptors and the deletion of obsolete procedures. The following table summarizes the changes in a portion of the CRVS revised by the General Surgery Subcommittee (#43500 - 43999 and 47000 - 49440).

	1969 CRVS	1974 CRVS
Total number of procedures	82	94
Total number of procedures designated BR (By Report)	7	16
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS	9
Total number of new 1974 procedure descriptors with relativities (unit values)	--	6
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to a previous CRVS	--	6

The Subcommittee members individually and jointly reviewed the 1969 CRVS and made suggestions for changes. The Chairman describes the process:

"We all reviewed the sections and met together to come up with our consolidated thoughts about 'is the procedure obsolete or is it overvalued or is it undervalued'."

Concerning new procedures, the Chairman states:

"Most procedures were already established. In the case of new procedures, it

"was just a matter of recognizing what is now being done and developing a specific wording of the procedure and putting it in the book in the appropriate place."

Basis for 1974 CRVS Unit Values

The General Surgery Subcommittee reviewed the 1969 CRVS unit values and made changes only when they felt the relativity was not appropriate. Values for new procedures were determined based on their relativity to established 1969 procedures. The Subcommittee's deliberations and interim reports to the CRVS Committee were in terms of 1969 unit values. The Chairman says:

"... when we felt that values in the 1969 RVS book were appropriate, we ... retained the relativity from the 1969 study and put that same relativity ... in the 1974 study."

On relativities for new descriptors, he comments:

"We used the value from the 1969 RVS book to compare and come up with the appropriate unit value for a new procedure. We would try to interpolate a new procedure in the appropriate value area ... It was the opinion of our individual committee members and the subcommittee as a group that those were appropriate values ..."

The Chairman agrees that where the CRVS Committee accepted the Subcommittee's recommendations, the relative unit values are based on his and his Subcommittee's judgment.

* * * * *

The General Surgery Subcommittee's final recommendation to the CRVS Committee was a revised list of coded 1969 and new procedure descriptors, unit values and a dollar charge for each procedure. The dollar amount was primarily the product of multiplying the unit values agreed upon by the subcommittee by a common factor of $39.00. The $39.00 factor was the average median conversion factor for 1969 RVS unit values based on a survey of California general surgeons in late 1973

and early 1974.

The survey was performed by the General Surgery Subcommittee. A questionnaire listing 32 procedures which may be performed by general surgeons was mailed to approximately 1,400 general surgeons then listed in the California section of the American Board of Surgery. The purpose of the survey as stated on the questionnaire was to:

> "... help us evaluate the accuracy of computer information and will help establish a basic value in the case of the new procedures which have not previously appeared in the book. The average dollar values will be converted into units in the published book and the present plan is to go back to a unit value system which will apply to all specialties."

The surgeons were requested to provide the current fee charged and the number of times they performed each of the listed procedures in the previous two years. Responses were received from approximately 300 surgeons. As noted previously, many of the procedures included in the survey would also be performed by specialists other than general surgeons; consequently, the sample of responses received would be even smaller when related to the total number of doctors who perform the sampled procedures. Of the surgeons surveyed, approximately 21% responded (300 divided by 1,400). However, according to the American Medical Association Distribution of Physicians in the U. S., 1973, there were 2,177 general surgeons in office-based practice in California. Thus, the 300 survey responses represent only about 13% (300 divided by 2,177) of all the general surgeons in California.

A median fee and a median fee weighted by the number of times the procedure was performed was determined for each of the 32 procedures. These median fees were then converted to average median dollar values per 1969 CRVS unit. The mean conversion factor per 1969 unit was $38.37 and the weighted median conversion

factor was $39.66. The Chairman felt that the $38.37 factor was most reliable and proposed to use it in his presentation to the CRVS Committee. On Feburary 18, 1974, he wrote to his subcommittee members:

> "...when we are asked to present this material to the parent committee, I will plan to use the average median conversion factor of $38.37 multiplied by the unit value which we have previously established in our meetings."

In response to the above letter, one subcommittee member cautioned the Chairman that the survey dollar values:

> "...should be used with the greatest possible caution. The largest number of responding physicians (for a specific procedure - #44140) was 264; some of the figures are based on as few as 21 doctors... Insist on a conversion figure of at least 40 for work done by Board Certified Surgeons, 38 ... for non-certified surgeons."

The CRVS Committee subsequently directed the subcommittee to use a rounded-off $39.00 factor.

The dollar values for established and new procedures finally recommended by the subcommittee were primarily the product of the unit values as determined by the subcommittee multipled by the $39.00 conversion factor. The CRVS Committee accepted the General Surgery Subcommittee recommendation for about 78% of the procedures (54 procedures accepted as recommended by the subcommittee ÷ 69). The CRVS Committee subsequently converted the dollar values to the 1974 unit values by dividing with a constant $60.00 factor. The unit values were rounded off according to pre-established criteria. For example, procedure #43500 had a 1969 unit value of 12. The subcommittee retained this value and, multiplying it by $39.00, recommended a dollar value of $470.00. The CRVS Committee accepted $470.00 and, dividing it by $60.00, approved a unit value of

7.8 units for the 1974 CRVS. (12 times 39 = 468; rounded to 470 divided by 60 = 7.8).

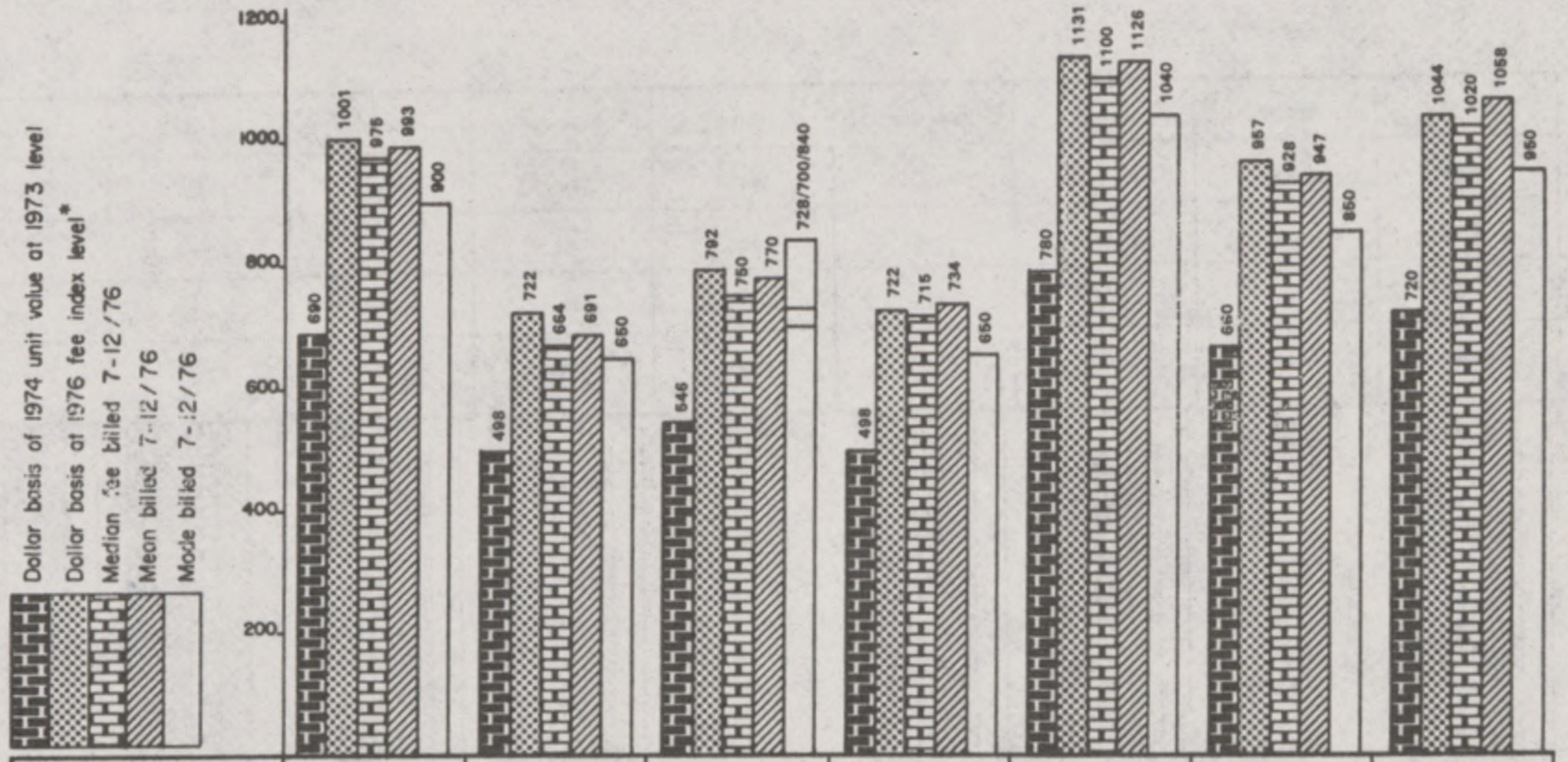
Comparison of 1974 CRVS Values to Fees Subsequently Billed CPS

The accompanying charts compare the statistical characteristics of fees billed CPS by surgeons to the dollar amounts on which CRVS unit values were based. For the comparison, we selected the 17 most frequently billed procedures[1/] in Medicare for the period July-December 1976.

While 15 of the 17 procedures shown on the following pages have coefficients of variation below 0.2, in several cases the modes represent less than 50 percent of the total charges. For example, the mode for procedure No. 47600 represents 13 percent of the total, and the mode for procedure No. 47605 represents 18 percent of the total.

1/ The procedures were selected from two sections of General Surgery.

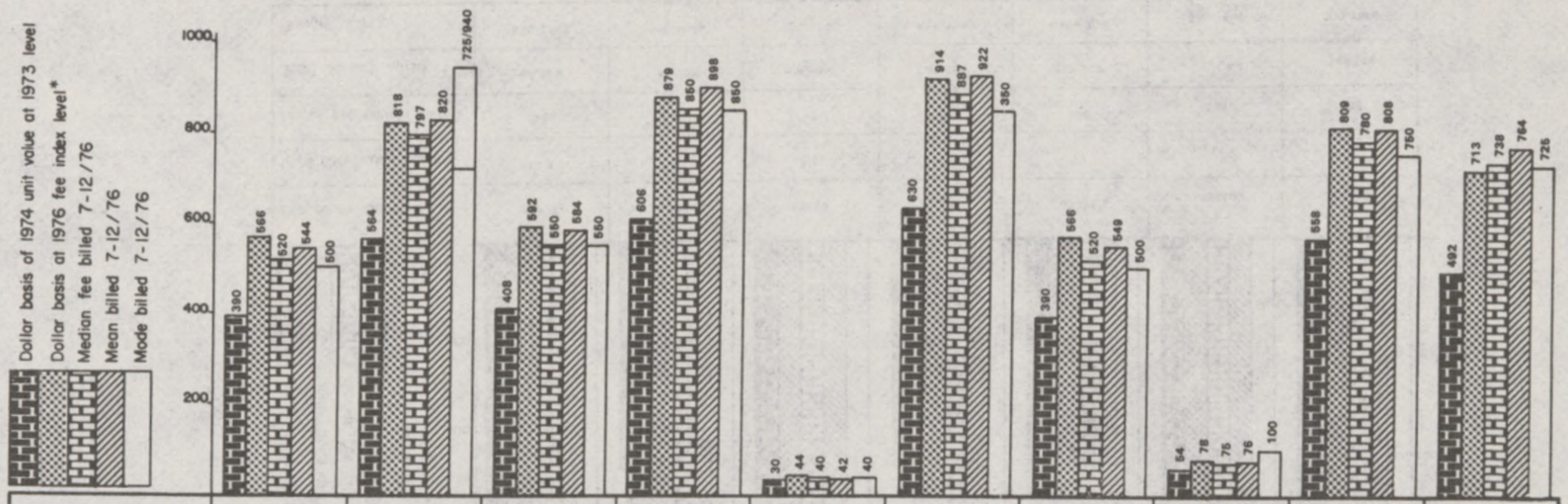
General Surgery (Procedures No. 43500—43999)
Comparison of 1974 CRVS to Fees subsequently billed CPS
7 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	43825	43830	43820	43840	43635	43640	43630
1974 CRVS unit value	11.5	8.3	9.1	8.3	13	11	12
No. of procedures billed	56	59	76	87	156	181	235
Total dollars billed	55,595	40,782	58,504	63,864	175,602	171,477	248,598
Range	630-1449	500-1040	531-1185	455-1150	840-1700	630-1500	700-1660
Standard Deviation	37.96	11.79	24.51	24.59	57.86	46.72	61.82
Coef. of Variation	.038	.017	.032	.034	.05	.049	.058

* Increase in surgery fee index (3 years 1973-1976) 45%

General Surgery (Procedures No. 47000—49440)
Comparison of 1974 CRVS to Fees subsequently billed CPS
10 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	47100	47720	49020	47420	49080	47610	49000	47000	47605	47600
1974 CRVS unit value	6.5	9.4	6.8	10.1	.5	10.5	6.5	.9	9.3	8.2
No. of procedures billed	54	54	58	93	306	409	476	569	684	931
Total dollars billed	29,383	44,288	33,852	83,483	12,945	377,089	261,165	43,518	552,455	711,506
Range	350-760	588-1275	400-816	680-1500	28-70	600-1500	350-850	49-125	550-1200	516-1230
Standard Deviation	80.44	37.36	1.28	27.67	9.44	44.07	99.73	16.34	11.27	21.04
Coef. of Variation	.148	.046	.002	.031	.225	.048	.18	.215	.014	.028

* Increase in surgery fee index (3 years 1973-1976) 45%

EXAMPLE #5

SURGERY SECTION

COLON AND RECTAL SURGERY

1974 Subcommittee Members (Proctology)

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Douglas F. Smiley, M.D.
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Los Angeles, 90017
213/482-8411

* * * *

The Proctology Subcommittee was an ad hoc committee of the General Surgery subcommittee. The Proctology Subcommittee members were directed by the CRVS Committee to review a tentative revision of a portion of the CRVS that dealt with their specialty. No chairman was designated initially, however, subsequent correspondence indicates that the review of this section was supervised by Doctor Birnbaum. By letter dated June 21, 1973, the CRVS Committee directs:

> Please focus your review on the coding and nomenclature only, since values are not being considered at this time. However, if there are suggestions about values, they will of course be considered by the committee when that subject comes up."

The members were supplied a telephone credit card number and directed to provide a joint revision or individual suggestions. Subsequently, the CRVS Committee arranged a telephone conference between the four Proctology members and the chairman of the General Surgery Subcommittee. The Proctology Subcommittee made its recommendations to the General Surgery Subcommittee Chairman in a telephone conference in July, 1973. The procedures reviewed by the Proctology Subcommittee (#44000-46999 inclusive) were discussed separately item by item in the telephone conference which lasted five or six hours.

Modification of Desriptors and Procedure Numbers

The following table summarizes the changes from the 1969 to the 1974 CRVS or the section considered by the Proctology Subcommittee:

	1969 CRVS	1974 CRVS
Total number of procedures	104	122
Total number of procedures designated BR (By Report)	12	25

	1969 CRVS	1974 CRVS
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS	13
Total number of new 1974 procedures descriptors with relativities (unit values)		11
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to the 1969 CRVS		10

The apparent chairman of the ad hoc Subcommittee states that the final recommendations to the parent committee were made by the General Surgery Subcommittee. He and the other Proctology Subcommittee members "suggested that changes be made in many (procedure descriptors)." The chairman points out that he does not know which and to what extent his committee's recommendations were accepted. The suggestions were not a unanimous committee recommendation, but the individual opinions of the committee members. He explains the discussion:

> "Member A might say, this should be called such and such or I would say, no, I think it should be called such and such. He might say it's worth X units and I would say, no, I think it's worth Y units. So this was an input to Doctor Johnson (Chairman of the General Surgery Subcommittee)...what happened...subsequent to that, I have no way of knowing...undoubtedly (our input) influenced the ultimate decision as to the finalizing the 1974 RVS."

The Proctology Chairman points out that the input was the "judgment of representatives of the specialty throughout the State."[1/] In making his suggestions, he used a booklet, "Relative Values for Colon and Rectal Services", published by the American Proctologic Society and the results of a survey which had been performed by the Proctologic Society of Northern California. The chairman acknowledges that he was only a participant in the establishing the 1974 descriptors. He does not remember

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1/ In answer to a specific question he said, "The CRVS is a form of fee schedule, even though those who originated it emphasize that it is not and that its very purpose is to avoid a monetary fee schedule."

keeping any notes, and he disposed of most of his material upon retirement. Neither he, nor the Proctologic Society of Northern California (now the Northern California Society of Colon and Rectal Surgeons) could provide any information on the survey. In response to a request for information, the Secretary-Treasurer of the Northern California Society for Colon and Rectal Surgeons wrote on September 2, 1977:

> "I have totally reviewed the minutes of our quarterly meetings from 1970 up to the present. I am able to find only one pertinent reference that might fit the matter under consideration by your Congressional investigatory committee on the California Relative Value Studies. I quote from the minutes of the March 1972 meeting of the then Proctologic Society of Northern California, - 'A discussion concerning the 1969 California RVS and especially the section on proctologic procedures was held. Doctor Kirchner will survey the membership regarding some basic charges and procedures that should be included in a revised procedural listing.'
>
> There is no further reference to such a review in subsequent meeting notices about the subject material for the meetings to be held, nor in minutes of subsequent meetings."

Basis for 1974 CRVS Unit Values

The Proctology Subcommittee was provided a tentative revision by the CRVS Committee. Among other information, this tentative revision included a procedure code, procedure descriptors and unit values for established 1969 and new descriptors. The unit values were in terms of 1969 CRVS units. The Proctology Subcommittee evaluated both the descriptors and unit values and made oral recommendations to the chairman of the General Surgery Subcommittee. Using the tentative revision or a worksheet, the Proctology Chairman compared the CRVS relativities established by the American Proctologic Society. The Chairman said that his subcommittee ..."did not assign dollar values. We may have assigned some unit values."

The final recommendation for this subsection was made by the General Surgery

Subcommittee. The recommendation included a dollar amount which generally was equal to the 1969 unit value or an adjusted unit value for old and new procedures multiplied by a constant $39.00 conversion factor. (See pages 78-80 for background on the development of the $39.00 factor). The CRVS Committee accepted the General Surgery Subcommittee recommendations for about 67% of the procedures in this subsection. (56 procedures accepted as recommended divided by 84 procedures with unit values) The CRVS Committee adjusted or added dollar values for the remainder procedures and subsequently converted all dollar values to 1974 unit values by dividing the dollar values with the constant $60.00 factor used for the entire Surgery Section.

The following procedures demonstrate the revision process in the Proctology Subsection:

1	2	3	4	5	6	7	8
1969 Procedure Number	1969 Unit Values	Comparable 1974 Procedure Number	1969 Unit Value as Adjusted by Subcommittee	Dollar Conversion Factor	Dollar Value	Dollar Conversion Factor	1974 CRVS Unit Value
44050	14.0	44050	14.0	$39.00	545	$60.00	9.1
44140	18.0	44140	22.0 [1]	$39.00	(858) 720 [2]	$60.00	12.0
44950	9.5	44950	9.5	$39.00	(370) 350 [2]	$60.00	5.8
45110	26.0	45110	30.0 [1]	$39.00	(1170) 921 [3]	$60.00	15.5
@	@	46045	2.4	$39.00	(94) 83 [3]	$60.00	1.4

@ Procedure new to the 1974 CRVS.

1 Unit value increased by the CRVS Committee.

2 Dollar value in parenthesis adjusted to equal median charge per General Surgery Subcommittee Survey.

3 Dollar values in parenthesis adjusted by CRVS Committee.

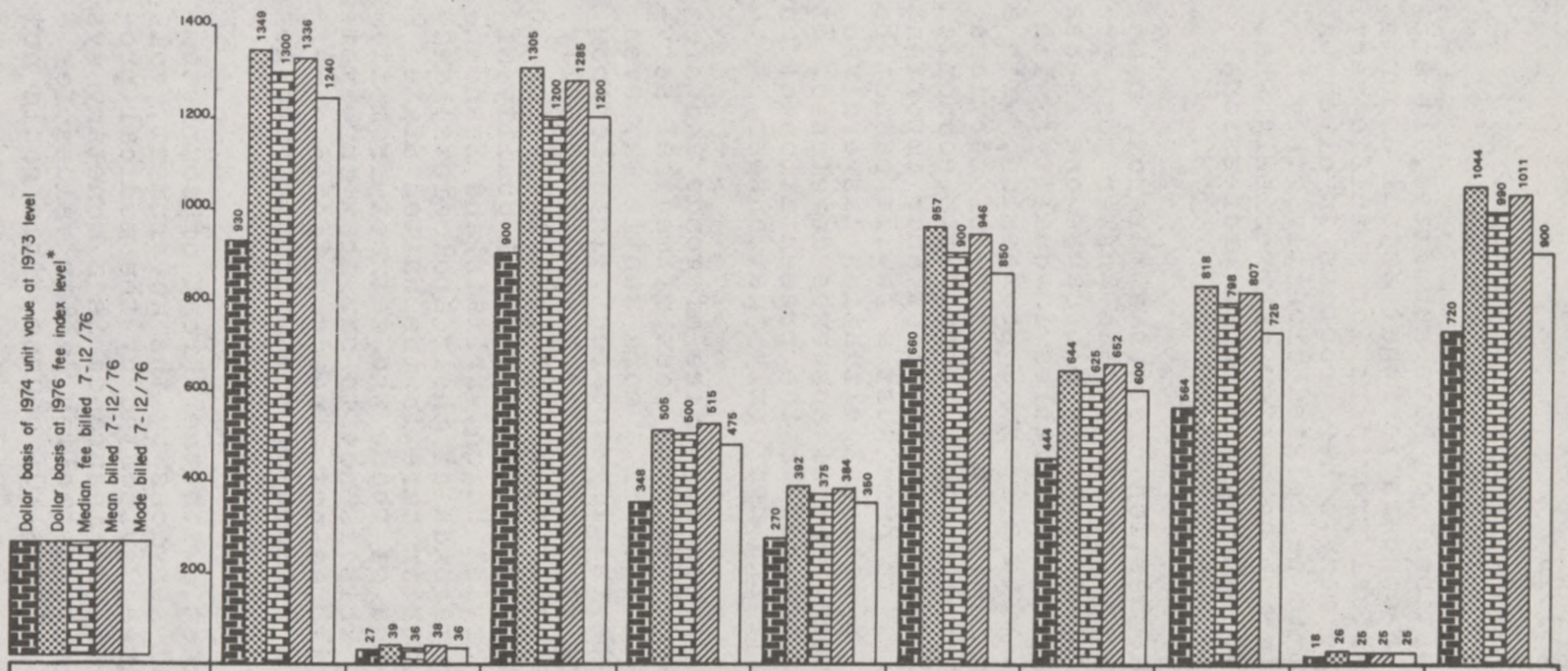
Comparison of 1974 CRVS Values To
Fees Subsequently Billed CPS

The accompanying chart compares the statistical characteristics of fees billed CPS by surgeons to the dollar amounts on which CRVS unit values are based. For the comparison, we selected the ten most frequently billed procedures under the Medicare Program during the period July-December, 1976. While nine of the ten procedures shown have a low coefficient of variation, several have modes which represent less than 50 percent of the total charges billed. For example, the mode for procedure No. 44140 represents 15 percent of the total, and the mode for procedure No. 44005 represents 9 percent of the total charges.

Subcommittee Chairman Comments to Example #5

Pages 84 through 90 of this draft were submitted to the Subcommittee Chairman for comments. His comments dated November 2, 1977 are included as pages 90.a through 90.g of this report. Attached as Appendix G is the Chairman's Curriculum Vitae.

General Surgery - Proctology (Procedures No. 44000—46999)
Comparison of 1974 CRVS to Fees subsequently billed CPS
10 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	45110	46320	44145	44950	46255	44120	44320	44005	46500	44140
1974 CRVS unit value	15.5	.45	15	5.8	4.5	11	7.4	9.4	.3	12
No. of procedures billed	105	126	202	243	249	275	282	342	592	1070
Total dollars billed	140,298	4,834	259,570	125,155	95,688	260,114	183,953	276,141	14,796	1,082,228
Range	950-2000	26-60	900-2100	360-850	245-630	600-1500	420-1000	525-1300	15-35	640-1600
Standard Deviation	90.44	7.53	3.89	87.40	63.12	59.10	2.60	26.14	5.23	54.53
Coef. of Variation	.068	.198	.003	.17	.16	.062	.004	.032	.209	.054

* Increase in surgery fee index (3 years 1973-1976) 45%

43-113 O - 79 - 11

TO: Mr. Felix Brunner

FROM: Dr. Walter Birnbaum

DATE: November 2, 1977

In answer to the questions you have submitted, it appears to me that your basic concern is "What actual amounts should be paid to medical providers for specific services?" Even though there are many other problems involved which at first do not seem to be related directly, they all have their origin in the matter of precisely what dollar amounts can be equated with what professional services.

The answer to such a question creates a paradox, namely, that there can be no answer and yet an answer must promptly be found. There can be no answer because one is dealing with intangibles, with variables in quality, with benefits to society, with a learned profession, with a multitude of providers, with a complexity of services that cannot be reduced to code numbers, with economic principles, with political implications and, importantly, with human nature, to name just a few.It cannot be denied, though, that a national situation has evolved which demands that some kind of answerbe developed. It must be developed,as opposed to the presentation of an easy, ideal, immediate and uniformly just answer.

Economic principles govern the price of goods and of services in the marketplace. The cost of medical services are similarly affected in a more subtle way even though this may not be readily apparent. Interference with these underlying economic laws has, historically, dislocated the social system, almost invariably for the worse. One need only consider the overall quality of medical care in the Soviet Union, Britain and Scandinavia (despite the propaganda of their apologists) and compare it to the superior care in the United States (despite the propaganda of those who detract from it) to prove the point. This is not to say that our system is perfect nor that it has not already suffered considerable dislocation because of the evolution of the third-party element.

In the not too far past, with the threat of complete usurpation of medical services by the government, voluntary health insurance, supported by the medical profession, burgeoned. Since insurance is a monetary system, it was necessary to establish dollar values for income and for expenditures. Of course, this could not

be done by fiat without introducing all the undesirable elements which even then had been exhibited in fixed-payment programs. The ingenious "Relative Value Studies" was born. Despite some shortcomings, the R.V.S. has worked well and, under no matter what system of insurance which may evolve, it seems to be here to stay. The astonishing amount of thought, man-years of work and the broad base of input of the C.R.V.S. is sometimes lost sight of. The Preface to the 1969 edition of the C.R.V.S. is worth re-reading.

However, the key word in the title, "Relative Value Studies", is "Relative". Dollar values are still not established and the enigma of the insurance carrier was not solved. To quote from the Preface..."Thus, unit values...are truly reflective of the relationship among fees as they are actually being charged by physicians in private practice." but still no dollar value is assigned.

The concept of Usual, Customary and Reasonable fees seemed a logical solution to the dilemma. This had to be modified in include a "profile" and then a "regional profile". Now those objectives have revealed their weaknesses.

Reference to your computer printout of the charges for surgical services for a six month period tells the story of what has happened to the U.C.R. scheme and to the profiles. There is a wide range of charges for each of the procedures which, when examined by the statistical method, shows a curve that is strongly biased toward the high end. As an example, Procedure No. 44005, Enterolysis (freeing of adhesions) with Acute Bowel Obstruction shows charges ranging from $525 to $1300. Every other procedure is similarly distorted. Actually, such a detailed study is quite worthless as far as using it in a meaningful, productive application. It merely substantiates what almost anyone who has been involved with the system -- and this includes all of the medical providers -- could have stated when the computer study was initiated and, indeed, what many could have prophesied at a much earlier time. What the printout shows is that the amount of dollar charges are (1) meaningless as far as their true worth is concerned and that (2) they are charged in an attempt to raise profiles.

Is this an indictment of the medical providers? Is such behavior an indication of extortion, of abandonment of the lofty oath of the profession, of "biologic blackmail", of collusion by Organized Medicine? It would seem so when quoted out of context. On the contrary,

what these figures reveal is (1) an indictment of the system, not of the providers, and, more importantly, (2) that the economic laws of the marketplace, however convoluted, are immutable. Are the physicians charging "all that the Market will bear"? Of course they are. However, is it fair to use such a pejorative expression? It is not. Alll goods and services are priced in this way in a free enterprise system. The charges for procedures noted above are fictitious as far as their real worth is concerned but are merely indirect manifestations of the play of the marketplace. Any new system, be it national health insurance, various schemes of governmental regulation, Health Maintenance Organizations or even complete socialization of Medicine will not alter these elemental pressures which will become evident, either financially or by deterioration of services.

Three other important considerations immediately come to mind: (1) What should be the extent of the regulatory function of government? (2) What quality of medical service does the U.S. public require? (3) What should be the social role and status of the physician? I shall not dilate on these questions although the answers have an intimate bearing upon the subject under consideration.

To get down to the specifics, in answer to some of your questions, one must assume (quite possibly incorrectly) that there is going to be either a continuation of the present method of health insurance or some modification of it and that, regardless of the outcome, a R.V.S. will have to be employed. If, of course, legislation results in a salaried system, a panel sysytem or some like system, your study and these remarks will be of little value.

A fixed, universal fee schedule would have all of the disadvantages of price-control already displayed in other areas of the economy. In a way, the R.V.S. concept is also a form of fee schedule, even though those who originated it emphasize that it is not and that its very purpose is to avoid a monetary fee-schedule. Unlike a fixed fee-schedule, though, the R.V.S. has a flexibility which cannot be denied in a system as complex as the delivery of health care to a vast and varied population. Geographically, for example, there are well-documented differences in the cost of doing business and in the cost of living. Overhead (only one item of which is the well known high cost of insurance) as well as the cost of the necessities of living are much greater in New York City than they are in a small farming community

in the Midwest. Of course, these features could easily be factored into payments based on the R.V.S. The U.C.R. concept was an attempt to do this but, as noted, was not completely successful for other reasons.

There arises, too, the question of whether the quality of service should be considered. Should a specialist who has had extensive graduate training with loss of income for many years during his training, who must belong to several specialty societies, who must frequently attend world-wide meetings and whose productive years have been shortened be allowed more for performing the same, coded procedure as his less well trained colleague? Unfortunately, the answer must be negative. To set standards of relative quality would be an impossible task. Further, the percentage of specialists is now high nor can the Family Physician be penalized for performing a vital service which, in itself, has become a "specialty".

One apparent solution would be to "freeze" profiles, individually and regionally, at a given time, present or at a date in the past and to alter them proportionate to a cost-of-living index. To fix a dollar amount to the unit value in the R.V.S. as the total payment for a procedure, however, would be identical with a fixed fee schedule and would produce the same disastrous result as when this was done for Medi-Cal. There must be an allowance for competition. This could be done by an "assignment" arrangement such as is in effect with Medicare. That is, a physician-provider could either elect to accept a payment-in-full paid by the insurer or to charge an additional amount to the patient-beneficiary. This appears to be working reasonably well with Medicare. On the other hand, such a method would be contrary to the Blue Shield system in which physician-members agree to accept insurance payment as payment in full. This, too, has worked well for many years for a variety of reasons. It must not be lost sight of that Blue Shield is operating in a competitive insurance market, that its premiums must be controlled and that, in turn, it must control its payout to physician-providers. The premiums for Medicare have been rising steadily and it is only because of the non-governmental role of Blue Shield as fiscal intermediary that it has any degree of efficiency.

As to the "reasonableness of fees charged", there are many factors involved. The "fees charged" have been discussed above and, as was pointed out, are fictitious under the profile system. It would be better, then, to speak of the "reasonableness of insurance payments made" here and not to include direct payments by the beneficiary. (1) The listing of a procedure by code and name does not begin to tell the story of what is involved in executing it. For example, let us enlarge on No. 44005,

Enterolysis (freeing of adhesions) with Acute Bowel Obstruction. The operation itself, from incision to closure of the abdomen, might take from one to three hours. During this time, the surgeon is "captain of the ship" of the entire surgical team with all of the responsibilities attached thereto. However, before the operation --- which is often at night or during a holiday --- the patient must first be met. A careful, complete history must be taken and a physical examination performed and interpreted. Laboratory studies and X-Ray examinations are made, inspected and interpreted. Often old records must be obtained and examined. The problem must be discussed with the referring physician, the patient and the family. Pre-operative measures must be instituted --- such as the administration of parenteral fluids, nasogastric suction, catheterization, etc. A list of orders must be written. The surgeon himself must then prepare for the operation. After the operation there are yet more orders to be written, more entries to be made in the chart and the operative procedure to be dictated in detail (later to be corrected and signed). After the operation itself there is further discussion with the family. Then there come daily visits, more decisions, more entries in the record. Bedside teaching is often done. At the time of discharge from the hospital, considerably more "paper work" is involved. The mandatory detail and completeness of hospital records is completely unappreciated by the uninitiated. The patient is then examined and treated for, in this example, an allowed 90 days. Correspondence and telephone communication is often involved and, inevitably, many forms to be completed. All this in an ideal situation where all has gone smoothly with no complication.

What is the monetary value of this work? How may it be compared with the pay of a highly skilled mechanic? What of "overtime" (see statistics for hours worked per day and per week)? Note, too, that payment represents "gross income", a large portion of which must be subtracted before "net income" is realized. Note that there are no hidden "fringe benefits".

(2) How does the skill of a well-trained surgeon compare with other skilled workers? There are few comparisons which can be made. Indeed, a "learned profession" is not so classified. It must be remembered, too, that to reach the pinnacle of a skilled surgeon there have been years of competitive selection amongst peers --- from early school days on --- so that he represents a position high on the social pyramid. This is not an elitist attitude but a statement of fact. I can speak here most authoritatively of the trained surgeon but this

applies as well to any other branch of medical prectice.

(3) How does one place a value on the relief of suffering, prolongation of life or rehabilitation of humans? Historically, throughout the ages, the value has been set high.

However, as noted, one does have to set a monetary value, procedure by procedure. One way of doing so might be to start at the end and, so to speak, work backward. One might attempt to judge, roughly, what the social position of a physician should be as measured financially, i.e., what his income should be. Many studies have been made (see, for instance, publications in "Medical Economics") which show that, while physicians are in a generally comfortable income bracket, the peak of the statistical curve by no means falls into what is considered to be a "wealthy" segment. From years of personal experience, I feel that the "average" physician is about where he should be in the financial spectrum. This, then, can be interpolated back to his fees or to his insurance payments which --- with exceptions, of course --- are probably now "reasonable". Again, as noted, they should be kept that way.

There is the possibility that our entire system of the delivery of health care is wrong. Perhaps others are better. The multi-layered system of medical care, such as in the Soviet Union, with minimally trained, first-aid type doctors at the lower levels on up to a relatively few, selected specialists at the top or the readily available "bare-foot doctors" of the People's Republic of China or the impersonal socialistic plan of Sweden may be superior. I do not believe so nor do I believe that the American public would tolerate such a change.

Whatever system may eventuate it is of the greatest importance that it be controlled by the private sector as opposed to government. There should be representative input by industry, labor and the public at large. The insurance industry and the medical profession must be designated as the executors of any plan for only in this way can optimal efficiency and expertise be attained. This conclusion can be substantiated beyond reasonable contention. The huge success of Blue Shield with its great number of subscribers was founded by and is governed by physicians. It is a shining example of a profession-industry coalition. It would be healthy to have governmental agencies, consumer and other special interest groups and the media snapping at the heels of the administrators of the health delivery plan

but these interests should never be allowed to occupy policy making or executive roles.

There are several other tangential matters which could be dilated upon such as weaknesses in the M.V.S., catastrophic health insurnace, abuse of the system by providers and beneficiaries, the rating of new providers, etc., which could expand this dissertation into a book.

It may be that any of the matters discussed will soon be moot and that universal, government-controlled medical care, with fixed fees or an 8-hour-shift, salaried-physician system (as in some Health Maintenance Organizations) will be foisted on the American people. What will be sad, however, is that the people may never be aware --- as has been the case in those countries where it has happened --- of its deteriorization.

Finally, I can say that, despite cynicism by some, the American physician sets the interest of his patient above all else. Exceptions are rare. I can attest to this after over 40 years in the profession. In the countless councils of which I have been a part, the good of the patient (or "the people", if you will) is always the paramount issue.

WALTER BIRNBAUM, M.D.

EXAMPLE #6

SURGERY SECTION

ORTHOPEDIC SURGERY

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The Orthopedic Surgery Subcommittee reviewed the entire Musculoskeletal System Section. The Subcommittee assigned responsibility for the various subsections to individual members; for example, the segment dealing with surgery on the hand was assigned to a member who specializes in hand surgery. The Plastic Surgery Subcommittee also contributed to the revision of this section.

There were approximately 890 procedures listed in the Musculoskeletal System Section of the 1969 CRVS. The 1974 CRVS includes approximately 1250 procedures. For this example, we reviewed the revision and changes in a portion of this section (Procedures #20000-24999 inclusive).

Modification of Descriptors and Procedure Numbers

The Orthopedic Surgery Subcommittee reviewed the 1969 CRVS and recommended changes in the descriptors. The following table summarizes the changes from the 1969 CRVS to the 1974 CRVS for a portion of the Musculoskeletal System Section.

	1969 CRVS	1974 CRVS
Total number of procedures	241	400
Total number of procedures designated BR (By Report)	36	115
Total number of procedures designated RNE (Relativity not established)	Term not used in 1969 CRVS	23
Total number of procedures designated SV (Sum of Services)	24	28

	1969 CRVS	1974 CRVS
Total number of new 1974 procedure descriptors with relativities (unit values)	--	87
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to a previous CRVS	--	61

The Orthopedic Surgery Subcommittee was instructed first to update the descriptors and, second, to update and assign relativity to the procedures. The revision of the descriptors was primarily the Subcommittee's product. The Chairman of the Subcommittee said their initial job "was to clean...up" the descriptors.

They added descriptors for new procedures not listed in the 1969 CRVS based on their knowledge of Orthopedic Surgery and by using the "Relative Values of Orthopaedic Services" of the American Academy of Orthopaedic Surgeons. The Chairman summarizes the revision of the descriptors:

> "...we would look in there (the American Academy of Orthopaedic Surgeons publication) and would try to decide what seemed to be the best wording...the Academy had many descriptors that were not in the CMA so we used some of those. In updating, we were trying to get rid of a lot of peoples' names attached to surgical procedures and define the operations. Many of the operations are listed by names of people; and we tried to get rid of those...The CMA wanted them (the descriptors) to come out a little more technical. Of course, they also wanted to update the book and bring in all the new operations."

Basis for 1974 CRVS Unit Values

The Orthopedic Surgery Subcommittee reviewed the relative value of the procedures listed in the 1969 CRVS and changed the value if it did not seem appropriate. The Subcommittee retained the 1969 value for a majority of the old procedures and assigned relative values to new procedures based on their relativity to established procedures. During its deliberations, the Subcommittee had available and considered 1) charge data provided by the CRVS Committee including charges billed Blue Shield and Blue Cross and 2) the American Academy of Orthopaedic Surgeons' "Relative Values of Orthopaedic Services."

In addition, the Subcommittee members informally polled Orthopedic Surgeons in their respective communities.

In response to the December 11, 1974, CMA request for evidence in support of charges submitted to the CRVS Committee, the Chairman of the Subcommittee wrote on December 19, 1974:

> "There were three basic guidelines used for the establishment of relativity in the orthopedic section other than the material presented by you to us from the insurance companies and particularly Blue Shield.
>
> "The members of the Orthopedic Subcommittee representing various parts of the State polled members of their own orthopedic community which included San Francisco, Palo Alto, Roseville, Fresno, Los Angeles and San Diego, to determine charges in those areas which were new or out of line.
>
> "The second source was the chairman's personal communication with the orthopedists in Palo Alto and, particularly in the section of casting and braces, a background of information from the local hospitals as to their charges.
>
> "The third source of information was from the Santa Clara Valley Orthopedic Club, comprising approximately 70 members from the suburban large cities the size of San Jose and Palo Alto, down to the smaller country areas, such as Gilroy. This was done by direct communication at Santa Clara Valley Orthopedic Club meetings and by presenting the orthopedists with a questionnaire such as submitted with this letter and with the answers coming in a fashion such as submitted in the accompanying letter by Doctor Josephson."

During the deliberations, there was disagreement between the Subcommittee and the CRVS Committee concerning the reliability of the charge data obtained from Blue Shield and other carriers. The Subcommittee did not feel that this data reflected fees charged by Orthopedic Surgeons nor what they thought the procedures were worth. The Chairman explained:

> "When we read what the relative value was on the basis of what we thought were meager statistics, they in no way reflected what really was being charged by orthopedists or what we thought the procedure was worth ... the orthopedists were unhappy with the RVS ... the RVS supposedly reflects what the charge is throughout the State, but historically some procedures have been done by general practitioners and general surgeons, (consequently the RVS) reflected ... a rate that was historically

low. Other procedures had classically never been done by general practitioners, (but) in university centers and big cities where the charges are relatively high... so we had (there was) the disparity,... we (the subcommittee) wanted to get a relativity applicable to the system... we were trying to establish a relativity today, and what we thought was relativity between operations and the complexity in the work... yet we were told (by the CRVS Committee) 'that is what you got to go by - by what is reflected in the past'. "

The chairman cannot remember if and how the historical charge data was finally used by the subcommittee, but he believes the subcommittee determined unit values based on their judgment as to the relative worth of procedures. He recalls,

> "I think... we used our own values (wanting) to go with what we felt was relative. We are going to do it our way. We are going to make one procedure relative to another procedure."

For the most part, the subcommittee deliberated in terms of unit values and used conversion factors and dollars as a tool to evaluate the unit values established. For many established procedures, the 1969 unit values were retained; some were changed. Values for new procedures were based on their relativity to similar established procedures. The American Academy of Orthopaedic Surgeons' "Relative Values" was used as a guideline.

The chairman said,

> "Most of the unit values were accepted. We made changes in some of them if we felt they were out of line. If we didn't think that the relativity - in our mind - was right, we would change (it). We would present our unit values to the CRVS Committee."

If the CRVS Committee disagreed, the values would be changed back to the original 1969 values or use RNE (Relativity not Established). For new procedures, the chairman said the subcommittee,

> "... found one that was similar to it and was worth about the same, in our committee's experience. If there was disagreement, and we really were not sure, then... each (member) tried to poll his community... We would sometimes just borrow from the 'Orthopaedic Relative Values' (of) the American Academy of Orthopaedic Surgery Guide."

In June 1974, the chairman responded to a letter criticizing the CRVS by pointing out that,

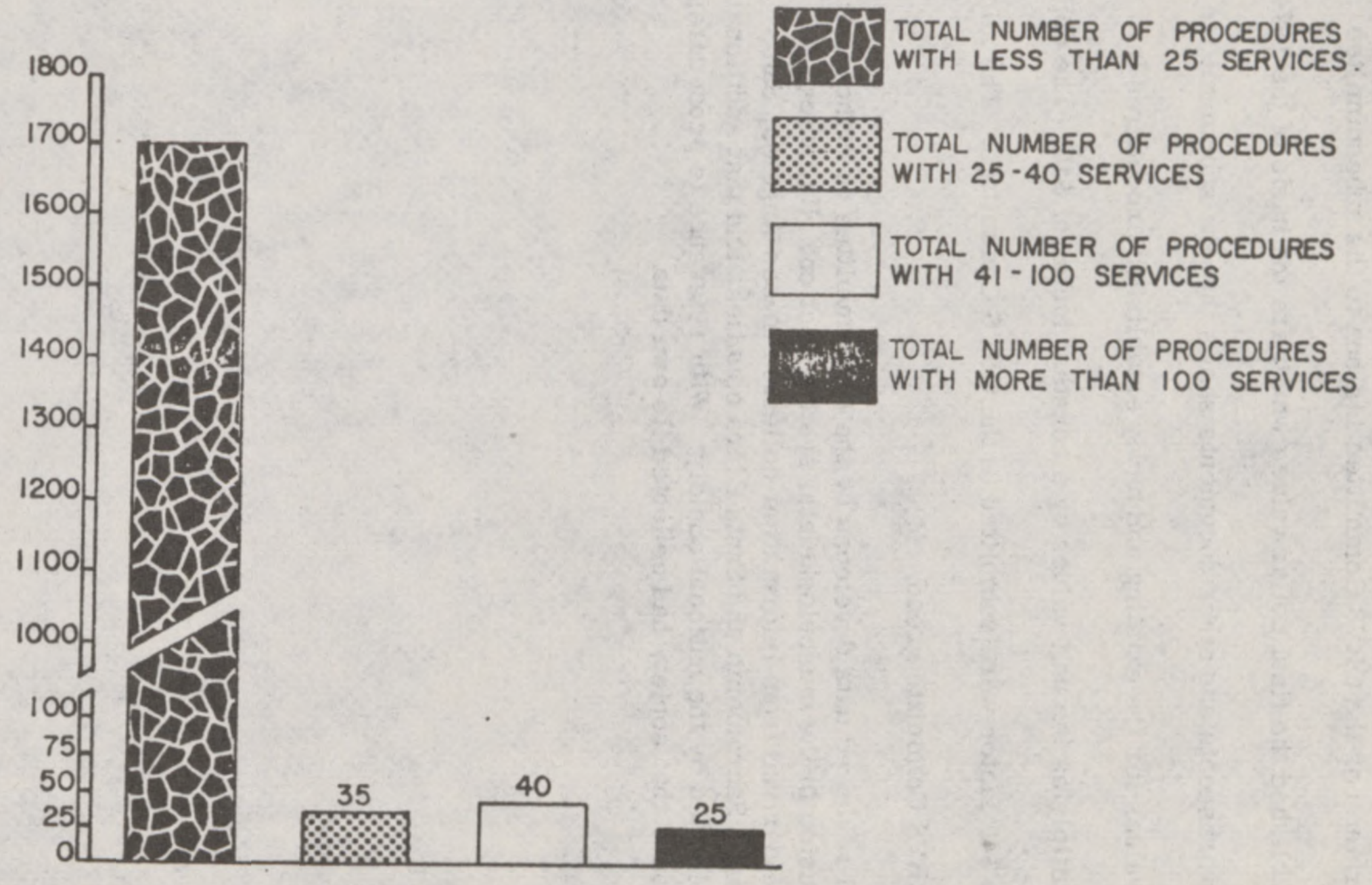
> "Our orthopedic committee attempted to transfer the American Academy of Orthopaedic Surgeons' Relative Value Study to the California Medical Association and this concept was rejected by the parent committee. We were naturally disappointed."

As noted previously, there was considerable disagreement between the Orthopaedic Surgery Subcommittee and the parent CRVS Committee. Early in 1974, the Chairman reported on the subcommittee's progress,

> "You will note changes in the pricing as compared to the 1969 R.V.S. and I might say a word about the Committee's philosophy in regard to the pricing. We were very disappointed about the amount of statistics to base the pricing upon. It was also unanimous feeling of the Committee not to accept the Blue Cross, Blue Shield or other statistics as presented to us as being entirely inadequate, and although reflecting a statewide input, not reflective of the orthopedic and/or surgeon community.
>
> Several members of the Committee were adamant concerning the change in relationship of procedure, pricing and felt that they would rather resign than parrot the printout statistics provided to the Committee."

As indicated on page 20, CPS' Standard Program charge data represented the most comprehensive information available, and that charge data for procedures with fewer than twenty-five (25) services could not be considered reliable or reflective of the practice of medicine in California. The following chart shows the frequency of orthopedic services reported by CPS and made available to the CMA/CRVS Committee:

FREQUENCY OF ORTHOPEDIC SERVICES
REPORTED BY CPS STANDARD PROGRAM
TO CMA FOR '69' CRVS UPDATE



Neither the chairman nor the CRVS Committee Liaison to the subcommittee remember who established the final dollar values which are the basis of the 1974 CRVS. Review of worksheets and other documents shows that the subcommittee converted the unit values for the existing and newly established procedures into dollar values by multiplying the unit values by a constant factor of $40. The dollar values based on the $40 factor were submitted to the CRVS Committee. The minutes of the June, 1974 CRVS Committee read,

> "Doctor Campbell reviewed data developed by the subcommittee on orthopaedic surgery for inclusion in the musculoskeletal system section. He indicated that figures were derived from information collected in Los Angeles, San Francisco, Fresno, Sacramento and Santa Clara counties, and that additional data had been collected by the national society. With reference to procedures relating to the hand, that society had collected its own data

and this would be discussed later by Doctor Ashworth. Doctor Campbell said that he would send a written report about the data collected. On the average, figures indicated that orthopedic surgeons are using a factor of $40.00 per unit; however, not all figures were accepted on this basis, since other specific data showed that this was not universally applicable."

The CRVS Committee accepted the subcommittee's recommendations for about 80% of the 234 procedures with values included in our analysis. The CRVS Committee subsequently converted the dollar values based on the $40 factor into 1974 CRVS units by using the constant divisor of $60 used for the entire surgery section.

The following examples demonstrate how the 1974 CRVS unit values were determined for the majority of procedures reviewed:

1	2	3	4	5	6	7	8
1969 Procedure Number	1969 Unit Values	Comparable 1974 Procedure Number	1969 Unit Value as Adjusted by Subcommittee	Dollar Conversion Factor	Dollar Value	Dollar Conversion Factor	1974 CRVS Unit Value
21390	14	21390	14	X 40 =	560	÷ 60 =	9.3
22315	7	22315	7	40	280	60	4.7
@	@	23039	12	40	480	60	8.0
23120	8.5	23120	7[1]	40	280	60	4.7
23680	14	23680	17[1]	40	680	60	11.5

@ Procedure new to the 1974 CRVS

1 Unit values changed by the Subcommittee

43-113 O - 79 - 12

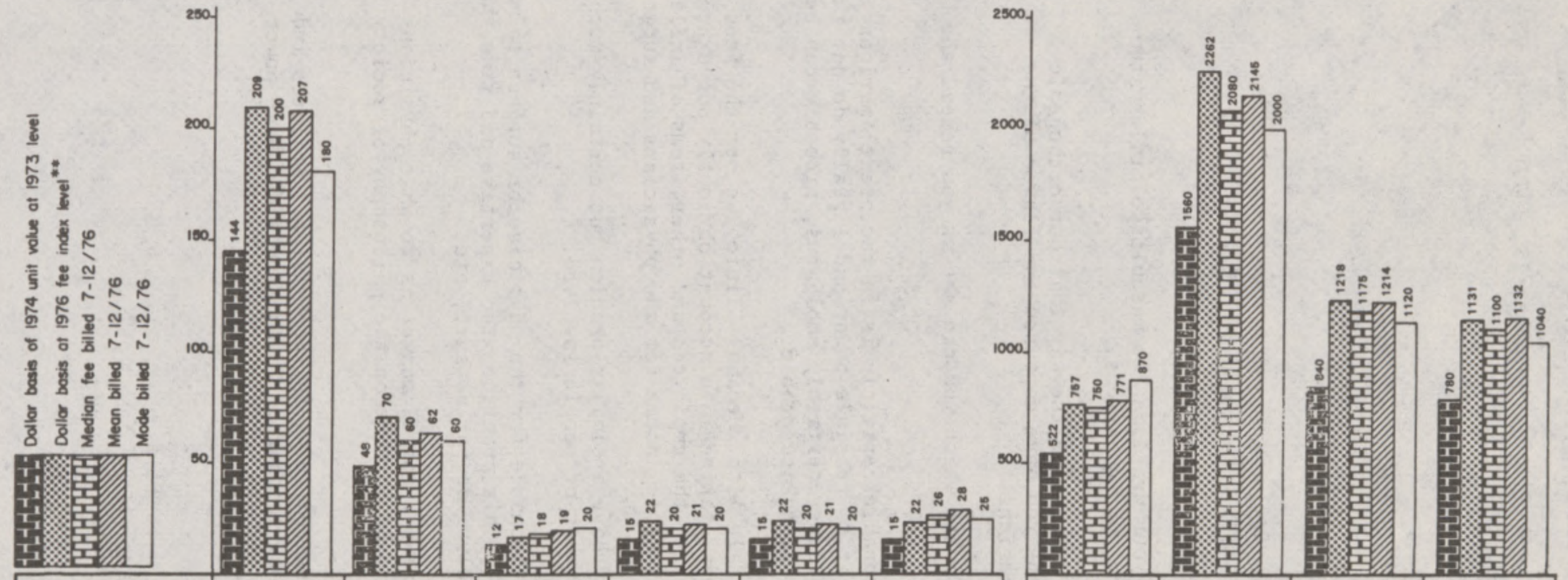
Comparison of 1974 CRVS Values to
Fees Subsequently Billed CPS

The accompanying chart compares the statistical characteristics of fees billed CPS by surgeons to the dollar amounts on which CRVS unit values are based. In addition to six most frequently billed procedures that fell within the series of procedures included in our review of the subcommittee deliberations, we included four other frequently performed procedures within the musculoskeletal surgery section. Six of the ten procedures on the following page have a coefficient of variation below 0.2. However, in several cases the mode represents less than 50 percent of the total charges billed. For example, the modes for procedures numbered 27244, 27236 and 27130 have modes representing 21%, 17% and 17%, respectively, of the total units billed.

Subcommittee Chairman Comments to
Example #6

Pages 91 through 99 of this draft report were submitted to the Subcommittee Chairman for comments. The Chairman's comments dated November 18, 1977 are included as pages 99a - 99g of this report. Attached as Appendix H is the Chairman's Curriculum Vitae.

Orthopedic Surgery (Procedures No. 20000—25215)
Comparison of 1974 CRVS to Fees subsequently billed CPS
6 (+4) most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	20680	20220	20600	20605	20550	20610	27590*	27130*	27236*	27244*
1974 CRVS unit value	2.4	.8	.2	.25	.25	.25	8.7	26	14	13
No. of procedures billed	256	355	950	3,570	6,845	12,656	277	844	1765	1781
Total dollars billed	52,966	21,987	17,806	76,559	145,215	359,737	213,483	1,810,017	2,142,460	2,015,744
Range	130-320	42-108	11-27	14-36	14-36	21-54	522-1232	1400-3600	780-1980	720-1800
Standard Deviation	35.41	9.65	4.14	4.98	4.49	5.74	18.87	61.19	47.75	45.62
Coef. of Variation	.171	.155	.218	.237	.214	.205	.024	.028	.039	.040

* Four additional procedures which were not included in the review of the Sub-committee deliberation were selected based on the high unit value and high frequency of performance

** Increase in surgery fee index (3 years 1973-1976) 45%

PALO ALTO MEDICAL CLINIC

300 HOMER AVENUE, PALO ALTO, CALIFORNIA 94301 • (415) 321-4121

November 18, 1977

Felix Brunner, CPA
United States General Accounting Office
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Dear Mr. Brunner:

Here are the comments concerning your draft on the musculoskeletal system and some of my comments concerning your questions.

I would certainly agree with the writeup on the way that our orthopedic subcommittee functioned and I think you have captured the flavor of the committee members and the deliberations.

I have made a couple of penciled areas which you can see as you reread the draft.

The concept of customary and reasonable certainly is in the great American tradition but I am not sure that it is feasible today and I really do not think it has much meaning. It is very vague, certainly ambiguous, probably can be used as a license to making any pricing acceptable.

Certainly in the context of the Palo Alto Medical Clinic, we set the fees on the basis of our projected needs, taking into account obviously our expenses, particularly salary negotiations with the employees and other items of inflation, trying to maintain a just and reasonable income for the physicians and surgeons.

A doctor in private practice would have a similar problem but certainly much simplified because of the fewer number of people involved.

It really boils down to what is reasonable for the physician or surgeon to make as a living because of the nature of his practice, the expertise and time that he has spent in study, the risks involved as far as suit, etc.

I am certainly in no position to give a gospel answer as to what physicians and surgeons make, and it would depend in part on the philosophy of society in general.

Our society seems to be more interested in paying professional athletes and entertainers than they are in school teachers. Those groups who have power

such as the unions seem to be able to raise their wages and overall compensation and doctor's clout seems to come from their virtual monopoly on the system.

I do think that 90% or more of physicians and surgeons try to offer a service, compassion, love and understanding. It is the minority who are out to take advantage of the system.

Unfortunately, I think that theywill be able to take advantage of the system more under government regulations as has been seen with Medi-Cal and Medicare fraud.

We wonder what are the alternatives to the usual, customary and reasonable concept.

Such organizations as American Academy of Orthopaedic Surgeons has bent over backward to keep high etical standards and to be conservative and reasonable in their approach to medical care costs. Other groups, such as the California Medical Association, our own Santa Clara County Medical Society also have worked long and hard to keep medical care costs down. These organizations are vital and exist only because of the innumerable hours of voluntary service provided by the physicians themselves working in grievance committees and all the other myriad of committees which are trying to keep medical quality high and to keep costs down.

As the employer has to foot the bill for medical costs, he needs to be more involved in making sure that he gets his dollar's worth. The bottom line remains the same and that is who establishes the fees.

I certainly think it would be wrong to have the government do so as I feel that government medicine has not been as successful as private sector medicine. I have been involved in military medicine, Veterans Administration Hospital medicine and, of course, have been in contact with Crippled Children's Service, Medi-Cal, and Medicare.

None of these have I seen the same quality of care or cost benefit ratio as I have seen with a well run private sector, prepaid type of program, or even a fee-for-service program.

Specifically, Veterans Administration Hospital cost per patient, per operative procedure is far above that which is charged in private medicine. Military medicine similarly has a veryhigh cost per treatment at least in my personal experiences. Existing Medi-Cal programs demonstrate such a high administrative cost and are not a model for the future of medical care.

Obviously, a well worked out pre-paid program can eliminate so much of the need for paper work and administrative personnel that they would seem to be most logical.

Of all existing models of pre-paid care, the Workman's Compensation seems to be the best although the amount of paper work required to and from the physician is unacceptable.

I would personally like to see a growth in pre-paid plans, not necessarily of the HMO type but done through the private sector and government without subsidy on the part of government, so that the best plans will have the best chance of success.

I would certainly retain U.C.R. for the present but with definitions and with a ticin to the local areas.

For example, cost of living in Stanislaus County or Alpine County is certainly not the same as costs as doing business in the Greater Bay Area. Therefore, the fee paid for a service in one community should not necessarily be the same as in another.

I think accountability by audit is essential in order to prove that U.C.R. is indeed reasonable.

Our subcommittee did try to establish relatively. I do not feel that the objective was accomplished as well as I would have liked.

You wonder what are the motives for variations in charges. The family practitioner in Alpine County will undoubtedly charge much less than an orthopedic surgeon doing the same service, for example an injection of a trigger point, and within the orthopedic community an orthopedist in Fresno will charge less for the same procedure than an orthopedist in Los Angeles.

The history of charges in the Fresno area have always been less than those in Los Angeles but the cost of living is much less in Fresno than in Los Angeles. The cost of doing of doing business in a university hospital setting is also much different than that in a private practice.

For example, a patient coming to the Palo Alto Medical Clinic for After-Hour Emergency service will get a muchsmaller bill than the same patient going to the Stanford Hospital Emergency Room after hours for the same service. Specifically, the patient going to the Stanford Emergency Room for an acute tendinitis will have an initial fee just to be seen of approximately $70.00. The cost of medicines and possible x-rays will be added on top of that.

The same patient coming to the Palo Alto Medical Clinic to our "After-Hours Office" will have a fee for the after-hour service of perhaps $15.00 plus the medicine, xrays and injection fee if needed.

The hospital fees are set on the basis of the cost of running the emergency room which is a great deal different than the cost in a private office.

I do not think that orthopedic surgeons that are starting inpractice charge any different than one who has been in practice for 20 years, given the fact that they are in the same community. There is a difference in different portions of the State of California and even a greater difference as one travels across the country. I have spoken with many of my colleagues and have been impressed by the different fees charged for the same service, depending on whether the orthopedist is in South Dakota, New York City, Miami Beach, Florida, or Austin, Texas.

I do feel that the concept of a foundation would be invaluable. The fees are definitely lower. We are members of the Santa Clara Foundation for Medical Care and the cost of that patient is less than the fees for our private patient.

This is no different than the cost for an individual to obtain insurance through a group, vs. the cost to have an individual policy.

There is no doubt that the influence of increased malpractice insurance has caused dramatic increase in fees in the last several years. This certainly has happened here in our clinic and our community. Our malpractice costs quadrupled in one year and this had to be reflected by a dramatic increase in fees.

I do not feel that physicians charge high in anticipation of profile updates although this may be a pattern exhibited by a few.

I am afraid I cannot give you much comment on how the California Relative Value system affects the usual customary and reasonable concepts. As you know, our R.V.S. relativity was based on what was charged prior to the time of the establishment of the unit value. These charges were made on the basis of concept of usual, customary and reasonable. As the C.R.V.S. has been continued, the concept of U.C.R. obviously continues. As the R.V.S. has been adopted by Workman's Compensation and Crippled Children's Service, the U.C.R. concept has vanished. The result has been a fixed maximum fee schedule instead of a fee reference or fee guide based on relativity.

Most physicians resent this change and certainly fear that as government comes into more control, fee guides will all be fixed fee schedules as has been dramatically shown in the Medicare program.

It would seem that a pre-paid plan offered in the marketplace would be the best way to control prices. This would certainly be true if one could guarantee the quality of the plan.

We compete now with some of our pre-paid plans against Kaiser and others, and I would feel that government would be wise to encourage the developments of this concept through the private sector.

Please let me know if there are any other areas that you would like me to cover.

Sincerely,

Kenneth G. Campbell, M.D.

/mz

EXAMPLE #7

SURGERY SECTION

Ophthalmology

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The Ophthalmology section which lists surgery procedures on the eye was revised substantially. The following table summarizes the changes between the 1969 and 1974 CRVS.

	1969 CRVS	1974 CRVS
Total number of procedures	115	251
Total number of procedures designated BR (By Report)	13	45
Total number of procedures designated RNE (Relativity Not Established)	Term not used in 1969 CRVS.	15
Total number of procedures designated SV (Sum of Services)		4
Total number of new 1974 procedure descriptors with relativities (unit values)		129
Total number of new 1974 procedure descriptors with assigned relativities (unit values) which cannot be matched to the previous CRVS.		78

Modification of Descriptors and Procedure Numbers

The chairman of the Ophthalmology subcommittee who had served on the CRVS Committee since 1962 requested that a colleague act as a consultant and assist the Subcommittee in the revision of the Ophthalmology subsection. The chairman and consultant had been fellow members of a committee of the American Academy of Ophthalmology and Otolaryngology (AAOO) whose purpose was to establish better descriptors and better terminology to be used primarily for describing ophthalmology procedures and retrieving statistical information.

The consultant, who was the primary contributor to the revision, had been involved with medical terminology particularly in ophthalmology since 1960. He participated

in the preparation of an English coding system for the International Council on Ophthalmology published in 1968 and subsequently served as the secretary and chairman of the World Health Organization International Committee on Information and Terminology.

The Ophthalmology Subcommittee recommended to the CRVS Committee a list of procedure descriptors similar to a list previously established for the AAOO. The basic objective of the terminology list "is to convey accurately and in an unambiguous way" the procedure performed. The consultant to the Subcommittee felt that in order to avoid ambiguity, the CRVS and the C.P.T. lists should be compatible.

The work on the procedure descriptors that were finally recommended to the Parent CRVS Committee first began in 1970 under the auspices of AAOO. The terminology was developed by the AAOO Committee and submitted to the Academy membership for comments. A very small percentage of the academy membership, possibly one percent, commented on the proposed procedures. The consultant summarizes the history and similarities of the various Ophthalmology terminology lists:

> "The way we went about it was that first we devised a list which we thought would be appropriate to the needs of the ophthalmic community. That list was published by the (American) Academy (of Ophthalmology) and circulated to all its members, inviting comments and asking the questions - 'Are there additional items that should be on there? Are there items which are ambiguous that you cannot properly use? etc.' With that feedback, we revised the list. Next we provided input to the third revision of CPT, (Current Procedural Terminology published by the American Medical Association). While doing that... (we) became involved in the California revision.... It was logical to tie the two together, and we provided the same input to California. So, basically the same information with few refinements went into the California revision.... Through that mechanism, ophthalmology

> and otolaryngology are the two specialties that have 99 percent compatible sections in both CPT and the CRVS."

The substantial increase in the number of procedure descriptors between the 1969 and 1974 CRVS was due to a difference in the basic purpose of the source information.

The consultant explained:

> "...the scope of the terminology pursued by the Academy was much broader than just relative values.... if there are various modifications of one procedure that are generally billed at the same level, it doesn't make sense to separate them out for a Relative Value Study. But once you have that data recorded and on the computer (or other data system), you also want to be able to utilize that information for quality of care studies and for clinical research.... And it was for such studies (scientific rather than economics) that we needed some further amplification and clarification of procedures. That is the main reason (for the)increased number (of procedures)."

Basis for 1974 Unit Values

The Subcommittee began deliberations to determine relative values for the procedures after the procedure descriptors were approved by the CRVS Committee. The Subcommittee used as a basis the 1969 CRVS values and the Subcommittee members' professional knowledge and judgment. The Subcommittee deliberated in both 1969 CRVS unit values and dollar values. They reviewed the procedures converting unit values to dollars and vice versa using a variety of factors. Charge data from insurance carriers that was presented by the parent committee was used as a guide. The Subcommittee was not given copies of the various statistical data, but the information was available at the CRVS Committee meetings and some Subcommittee meetings. After the unit values were determined, the consultant compared their proposed values to the Minnesota Relative Value Studies. Although there is considerable similarity between the Minnesota RVS and the CRVS, the Subcommittee

did not borrow from the Minnesota publication. The similarity is due to the fact that both documents are based on the American Academy terminology and that the practice of ophthalmology is uniform throughout the United States.

In its deliberations of unit values, the Subcommittee computed dollar amounts for each procedure by using three approximate conversion factors that they determined represented various charge levels in California -- $30, $35 and $40. The final worksheet used by the Subcommittee and submitted to the CRVS Committee in November 1973 identified these factors as:

Low - Estimated statewide average in 1971

Medium - Current metropolitan values

High - Current acceptable to California Blue Shield reviewers

The Subcommittee consultant explained that:

> "The low figure represents a conversion factor of $30 and is considered (by the Subcommittee) to be in reasonable accordance with the estimated statewide average in 71 (based on insurance charge data). The middle figure represents a conversion factor of $35 and is considered to be in reasonable accordance with current metropolitan values. The high value represents a conversion factor of $40 and is in reasonable accordance with values that are currently acceptable to CPS reviewers."

According to the Subcommittee representatives, the $40 factor was derived from dollar amounts obtained from CPS reviewers. Neither the chairman nor the consultant could remember how many or which CPS reviewers gave them the information. There was one document available with values written by a physician during a meeting with subcommittee members. This physician was and still is serving as a CPS reviewer. The reviewer explained, and the Subcommittee representatives agreed, that the information given by the reviewer represented his

professional opinions as a practicing ophthalmologist and not an official CPS position on acceptable fees. The reviewer writes:

> "To the best of my memory, this was an informal meeting. After dinner at the home of Doctor Salomon, our wives attended a movie and we three physicians then discussed a list of procedures in ophthalmology. My opinions were solicited and given, as reflecting those of a private practicing ophthalmologist. Wherever possible, I indicated what my own fees were for various procedures. If there were procedures which I seldom or never performed, I was unable to contribute fee data. In the case of new procedures, I suggested that they should be 'By Report' (BR). At no time did I indicate that my fees, unit values, or conversion factors were those of Blue Shield of California. My input was that of an individual, practicing ophthalmologist."

The CPS Medical Director pointed out that there is no basis for a category of charge data labeled "High-current acceptable to CPS reviewers":

> "To my knowledge, there is no basis for such a category of data. All Blue Shield of California medical advisors ("reviewers") are admonished to recommend payable allowances, expressed in unit values, based upon professional medical opinion, in cases where unit values have not been established or where profile data are insufficient. Because of the variables of program differences and geographical areas, recommendations in dollars are not feasible. Conversion factors are lower in the Medi-Cal program than in Standard and Medicare, and they are lower in Shasta County than in Beverly Hills. There is, therefore, no proper way to advise payment in dollars.
>
> "As you know, in the past, the Medical Policy Committee has attempted to establish dollar maxima for certain procedures, but such a prerogative is not available to individual medical advisors."

The Subcommittee did not select from the three conversion factors. The Subcommittee submitted to the CRVS Committee three dollar value amounts for each procedure.

As a final review step, the Subcommittee arranged the procedures in groups according to their unit and dollar values in order to determine that each procedure

was comparable in value to other procedures with the same unit value.

In addition to procedure descriptors codes and other information, the final worksheet submitted to the CRVS Committee included unit values for both old and new procedures and the three levels of dollar values.

The CRVS Committee generally accepted the Subcommittee's lowest recommended dollar value, but since this was at a level estimated for 1971, the Parent Committee increased the value by 12 percent, the increase in the fee index between 1971 and 1973. The Parent Committee determined that an average $30 conversion factor was appropriate in 1971 based on median charges available for approximately 20 procedures.

The dollar basis for about 75 percent of the 187 procedures - both old and new procedures with a unit value in the 1974 CRVS - is equal to the 1969 unit value or a unit value as determined by the Subcommittee multiplied by $30 plus 12 percent and divided by the $60 factor used for the entire Surgery Section. For example, the 1974 CRVS unit value for five sample procedures was determined as follows:

1969 CRVS Procedure Code	1974 CRVS Procedure Code	1969 CRVS or Assigned Unit Value	Conversion Factor $30+12%($30)		Dollar Basis of 1974 CRVS		Surgery Conversion Factor		1974 CRVS Unit Value
65160	65091	10 x $33.60		=	336	÷	$60	=	5.6
@	65290	4			134				2.2
67300	67331	14			470				7.9
14855 1/	67974 1/	18			605				10
68540	68540	15			504				8.4

@ Procedure cannot be matched to a 1969 CRVS code; Relative Value of 4 assigned by Subcommitee
1/ Procedure listed in Integumentary Section in 1969 CRVS

Comparison of 1974 CRVS Values to
Fees Subsequently Billed CPS

The accompanying chart compares the statistical characteristics of fees billed CPS by surgeons to the dollar amounts which were basis for the 1974 CRVS unit values. We selected the ten most frequently billed procedures under the Medicare Program during the period July-December 1976. Medicare does not recognize some 1974 procedure numbers. For those 1974 procedure numbers not recognized by Medicare, the chart shows the 1974 procedure numbers and the corresponding 1969 numbers which are recognized by the Medicare Program. For a number of procedures that were divided into two or more 1974 procedures, an average 1974 unit value and an average dollar basis for the 1974 CRVS units is shown. For example, procedure #66620, (Iridectomy, any type -- independent procedure) listed with a unit value of 10 in the 1969 CRVS was subdivided into three procedures in the 1974 CRVS. Each 1974 procedure has a value of 5.6 units. Procedure #67200 (Destruction -- photo-coagulation, for tumor, Eales disease, etc., initial) listed with a 1969 CRVS unit value of 10 was subdivided into five procedures in the 1974 CRVS as follows:

Procedure #	Unit Value
67212	7
67214	7
67216	7
67224	8
67226	8

Average unit value 7.4 (or 37 divided by 5 = 7.4)

Eight of the ten procedures shown on the following page have a coefficient of variation below 0.2. The mode for procedure No. 67140 represents 58 percent of the total. The mode for procedure No. 67200

represents 40 percent. For procedure No. 66900, the five most frequently billed amounts which are within a range of $250 of each other, represent 60 percent of the total billed amounts as follows:

No. of Providers	Units Billed	Amount Billed	Percent of Units Billed
156	1040	$ 900	17.5
190	992	1000	16.7
143	977	800	16.4
67	291	850	4.9
41	325	750	5.5

Note: Time constraints and the absence of the chairman (he is on vacation) did not permit us to obtain Subcommittee comments for this section.

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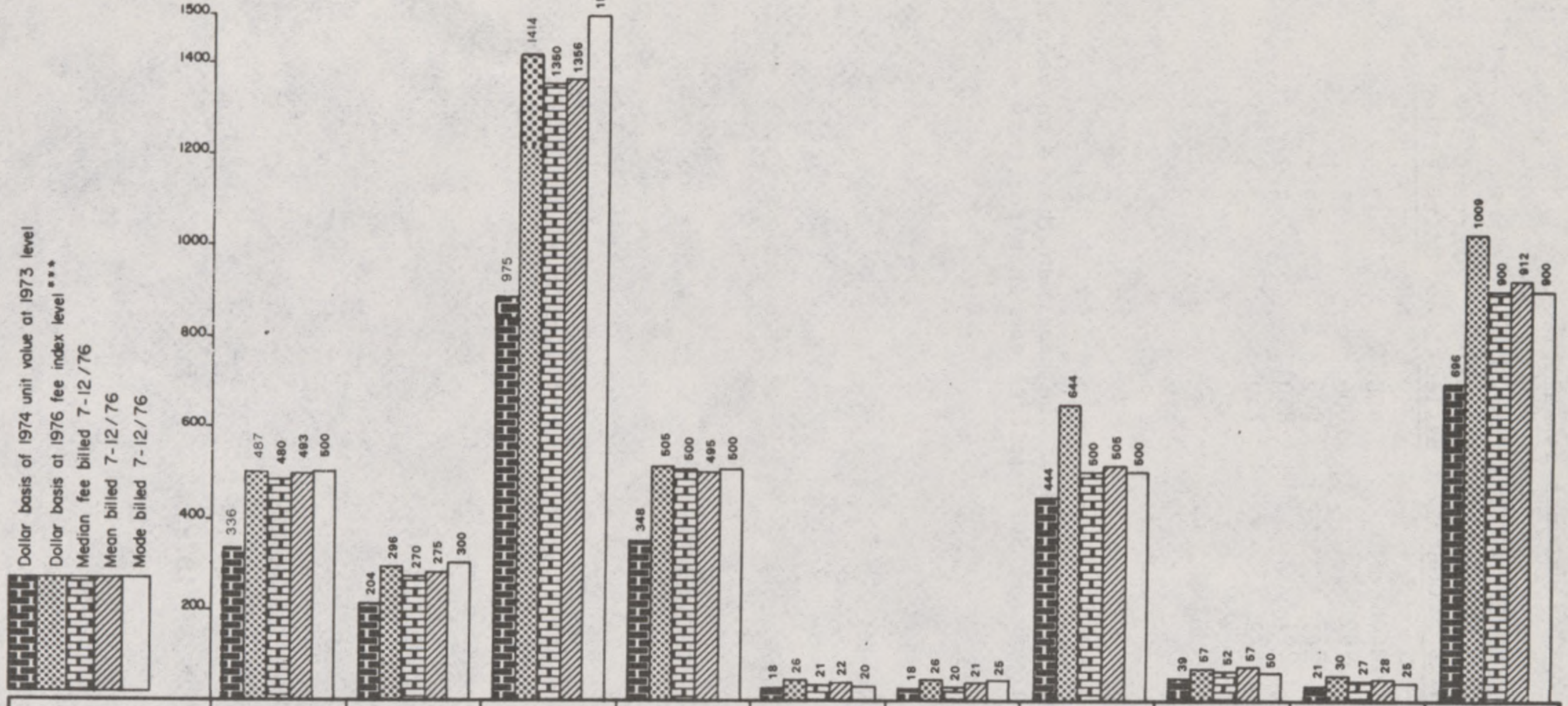
Ophthamology (Procedurees Nos. 65091—68899)
Comparison of 1974 CRVS to Fees Subsequently billed CPS
10 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	66625*/66635* 66630*/66620**	65420	67107*/67108* 67105**	67142*/67146* 67143*/ 67144*/67140**	68800	68840	67212*/67224* 67214*/67226* 67216*/67200**	67800	68820	66915*/66940* 66920*/66945* 66930*/66900**
1974 CRVS unit value	5.6 (avg)	3.4	16.25 (avg)	5.8 (avg)	.3	.3	7.4 (avg)	.65	.35	11.6 (avg)
No. of procedures billed	182	218	260	475	511	606	610	701	799	5,944
Total dollars billed	89,693	60,036	352,495	235,235	11,047	12,788	308,199	39,687	22,398	5,423,764
Range	350-900	210-413	1050-1800	350-800	14-36	14-30	350-800	42-100	21-50	700-1800
Standard Deviation	86.96	38.82	57.14	66.63	4.86	4.10	73.23	11.49	5.25	7.58
Coef. of Variation	.176	.14	.042	.135	.22	.195	.145	.201	.188	.008

* 1974 Procedure Code
** 1969 Procedure Code
*** Increase in surgery fee index (3 years 1973-1976) 45%

EXAMPLE #8

MEDICINE SECTION

Other than the subsection on Nephrology (see pages 55-58), we did not review the methodology used by numerous subcommittees in revising the procedure descriptors and the unit values in the Medicine Section. To review the activities and interview the chairmen of the committees who contributed to the revision of the Medicine Section would be a lengthy project. We do not feel that a detailed review of the revision of the remainder of the Medicine Section would contribute significantly to our review. Similar to the other examples, the final step in the process was the conversion of dollar amounts as accepted by the CRVS Committee to unit values. The approved dollar amounts for the entire Medicine Section were converted to unit values by dividing the dollar amounts by a constant divisor of $2.50.

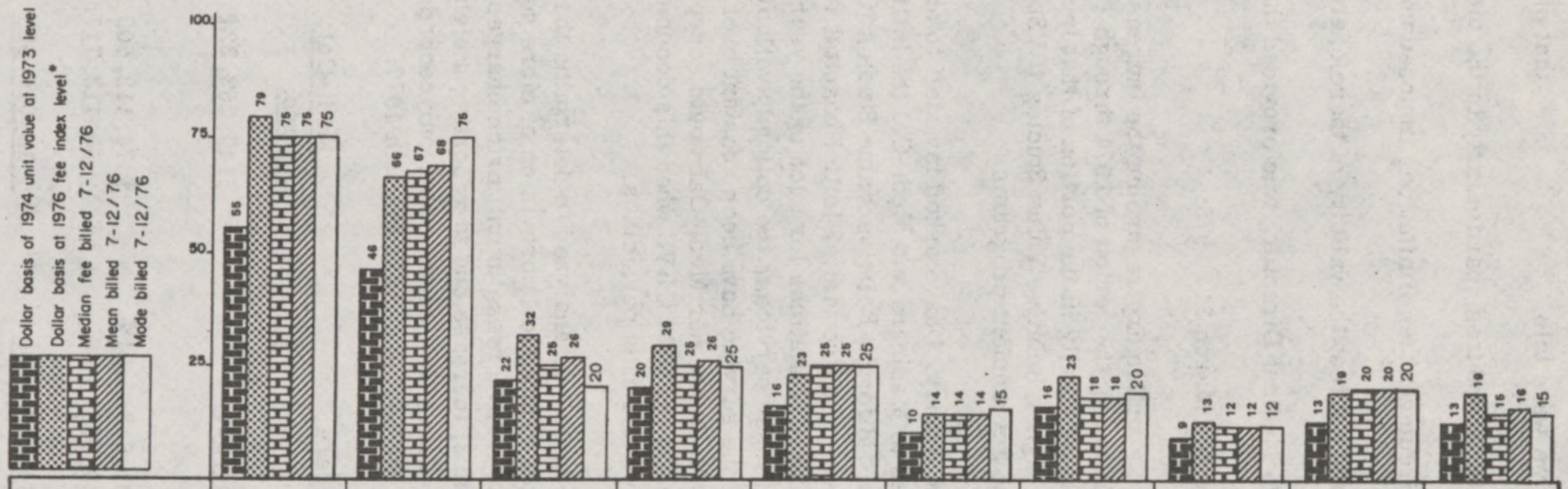
However, we examined the charges billed CPS for ten frequently billed medicine procedures under the Medicare Program. As in the other examples, the charge data considered was July through December 1976.

Comparison of 1974 CRVS Values to Fees Subsequently billed CPS

The accompanying chart compares the statistical characteristics of the ten selected procedures to the dollar amounts on which the 1974 CRVS unit values were based.

The chart shows the basis restated at the 1976 Fee Index level as well as the amount used at the 1973 level. Of the ten procedures shown on the following page, one has a coefficient of variation of less than .2. However, the mode for that procedure represents only 31 percent of the total units billed.

Medicine (Procedures No 90000—97799 Excluding Dialysis)
Comparison of 1974 CRVS to Fees subsequently billed to CPS
10 most frequently billed procedures in the Medicare program
July—December 1976



Procedure Code	90620	90220	90070	93000	90260	90240	90060	90040	90250	90050
1974 CRVS unit value	22	18.5	8.7	8	6.5	3.9	6.5	3.5	5.2	5.2
No. of procedures billed	51,142	65,717	89,737	145,476	203,610	242,146	518,791	622,580	781,005	995,637
Total dollars billed	3,861,355	4,475,381	2,354,149	3,733,262	5,089,081	3,406,587	9,398,334	7,726,073	15,604,076	15,527,127
Range	42-132	42-132	18-57	18-55	18-56	7-23	12-38	7-23	12-38	10-30
Standard Deviation	16.59	15.05	7.00	4.50	5.53	3.18	4.09	2.53	4.16	3.25
Coef. of Variation	.221	.221	.269	.173	.221	.227	.227	.211	.208	.203

* Increase in medicine fee index (3 years 1973-1976) 44%

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Do Physicians Graduate to Higher Unit Value Procedures

In Order to Circumvent Government Fee Limitations?

During the course of our work, we were told, that physicians tend to graduate to higher unit value procedures, particularly in the medicine section of the CRVS, in order to circumvent fee limitations imposed under some government programs. We did not test the validity of these charges. Instead, we referred the question to the CPS Medical Director, who provided the following statement and analysis in a letter dated March 31, 1978:

> "This letter is in response to your inquiry regarding the increase in charges for physician visits during the period of 1974 through 1977. I understand your interest is primarily in the portion of that increase related to physicians using higher Relative Value Studies (RVS) numbers to report services under the government programs.
>
> To assist in answering your inquiry, I have asked my staff to abstract from our records of charges to Medicare and Medi-Cal the billings for procedures identified in the California Relative Value Studies (CRVS) as initial office visits, follow-up office visits, initial hospital visits, follow-up hospital visits, and consultations for each of the years under consideration. For each of these services, the options available for reporting the complexity of the service have been constant over the four-year period. Neither Medicare nor Medi-Cal would accept the additional descriptors listed in the 1974 CRVS when this document became available for use by California physicians.
>
> Each series of CRVS procedures was analyzed to determine the amount of yearly increase in charges related to 1) provision of more services (i.e. increase in total visits), 2) increase in unit price charges for each procedure number, and 3) increase due to reporting a higher valued procedure number. Using 1974 as the base, our records reflect the following increases for the period of 1974 through 1977:

	Medicare		Medi-Cal	
	Dollars	%	Dollars	%
1974 Charges	$107,462,526		$140,263,224	
Increase Due to:				
Additional Services	$ 22,601,618	21%	$ 74,112,500	53%
Price Increase	49,530,658	46	80,113,717	57
Use of Higher Valued Procedure Numbers	8,314,466	8	16,010,685	11
	$ 80,446,742	75%	$170,236,902	121%
1977 Charges	$187,909,268		$310,500,126	

Attached as individual exhibits are graphs reflecting the total charge increase for each of the series of visits for Medicare **and Medi-Cal.**

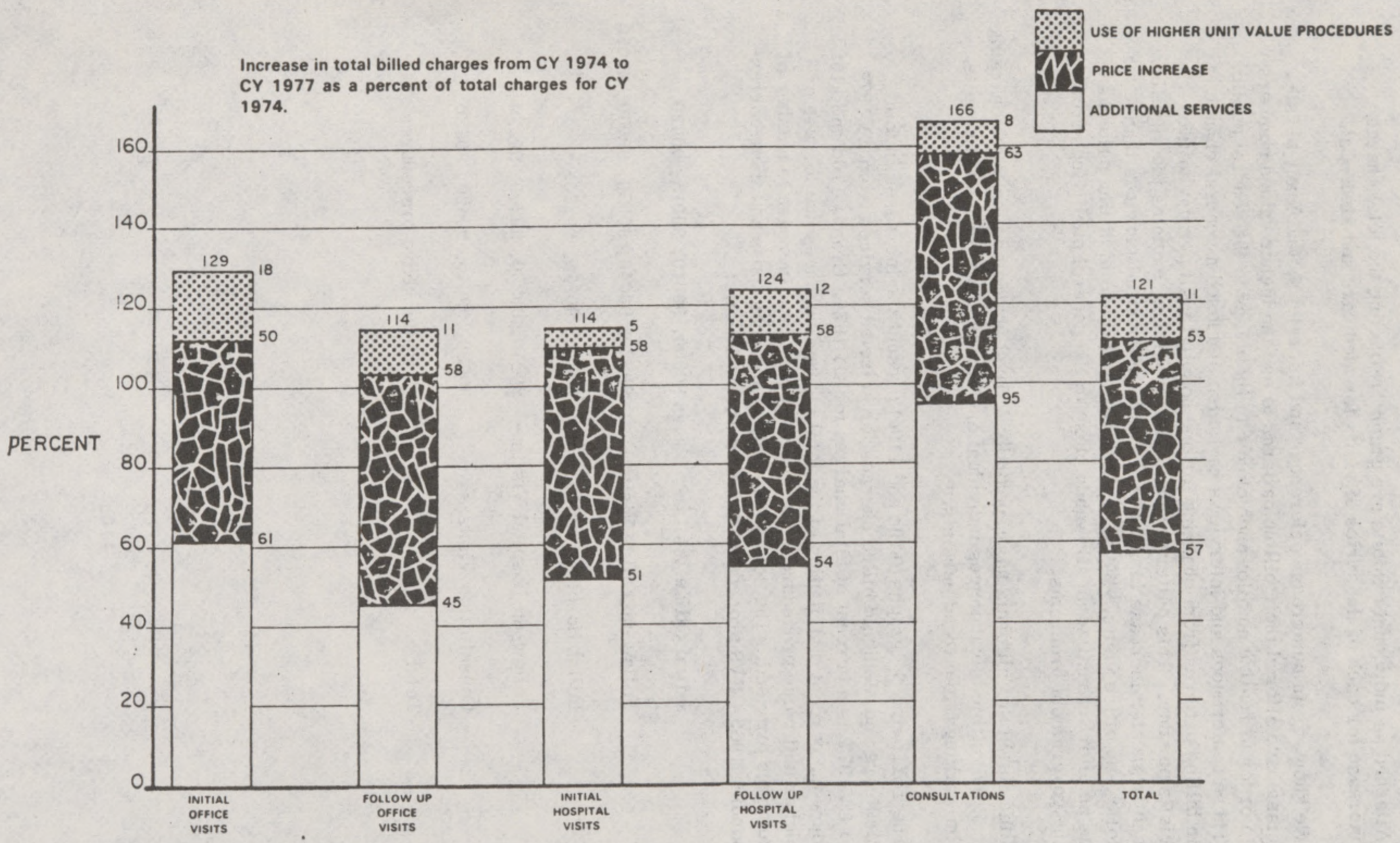
We know, from numerous conferences and interviews, that many physicians have altered their billing patterns to use the higher valued numbers in order to realize an allowance closer to their fees to the general public. These conferences and interviews have also disclosed a general change in billing patterns from charging for one hospital visit per day to two visits per day. This pattern change, in our opinion, explains the significantly greater increase in additional follow-up hospital services than follow-up office visits. We also attribute this change in billing patterns as an effort to realize an allowance close to the general public fees from the government programs.

Blue Shield of California has repeatedly warned physicians that such charging practice ultimately damages individual and community profiles but despite the warnings, the trend persists."

The following graphs (110c and 110e) present the increases in total Medicare and Medicaid billed charges for selected services from CY 1974 to CY 1977 as a percent of total charges for CY 1974. Graphs 110d and 110f show the percent distribution of the total charge increases due to: use of higher unit value procedures, increase in price, and increase in number of services provided. The selected groups of medical visits and their corresponding 1969 CRVS procedure numbers are as follows:

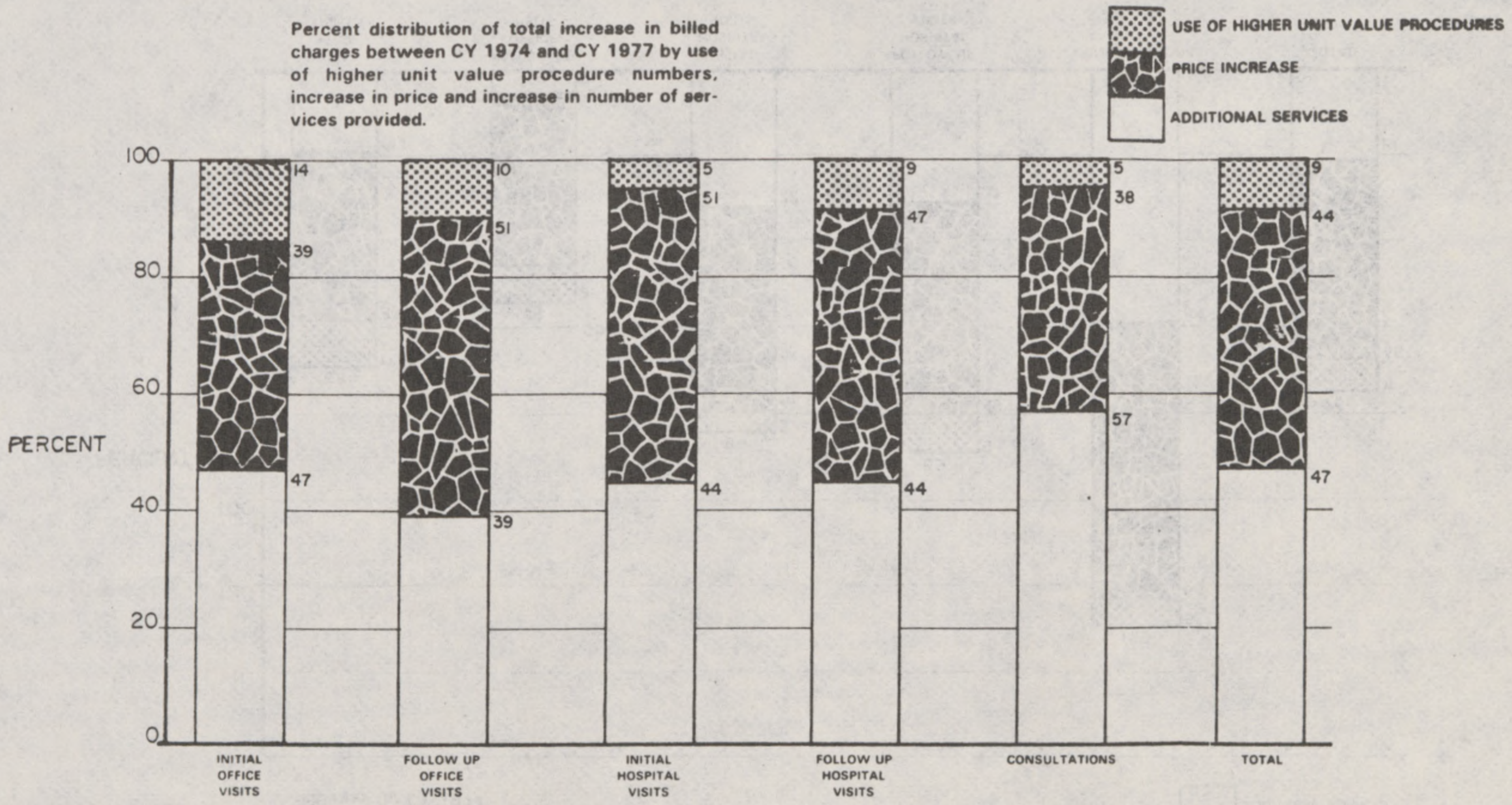
Initial Office Visits -	90000, 90010, 90015, 90020
Follow-up Office Visits -	90030, 90040, 90050, 90060, 90070
Initial Hospital Visits	90200, 90215, 90220
Follow-up Hospital Visits -	90240, 90250, 90260, 90270
Consultation Visits -	90600, 90610, 90620, 90630
Total -	all of the above procedures

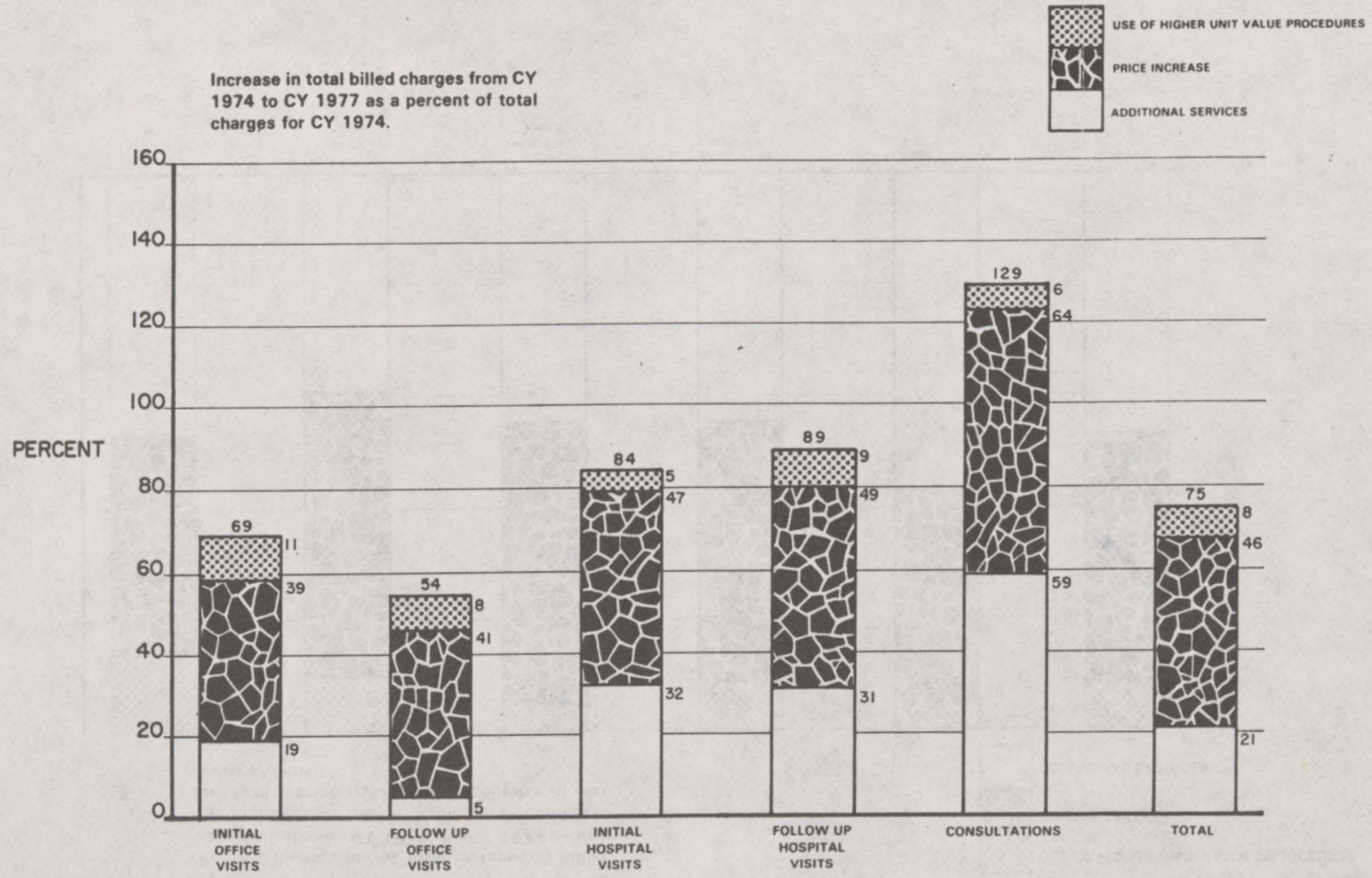
MEDI-CAL PROGRAM



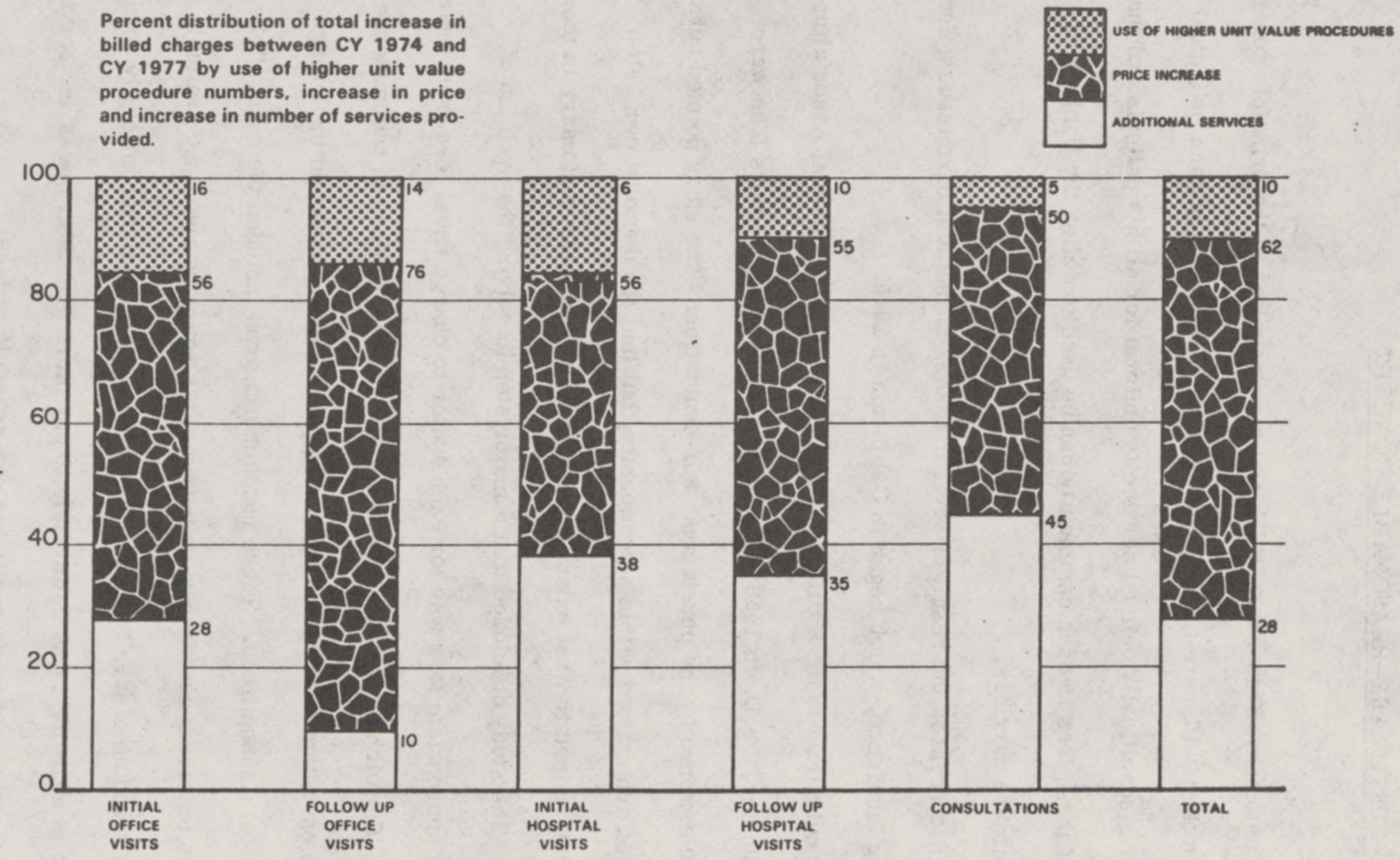
MEDI-CAL PROGRAM

Percent distribution of total increase in billed charges between CY 1974 and CY 1977 by use of higher unit value procedure numbers, increase in price and increase in number of services provided.




USE OF HIGHER UNIT VALUE PROCEDURES
PRICE INCREASE
ADDITIONAL SERVICES
Increase in total billed charges from CY 1974 to CY 1977 as a percent of total charges for CY 1974.
PERCENT
160
140
120
100
80
60
40
20
0
69
11
39
19
54
8
41
5
84
5
47
32
89
9
49
31
129
6
64
59
75
8
46
21
INITIAL OFFICE VISITS
FOLLOW UP OFFICE VISITS
INITIAL HOSPITAL VISITS
FOLLOW UP HOSPITAL VISITS
CONSULTATIONS
TOTAL

Percent distribution of total increase in billed charges between CY 1974 and CY 1977 by use of higher unit value procedure numbers, increase in price and increase in number of services provided.



110f

THE USUAL-CUSTOMARY-REASONABLE CONCEPT

Background:

Usual-Customary-Reasonable (UCR) are terms applied to the principle generally recognized in the health care industry that 1) the fees charged by each individual physician for a specifically defined service is uniform for all his patients and that 2) a range of these fees in each community can be used to define the liability of medical insurance carriers.

The UCR concept is the result of several studies of medical care issues, including medical care insurance, which began in California in 1945.

A study submitted to the California and Alameda County Medical Associations by Ernest Dichter, Ph.D. in 1950 made the observation that doctors fees were primarily determined by the physicians' self-evaluation. The study pointed out that competition existed within a community, but that the doctors' own self-evaluation determined to what extent he was bound by what was customary in the community. The study concluded that a major step in solving the problem of determining appropriate fees was for each doctor to charge equal fees from everyone he treated. The Dichter Study was used as a basis for some action recommendations made by the executive secretaries of the Alameda-Contra Costa and the Orange County Medical Associations. These recommendations included the suggestions, 1) "that each physician set his own valuation of his services and make available to patients his schedule of fees" and 2) "that the medical association officially condemn the practice of charging those better able to pay more than the value of the services set by the physician and contained in his own schedule of fees."

The same principle was further developed by subsequent studies performed by a special CPS Study Committee and the Medical Services Commission of the CMA. The CPS Study Committee introduced the term "average fee plan" in 1952. The 1954 Medical Services Commission Study replaced the term "average fee plan" with the term "usual fee indemnity plan" summarized as follows:

"USUAL FEE INDEMNITY PLAN

> If a physician charged the same fee for the same service to each of his patients it would be possible to write an indemnity policy, based on these fees, which would give real certainty and adequacy of reimbursement to the patients receiving his services.
>
> Similarly, if each physician charged the same fee for the same service to each of his patients, and if most of the physicians in a community had very similar fees, it should be possible to write an indemnity type insurance contract which would give certain, adequate reimbursement to the patients of this majority group of physicians.
>
> If, on the other hand, a patient sought care from a physician whose individual fee schedule was higher than that of most of the physicians in his community (by reason of unusual skill, experience or prestige), so long as the higher schedule was known to the patient, he would still have certainty of reimbursement to the extent that he would know exactly how much greater his expenses would be than the reimbursement schedule, and he would then knowingly and willingly be accepting less than complete reimbursement from his insurance.
>
> In the same way, any physician anticipating unusual difficulties in the care of a particular case should have the privilege of charging more than his usual fee by reaching an understanding with the patient concerned; after explanation of the unusual problem, before service was given. If there were to be any deviation from the usual fee, the patient should know it in advance.
>
> Briefly, the usual fee indemnity plan proposes that the insuring agency repay to the insured person most of what he has spent for medical care. If his physician charges him the usual fee charged by most doctors in his community, the amount repaid will be nearly all he has spent.
>
> This is just what most owners of medical care insurance thought they were going to receive when they bought their insurance."

Although other studies were being performed at the same time in other states, the California studies introduced and most clearly defined the term "usual fee" and importance of the concept in establishing certainty in health insurance coverage while retaining freedom of action for the patient and the physician.

The concept of full payment with no fee schedules was gradually adopted in various states. In 1954, Wisconsin Blue Shield offered a program based on the customery, usual and reasonable charges of physicians. A "no fee schedule" program became available throughout Wisconsin by 1957. Payment in full was made to physicians whose fees were deemed to be customary, usual and reasonable. In 1956, an Indiana military dependent's program was successfully operated with no fee schedules - physicians charging their usual fees.

In 1959, the Riverside California Medical Association requested that CPS offer a "no income clause" program. Such a program was written for one insured group on a pilot basis. The program was based on the payment of "usual, customary, and reasonable" fees. The terms were carefully spelled out and defined in the contract which provided for administrative review of claims by local physicians headed at that time by Dr. Herman Stone. The program was well received and soon spread to many other areas in California.

The terms "usual, customary" and "reasonable" came into common use, although they were not uniformly defined. A number of Blue Shield Plans with objectives similar to the usual fee indemnity plan introduced the term "prevailing fee" which was similar to the concept of "customary". The term "prevailing"

further eroded the already blurred meaning of usual and customary. The confusion in the terms became more apparent with the advent of the Medicare Law in 1965. The law authorized payment of a "reasonable" charge in whose determination "there shall be taken into consideration the customary charges for similar services generally made by the physician . . . as well as the prevailing charges in the locality for similar services." (See footnote on page 125 for difference in terms used by Medicare.)

Guideline definitions for the terms usual, customary and reasonable were adopted by the American Medical Association in 1968 as follows:

> " 'Usual' is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee):
>
> 'Customary' is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area;
>
> 'Reasonable' is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."

The AMA House of Delegates also resolved that "whenever these terms are used in contracts or laws, they be specifically defined in those documents." Despite the AMA attempt to precisely define the terms, many distortions have occurred in the use of the terms as well as in the original objective. For example, Medi-Cal calls for the payment of fees on the basis of usual, customary or reasonable "whichever is least." CPS has at times separated the "reasonable" portion of the concept and questioned fees despite the fact that the criteria of

of usual and customary were met. (See pages 132 - 138 of this report.)

Comments by Dr. Herman Stone

The charts comparing the CRVS to subsequent fees billed including applicable portions of the computer report were submitted to Dr. Herman Stone for review and comments. Dr. Stone, one of the original promoters who has been called the "father" of the UCR concept limited his comments to the history of the UCR concept.

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November 21, 1977

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San Francisco, California 94102

Re: 981004
U.C.R., The Riverside Plan

Dear Mr. Brunner:

Yes, the U.C.R. concept was, to use your words, "a noble idea." It was conceived for and developed in a small, idealistic, relatively homogeneuous, county medical society. It was my honor to have been president of the Riverside County Medical Association at the time.

I cannot competently answer all the questions you posed in your letter, but I shall do my best to give you a brief history of the usual, customary and reasonable, Riverside Plan.

The officers of the RCMA were approached by representatives of the employees of the Riverside plant of Food Machinery Corporation, who asked for a proposal for a contract for health care coverage of their employees. It was the desire of the employees of the Food Machinery plant that they might receive medical care by private physicians, who would be the personal choice of each insured. Furthermore, they wanted "certainty of coverage" for their health care needs.

The physicians of the RCMA for their part wanted "no fixed fee schedule" and as little interference by third parties as possible. The employee group and the physicians concerned were desirous of maintaining the traditional doctor-patient relationship and providing and receiving first class private medical care.

After many meetings and study sessions the original Riverside Plan was set in motion.

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Through the good offices of Dr. Omer Wheeler we were introduced to Dr. Arlo Morrison, then Chairman of the Board of California Physicians' Service, who listened carefully to our proposals and participated in the evolution of the plan. CPS at the time had certain funds available for small experimental efforts in the health care field.

The key to such a plan in our view - the key in allowing a patient to go to a physician of his choice, and in allowing that physician to treat the patient as he deemed wise, and to charge his usual fee - was a strong and respected Review Committee.

The original Review Committee was composed of the five immediate past-presidents of the RCMA, plus four additional members. Each of the former presidents, of course, had been elected by members of the Society and therefore had a certain prestige in the medical community and an effort was made to include on the Board representative doctors from the several communities in Riverside County, and from the various specialty groups.

To make the program work we needed certain specific definitions to be included in the contract. These words were the famous "usual, customary, and reasonable" terms. We defined them as follows:

Usual, was to be defined as that fee which a given physician would charge any patient who came into his office for a particular treatment or procedure.

Customary was defined as that range of fees charged by physicians of similar training and in the same community, thus recognizing that, as a matter of fact, different fees were charged for what otherwise would be the same procedure in Riverside, in Palm Springs, or in Hemet, and by individuals in general practice, as distinguished from those recognized specialists.

Reasonable was defined as being that fee which met the above two specifications and which additionally, in the judgment of the Review Committee, was, indeed, reasonable.

Claims made were submitted to the Review Committee, which met at regular intervals, and having reviewed the bill, authorized payment, or recommended alteration of the fees. If there was to be a change in a fee, a member of the Review Committee, coming if possible from the particular physician's own community and own specialty, would discuss the matter with him. Generally, agreement could be reached. If it could not, then the physician was entitled to present his point of view to the entire Review Committee, whose judgment was final.

At the outset a survey was made to determine the fees charged for a variety of procedures in each of a variety of communities in Riverside County, and these served as a confidential source of information to the Committee. They were not made public.

It was our feeling that the program would work best if, indeed, in a particular patient-physician encounter, the doctor didn't even know that the patient had this insurance, but rather treated his patient as he historically had, and assessed his appropriate earned fee.

That the concept was correct, and that the program did work, may be verified by the record which indicates that at the end of the first year's contract with Food Machinery we were able to give the insured employees an option of reduction of premium, or additional coverage. There was at the time, and continues to be, an excellent competing idea, the San Joaquin Plan, or San Joaquin Foundation, which I believe was largely the child of Dr. Donald Harrington and his associates. As a matter of fact, in the years that followed Dr. Harrington and I were from time to time invited to discuss our programs at various places in the Western United States, sometimes from the same podium.

As additional companies were added to the Riverside Plan, each with their own specific basket of negotiated health insurance needs, and as the personnel of the Riverside Plan Review Committee changed year by year, the concept itself came to be changed. I am sure your studies and the records widely available in California and in the offices of the California Medical Association and California Blue Shield, will attest that.

I was not involved in the evolution of the California Relative Value Study and cannot therefore respond to your questions on that subject.

The U.C.R. concept, in my view, remains a noble and workable idea. It does require, however, respect and cooperation of the physician group involved and does, I believe, therefore, lend itself best to small county medical societies, or subdivisions of larger county medical societies, or in appropriate instances to specific, well organized hospital staffs.

You ask about the effect of the doctor's self-esteem and opinion of themselves relative to fees; I should say, yes, these are legitimate effectors, but that the esteem of the community he serves and certainly the documented credentials of the man, do and should have more effect. The given physician's self-esteem and self opinion would influence his usual fee, but the customary would be judged by comparison with similarly trained physicians in the same community, and in final analysis, the fee according to the Riverside Plan, would be approved by a committee of his peers, as described for you earlier.

As I understand it, the C.R.V.S. was developed not as a fee schedule, but as a nomenclature catalogue, indicating the differing professional input involved in differing medical procedures.

The U.C.R. concept did not accept any "physicians' practices of charging more for patients who can afford more." Rather, it was our feeling that a given service by a physician with particular qualifications, had an honest intrinsic value of its own, regardless of who received the service.

You ask about the phraseology "usual, customary and reasonable" as distinguised from "usual, customary, or reasonable"; as we developed the program, we used the word "and." Our experiment was approved and applauded officially by the House of Delegates of the California Medical Association, as the record will show, but at a subsequent meeting of the House of Delegates a resolution was introduced from Los Angeles County, seeking to change, and changing, the word "and" for the word "or."

I hope that these remarks, while not addressing item by item to questions you posed, will provide the information you need concerning the Riverside Plan. If there are additional specifics, I would be happy to discuss them with you.

The Diechter Report should be available in the offices of the California Medical Association.

Very truly yours,

Herman H. Stone, M. D.

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INTERACTION BETWEEN CMA-CPS AND THE MEDICAL PROFESSION

As discussed in Chapter I of this report, CPS is a voluntary service organization sponsored by the CMA. The Board of Trustees of CPS is elected annually by the CMA House of Delegates, and a majority of the members of the pertinent CPS committees, such as the Executive, Finance, and Medical Policy committees, are on the CPS Board of Trustees and the CMA House of Delegates. Also pointed out was that CPS, in its Standard Business, Medi-Cal, Medicare, and CHAMPUS Programs, processes a large volume of claims. CPS, thus, can have a substantive effect in formulating and enforcing policies as they relate to reimbursement of physicians.

Whether these relationships constitute a conflict of interest or whether the CPS policies result in a deliberate manipulation of the medical economic environment has and continues to be the subject of an investigation by the FTC. The investigation encompasses about 71 Blue Shield Plans and the National Association of Blue Shield Plans, and is part of a large program in which information is being gathered about competition in the delivery and financing of health care services. It also includes an examination into the nature and extent of physician control of Blue Shield organizations and its impact on competition in the delivery of health care. We did not duplicate the FTC efforts; instead, we have concentrated on reviewing the minutes and supporting documentation of pertinent committees of CPS and the CMA. We believe the minutes are most likely to reflect the interactions between these two organizations. Specifically, we selected the minutes of the CPS Board of Trustees, the Medical Policy Committee, and the Finance Committee. At the CMA, we selected the minutes of the CMA Council and the Committee on Relative Values, including reports and

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documentation in support of the deliberation that took place within these bodies. As reflected by these minutes, we can only conclude that CPS attempts o act as mediator between the medical profession and the various interest groups, including the government and the patient. During the past several years, various resolutions have been introduced in the CMA House of Delegates condemning CPS for its practices as a fiscal intermediary on the basis that CPS is a "tool of government". Other resolutions introduced called for the severance of CMA's ties with CPS on the basis that the latter is nothing more than an indemnity company and not worthy of the relationship with the medical profession. All these resolutions have been widely rejected.

The 1974 CMA House of Delegates adopted two resolutions which pertained to CPS and the CMA. The first resolution addressed the issue of non-assignment of benefits to non-CPS member physicians. The second dealt with the appointment of a joint CMA/CPS committee whose purpose would be to propose solutions leading to the improvement of relationships between the two organizations.

A joint committee was subsequently established, and although its work has not been completed, its preliminary report takes the position that assignment of claims and direct payment to non-member physicians, rather than direct payment to patients, was beyond resolution by the committee. Specifically, the committee found itself unable to recommend a compromise between the philosophical position held by CPS that payment for services rendered by non-member physicians be made directly to the patient who in turn must then settle directly with the physician and that of non-member physicians that failure to honor their assignments is discriminatory. CPS's position is based on the fact that it is a service organization and that honoring member physician assignment is essential to its survival as a tax exempt organization.

With respect to the second resolution, the committee, among other points, recommended

1. The establishment of a new administrative membership composed of 60 individuals---36 of the individuals would be physician members of Blue Shield---three being appointed or elected by each of the 12 Councilor districts---(Councilor district option), with each physician eligible to serve two consecutive terms of three years. The remaining 24 individuals would be public subscriber members selected by Blue Shield, and that

2. (a) CPS Medical Advisors be located in several key parts of the State <u>in addition to</u> San Francisco,

   (b) Provisions be made to augment the number of Medical Advisors,

   (c) The terms of service of the Advisors be limited to (fixed period not yet determined) years, and

   (d) Additional assurances be provided to physicians to indicate that Medical Advisors are not permitted to review cases on appeal where such Medical Advisors have rendered the initial decisions.

The committee further recommends that the Medical Advisor system be strengthened in whatever additional ways can be found in order to gain the trust and confidence of health professionals.

* * * * * * * * * *

In another action the CPS Board of Trustees passed a resolution requesting that the CMA .reexamine the concept of usual, customary or reasonable on the basis that some fees may satisfy the statistical requirements of usual and customary, but would not be considered reasonable, if reasonable were to be defined as "not excessive or extreme" in the opinion of persons of experience and judgment. The resolution further stated that there is currently no effective

mechanism for determination of reasonableness. In summary, the resolution called for the CMA Council to redefine the term "reasonable" as it applied to UCR administration.

The question of redefining "Reasonableness" was discussed at two CMA Council meetings. Additionally, the Research Director of the CMA requested advice from CMA's Legal Counsel regarding CPS' request for redefinition of the term. In response, CMA's Legal Counsel made the following comments:

> "... In your letter of May 28, you state that the members of the Commission of Medical Services were concerned with 'possible legal implications of direct CMA involvement'. Since the CMA House of Delegates is the cradle if not conceiver of the UCR concept, I can see no legal impediment to the House of Delegates modifying its own definitions...."
>
> (Emphasis supplied.)

In spite of the opinion expressed by its Legal Counsel that the CMA Council was free to redefine "reasonableness" as CPS had requested, the Council took the position that the CMA would not provide the assistance to CPS. Instead, the Council recommended that CPS' resolution be referred to specialty societies for their information and investigation of fee patterns for reasonableness in their respective specialties. The CMA subsequently sent a letter to about 20 specialty groups in California requesting that they give consideration to the CPS request. The societies did not respond to the invitation to participate in reexamining the concept of "reasonableness".

* * * *

A detailed analysis of the CPS interaction with and effect on the medical community would be a major project in itself. Consequently, we believe that the most effective approach to analyze the influence of CPS on the CMA and the medical community is to review the activities between the CPS Medical Policy Committee and the medical profession, including the CMA Committee on Relative Value Studies.

The CPS Medical Policy Committee is charged with assessing the medical validity of the descriptors used by physicians and makes recommendations as to whether a charge is reasonable or whether a physician should be reimbursed and, if so, how much. This committee, thus, plays a key role in the diffusion of medical innovation and in assigning values to procedures which are entered in the CRVS by "By Report" (BR) or "Relativity Not Established" (RNE). The Committee also has the task of establishing reasonable fees where fees are considered unjustifiably high in relation to the physician time and risk.

The Medical Policy Committee meets approximately four times per year. Policy on specific issues is adopted at these meetings. The CPS Board of Trustees approves all policies before implementation. The Committee may form ad hoc committees to study and report on specific issues. The Medical Policy Committee invites to its meetings well known leaders in the medical community where the meetings are held. Invited guests can be CPS members or non-members. Often they are officers of the local medical society or specialty societies. The guests are encouraged to make presentations and participate in the deliberations but cannot vote on policy issues.

To effectively comment on the CPS Medical Policy Committee and its actions, we believe it is necessary to provide a brief description on how physicians may be paid under the various programs.

Methods of Paying Physicians

There are three basic payment methods in the medical industry: 1) fee-for-service, 2) capitation, and 3) salaried practice. In practice, the methods exist in many combinations. Fee-for-service has been the method traditionally favored by physicians and their associations. Fee-for-service includes the Usual, Customary, or Reasonable principle (UCR). (See pages 111 - 119 for history of UCR)

UCR is a method used primarily by Blue Shield Plans to limit physicians fees while recognizing the uniqueness of a physician's practice and the medical patterns within a community. UCR is intended to be flexible and responsive to change within the local medical community.

Under the UCR method, "physician profiles" and "area profiles" are established based on physician and other provider fees billed during a data base period,

usually one year.[1] Fee data accumulated by the carrier or fiscal intermediary during the data base period is subsequently arranged in frequency distributions and a median fee for each RVS coded procedure is established.

A list of the provider's median fees for each procedure forms his profile of "usual" fees. The 75th percentile of the aggregate of all providers' usual charges within a specifically designated geographic area is the area profile or "customary" fee for each procedure.[2] Under the UCR approach, a provider is paid his fee, limited to the amount of 1) his usual fee,or 2) the customary fee in the area whichever is lower. If his charge exceeds both of these limits, it may still be paid in full if it is deemed "reasonable" by a medical or peer review committee.[3] CPS payments to medical providers in California account for 20 to 25 percent of provider gross receipts from carriers. CPS determines the amounts of the payments as follows:

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1 CPS uses a data base period of one calendar year.

2 CPS has divided the State of California into 28 geographic areas or communities and established area profiles of customary fees for each area. The 75th percentile is used for area profiles. Physicians profiles are the median (51st percentile) fees. The terms applied to the profiles have evolved over the years. In the Medicare Program, "usual" is known as "customary" and "customary" as "prevailing". To eliminate confusion, CPS uses the terms Level I to refer to physician profiles and Level II to refer to area profiles.

3 The method of determining the "reasonable" fee varies depending on the carrier or plan. Reasonable in the Medicare Program means the lesser of billed amount, usual or customary.

CPS has in some instances established reasonable fee ceilings for certain procedures and uses these as usual or customary limits.

CPS has an active Provider Review Division that reviews individually claims not paid under the usual or customary measures.

Program		Payment Method
Standard Business	UCR	Usual or customary, based on charges for the specific procedures, if available, or other procedure in the same type of service (billed coefficient).
Standard Plan 24	Fixed Fee Schedule	Schedule based on conversion factors applied to 1974 CRVS.
FEP Low Option	Fixed Fee Schedule	Schedule based on a National Association of Blue Shield Plans. RVS applicable to entire U.S.
Medicare	UCR	Customary or prevailing profiles by specialty based on charge data of Medicare Program. Payments in Fee Screen Year 1978 (July 1977 to June 1978) will be based on combined 1976 charge data of Medicare claims billed to Occidental Life of California and claims billed to CPS for all programs it administers. The Economic Index and No Rollback Provisions of the 1972 amendments to the Social Security Act apply. Reasonable for the Medicare Program means customary or prevailing.
CHAMPUS	UCR	Same as Medicare except that the Economic Index and the No Rollback Provisions do not apply.
Medi-Cal	Fixed Fee Schedule	Schedule based on fixed conversion factors applied to the 1969 CRVS.

Under Medicare and CHAMPUS, physicians have the option to accept or refuse assignment on each claim. When a physician accepts assignment, he accepts the intermediary payment plus the patient's co-insurance portion as payment in full. When the physician refuses assignment, the patient is "balance billed" for the fee agreed upon with the doctor, regardless of the amount allowed by the carrier. The

same is true of a patient enrolled in the Blue Shield Standard Program as discussed in Chapter 1. (As shown on page 9, about 24.5 percent of Blue Shield's payments are made to member physicians.) Non-member physicians are paid directly by the patient who is responsible for the total fee regardless of the amount allowed by CPS.

CPS, CMA and Local Medical Society Influence on the Medical Service Industry

CPS, the CMA and county medical societies separately and jointly determine what is acceptable and ethical medical practice, what procedure codes are used, and what fees are paid for medical services. They also investigate and resolve disputes and consider questions of ethics.

When confronted with a new procedure which has not been recognized previously, the CPS Medical Policy Committee may seek the assistance of the CMA Scientific Board or Peer Review Commission to establish if the procedure is acceptable medical practice rather than an experiment or quackery. Once a new procedure has been deemed valid and acceptable medical practice, the Committee may request that the CRVS Committee designate a procedure number to be used in processing claims and paying for the procedure.

As noted previously, CPS uses the UCR method to set limits for fees paid for well established procedures. In addition, CPS establishes maximum fee levels for additional procedures. In order to avoid individual review of thousands of claims submitted for "By Report" (BR) or "Relativity Not Established" (RNE) procedures, CPS establishes maximum fee levels or unit values for payment of these procedures without review. BR procedures are procedures which are not standard and have not been assigned relative values. RNE procedures are standard procedures which were not assigned unit values because adequate charge data were not available at the time of the CRVS

revision. CPS establishes maximum fees or unit values for these procedures based on actual charge data for the specific procedure or on the relativity to other procedures. In summary, if a claim is received by CPS for a service which has no charge history, such as a BR or RNE type of service, the claim is sent to a medical reviewer who specializes in the field of that particular service. This medical reviewer then sets a relative value based on his own knowledge of that service vis-a-vis other services. After enough claims for a particular service are received, a firm relative value is established. Also, CPS uses the CRVS unit values in establishing profile payment screens. Specifically, each year CPS establishes high-low dollar coefficients per unit value for each type of service charged under the Medicare, CHAMPUS and Standard programs. These parameters are established in the form of payment screens, or computer edits which eliminate the extremely high or extremely low charge data entered into the claims processing system. For example, the payment screen would reject a claim for the profile data base if the amount charged was unrealistic in relation to services provided. The high-low coefficients are based on the 1969 CRVS' actual or derived unit values. (See discussion on page 30 for high-low parameters.) Since the payment screens are high-low dollar coefficients per CRVS unit values, these coefficients respond to changes in charges. As charges increase over time, the payment screen will also eventually be raised by type of service. A paper entitled "Medical Technology and The Medical Care System", prepared by an Associate Professor of Medicine, University of California School of Medicine, states:

> ". . . A payment screen is the highest allowable reimbursement for a service. Since the payment screen is based on the relative value for a service, which in turn is based on charges, there is a built-in inflationary bias. This is because as long as charges are allowed to rise the payment screen will eventually be raised for that service. . ."

The method for setting these parameters is largely subjective; a CPS official states:

". . . The method for setting these parameters is largely subjective taking into account Blue Shield and Occidental experience with billings received during the calendar year, the Economic Index used in Medicare and profiles for the previous fiscal year.

"Once the parameters are developed, they are checked by the Vice Presidents/Directors of the programs Blue Shield administers and the Director of the Occidental Medicare Program. If any one of these people suggest any change in the high/low parameters, the proposed changes are analyzed, considering the above factors.

"If the proposed changes appear valid, the entire set of parameters again goes through the Vice President/Director approval process. Ideally, these parameters should exclude the same volume of data from both the high and low limits. If the amount of data dropped is too great or too unbalanced, the parameters are revised and the data base tested against the new parameters . . ."

For physicians accepting assignment of the claim, CPS in effect determines the fees for these procedures. For non-assigned claims, what CPS allows influences what additional amounts must be paid by the subscriber. At CPS, the average rate of cutbacks for assigned claims parallels closely the rate of cutbacks of non-assigned claims.

Reasonable fee limits may also result from an investigation or peer review by a local medical society. Fee levels are not publicized by neither CPS nor peer review committees. Peer review committees usually limit their determination to the specific case. Determinations are made as to the carrier's liability, and do not protect the patient against a higher fee.

CPS looks to the CMA and local peer review committees for the resolution of disputes not satisfactorily resolved by a CPS Medical Advisor Review Panel engaged by the Provider Review Division. CPS has an arrangement with county medical societies for the societies to provide CPS with local peer review. Peer review

committees or committees on insurance review will examine the case and render an opinion. If the dispute is not resolved after a local peer review, CPS may ask the CMA to establish a Committee on Appeals to consider the dispute.

CPS has a Provider Review Division to review questionable claims or claims listing RNE or BR procedures. Claims listing procedures which do not fall within the CPS pre-determined UCR or other limits are removed from the CPS automated processing system and referred to the Provider Review Division. In addition to the full time Provider Review staff, CPS engages a group of consulting physicians who individually review questionable claims. CPS consultants, Medical Advisors, make a determination as to the appropriate procedure and/or fee. If either the provider or patient disagrees with the Medical Advisor's determination, a Medical Advisor Review Panel may be impanelled to review the case. The panel may consider, but is not bound by, opinions of local medical societies. Medical Advisor Panel decisions are not binding on non-member providers. The non-member physician who has chosen not to accept assignment may "balance bill" the patient for the difference under the CPS Standard Program, CHAMPUS or Medicare.

Disputes not resolved by the Medical Advisor Review Panel may be referred to a local peer review committee, and if still not resolved, to a CMA Committee on Appeals. Like Medical Advisor Review Panel decisions, local peer review or Committee on Appeals decisions are not binding. The provider or subscriber may request arbitration under the Standard Program or an administrative hearing under the government programs.

A large volume of claims is considered by the Provider Review Division annually. The majority are paid according to the Division's determination. In 1976

CPS Advisors reviewed over 500,000 claims before payment, reducing benefit payments by approximately $17,000,000.

The following schedule shows Volume and Benefit Reductions attributed to CPS Medical Advisors and CPS corporate medical policy for the period January through May 1977:

Program	No. of Services - 1977	Reductions - 1977
Medi-Cal	259,935	$ 6,563,331
Medicare	399,915	5,513,887
CHAMPUS	2,244	461,875
Standard	26,883	2,419,927
Total	688,977	$14,959,020

The preceding discussion is provided so that the reader may be aware that any actions taken by the Medical Policy Committee, as discussed below, may have a substantial impact on the patient rather than the physician.

The Provider Review Division of CPS also investigated 1,412 providers. The majority of these cases were closed by CPS. The following table shows the authority for closing the cases:

Closed by CPS		
Without Provider contact	330	
Field Representative contact	388	
Advisor contact	506	
Advisor Panel Hearing	92	1,316
Closed by Local Medical Society		
Committee Hearing		87
Closed by CMA		
Appeal Committee Hearing		9
		[1] 1,412

[1] Investigation by Program:

Medi-Cal	315
Medicare	746
CHAMPUS	67
Standard	284
	1,412

The interaction and effect of CPS Medical Policy, the CMA and local medical societies and physicians is demonstrated by three examples of events and circumstances summarized below.

EXAMPLE #1
TOTAL HIP REPLACEMENT

This operative procedure was initially done under grants and only a few specific surgeons were provided with the "glue" (Charnley Cement) to perform the procedures. In San Francisco, this grant (probably under FDA license) was given to Doctor W. Murray of the University of California and Doctor Soto-Hall of St. Joseph's Hospital. Apparently these two physicians set the fee of $1,500.

In March 1972, the Medical Policy Committee of CPS voted to limit total hip replacement to $1,000, or thirty 1969 unit values. The decision to limit the fee was based on data provided by other Blue Shield plans. The data showed that charges 1) in Florida ranged from $1,000 to $1,500; 2) in Arkansas about $1,000; 3) in New Jersey ranged from $900 to $1,500; and 4) in Michigan ranged from $700 to $900. Whereas, charges in California ranged from $900 to $2,500 with the majority being $1,500.

The $1,000 fee limitation had an adverse effect on subscribers (patients) because fees billed by physicians were rising to $2,500 to $3,000 and subscribers were being balance billed by the non-member orthopedic surgeons. In essence, subscribers were required to pay the difference of $1,500 to $2,000 above the amount paid by CPS.

Also, the orthopedic surgeons put pressure on the Medical Policy Committee. A surgeon representing the Medical Care Foundation of Sacramento wrote that,

"Here at the Medical Care Foundation the charges that received from orthopedic surgeon members performing this procedure range from $1,200 to $1,600, with the majority being at $1,600. This reflects a $40 conversion factor on the 1969 RVS which has a total unit value of 40 for this procedure (27130).

"In reviewing this question of proper payment for total hip replacement with other orthopedic surgeons in our community, the consensus is to use the 40 units assigned in RVS with the usual conversion factor for that particular locale. The Medical Care Foundation now has an allowable charge of $1,400 for this procedure for the Sacramento five county area."

Another surgeon representing an orthopedic group in San Francisco stated that,

"Arthroplasty of the hip, regardless of its evolution, demands the expertise of the orthopedic surgeon in the development of a new hip joint, the implications of major infection, malpractice, and six months of follow-up care. The RVS Schedule clearly reveals a total hip arthroplasty as a 40-unit procedure. By usual and customary conversion, this would make the total fee a minimum of $1,500.00. By disregarding the RVS Schedule, CPS has clearly ignored the established practice in this community."

An orthopedic surgeon practicing alone stated that,

"I am writing to express sincere concern with the apparent decision regarding fees for total hip replacement arthroplasty and total knee arthroplasty. As you know, the 1969 Relative Value Study, Item 27130, lists a 40 unit value. At prevailing usual and customary fees amongst orthopaedic surgeons in San Francisco, this translates into $1,600.00 total fee for this procedure. Blue Shield has suggested a $1,000 fee which, in my opinion, is unfair and not consistent with local practice. If maintained, the fee would be less than that for cup arthroplasty and that does not represent reality."

The Medical Policy Committee's recommendation to increase the fee to $1,500 was taken to the CPS Board of Trustees in March 1973. The Trustees' recommended a maximum fee of $1,000 be paid and that the Medical Policy Committee reconsider its position. With respect to the Board's decision, the Medical Director states that, "This is one of the rare instances in my experience where the Board of Trustees said we can't accept that. Go back and reconsider."

The question of reasonableness was settled shortly after by following the concept of usual, customary or reasonable (UCR). By that time, CPS had accumulated sufficient charge data to establish the UCR level.

In the Medicare Program, Orthopedic Surgeons' customary profiles based on calendar year 1976 charge data for procedure #27130 (Total Hip Replacement) range from:

	High	Low
San Francisco	$2,600	$1,500
San Diego	$2,600	$1,920
Area 25 (Los Angeles area which includes Beverly Hills)	$3,000	$2,000

EXAMPLE #2
CORONARY BYPASS

Coronary artery bypass procedures (33510 - single artery; 33515 - two coronary arteries; 33518 - three or more arteries) were first listed in the 1974 revision of the CRVS. Although these were new procedure codes in 1974, the procedures were assigned a relative value. The procedures had been performed by heart surgeons previously. (See pages 70 - 72 for methods used in arriving at relative values for cardiovascular surgery.) The values assigned to these procedures represent 1973 fees of $1,500, $1,950 and $2,250 respectively.

The following comments by the Medical Director describe CPS' attempt to establish reasonable fee levels for coronary artery bypass procedures:

> "On May 24, 1972, at a time when Blue Shield was receiving claims for as much as $4,300 from heart surgeons, the Medical Policy Committee voted to allow a maximum of $1,300 for a single valve or single coronary bypass; and $1,500 for a multiple procedure, double valve, or double coronary bypass. Following this action, numerous letters of protest and decisions by local peer review committees reflected dissatisfaction among the provider community.

"On May 9, 1973, the Medical Policy Committee reconsidered the topic. Forty-two guests attended that meeting and submitted testimony, sometimes acrimonious.

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"It was then voted to allow a maximum of $1,800 for a single coronary bypass and $2,000 for a multiple coronary bypass.

"This policy remained in effect until September 24, 1975, at which time the Medical Director reported to the Medical Policy Committee that there had been considerable protest from both providers of the service and subscribers (who were compelled to pay the difference between Blue Shield's maxima and non-member surgeons' charges). Blue Shield's remuneration was considerably less than that paid by other carriers. There was lengthy discussion. "Concern was again expressed that the resultant high billings would encourage the support of national health insurance, and that the principle of UCR could no longer be relied upon to maintain reasonable fees."

"It was then voted to accept the recommendation of the Medical Director 'that valve, single coronary bypass and multiple coronary bypass surgery be paid based on profiles maintained in accordance with traditional Blue Shield practice in UCR fee administration.'"

Although the policy to pay for these procedures on a UCR basis has remained in effect, CPS has attempted on an individual case basis to pay a reasonable fee level for these procedures. For example, in 1976, the CPS Provider Review Division, took a typical case of a fee dispute to a Committee on Insurance Review in Southern California. In this instance, the fees submitted by the physicians met the area profile and criteria of usual, customary or reasonable. CPS felt that this case could be a good test case for redefining the question of reasonableness. In essence CPS questioned---is this fee reasonable, not "or" is it reasonable. CPS further requested that the Committee on Insurance Review specifically state its rationale for arriving at its decision. CPS was looking for a decision which would specifically state "why" this fee was or was not reasonable.

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In its decision, the Committee on Insurance Review reduced the surgeon's fee from $4,800 to $3,700, but did not address the question of reasonableness. With respect to the decision, the CPS Medical Director states that the Committee on Insurance Review essentially agreed with CPS fee determination but failed to define the "or reasonable" of the UCR concept. The decisions by the Committee on Insurance Review, which are not published, routinely include a disclaimer stating that "this is the liability of the insurance company and any arrangement the patient has made with the doctor in advance remains in effect". The decision does not protect the patient but only the insurance carrier. Furthermore, any decision rendered by the Committee on Insurance Review with regard to a fee dispute only applies to a particular claim and cannot be used by CPS as a precedent for other claims. The same applies, incidentally, to fee dispute decisions rendered by the CMA's Committee on Appeals Division.

Charges billed to CPS in 1976 were used to establish the customary profiles currently used by CPS. However, CPS recently established maximum amounts allowable for these procedures. The Medicare Program profiles for the artery bypass procedures in three areas in California are as follows:

	#33510 Single Artery			#33515 Two Arteries			#33518 Three or More Arteries		
	High	Low	No. of Services	High	Low	No. of Services	High	Low	No. of Services
San Francisco	$2,800	$1,750	24	$3,520	$2,500	43	$3,300	$2,500	37
Sacramento	$2,325	$2,225	9	$3,040	$2,560	16	$3,534	$3,040	46
Napa, Marin & Solano Counties*	$2,500	-	2	$3,800	$3,200	13	$3,800	-	21
Maximum allowable during comparable period by CPS for Standard & Medicare all California	$2,400			$3,000			$3,000		

* There is only one group of associated surgeons performing these procedures in this geographic area.

Comparable information is not available for the Southern California counties because Occidental Insurance Company, the primary Medicare Carrier for Southern California, cannot recognize the 1974 CRVS coding. The 1969 CRVS, which is still being used by a substantial number of physicians, both in Northern and Southern California, and Occidental, does not differentiate between a single, double or multiple coronary bypass.

The reason for establishing dollar maximums rather than pricing the claim by the UCR method is given in the following memorandum prepared by CPS' Medical Director:

> " . . . First, until the publication of the 1974 CRVS, there were no listed procedure numbers for this service. The volume was too great to rely on individual advisor pricing and the Medical Policy Committee established maximum fees. This was also a conscientious effort on the part of Blue Shield of California to reduce the prevailing charge level on the basis that the prevailing charge for the procedure was "unreasonable" in relationship to all other medical services.
>
> "With the publication of the 1974 CRVS, the Blue Shield Medical Policy Committee authorized the coronary artery bypass surgery procedure returned to UCR profiles. This was attempted, but the lack of detail on charges for this procedure defeated the profiles. Failure of Medicare and other major carriers to recognize the 1974 CRVS has limited its use in cardiovascular surgery. Therefore, we have no recourse but to continue treating the procedure as by-report service until sufficient data are collected to allow establishment of appropriate profiles. . ."
>
> The maximum allowable has recently been (September 1977) increased by 6.35% to $2,600, $3,200 and $3,200 respectively.

Coronary artery bypass, graft surgery is being performed with increasing frequency. Costs for these procedures have also increased. During 1976, about 60,000 such surgeries were performed in the United States at a total approximate cost including hospitalization of about $900 million CPS received claims for about 4,000 such procedures

in 1976. The average total cost for an artery bypass surgery is about $15,000 including hospital costs. Specialists in coronary surgery indicate that under normal circumstances it takes two to four hours to perform a single artery bypass surgery. Included in the service is ninety days of normal, post-operative, follow-up care.

Encouraged by a recent study, the "National Cooperative Study to Compare Medical and Surgical Therapy for Unstable Angina Pectoris" conducted by the National Heart, Lung and Blood Institute of the National Institute of Health, the CPS Medical Policy Committee continues to review the necessity of coronary artery bypass surgery as opposed to conventional medical treatment.

At the July 13, 1977 meeting of the Medical Policy Committee, the CPS Medical Director recommended specific guidelines for the payment of coronary bypass surgery. The proposed guidelines provided for a review by a medical advisor of claims for surgery not falling within specific, pre-established guidelines for diagnosis. Several invited cardiac specialists objected to the proposed guidelines on the grounds that the National Cooperative Study was not conclusive, other studies have shown different results and "that the current state of the art does not permit establishment of definitive guidelines indicating appropriate candidates for coronary artery bypass surgery." The recommendation was tabled until the September 1977 meeting; an ad hoc committee was assigned to study the issue and report its conclusions at that time. The ad hoc committee declared unanimously that criteria for the review of claims for coronary artery bypass surgery can be developed. Guidelines which are restricted to internal use by CPS in reviewing claims were approved at the September 28 meeting of the Medical Policy Committee.

APPENDIX A

CALIFORNIA MEDICAL ASSOCIATION

731 Market Street / San Francisco, California 94103 · 415·777-2000

CONFIDENTIAL

December 11, 1974

Gary Kardos, M.D.
45 Castro Street, #227
San Francisco, California 94121

Dear Doctor Kardos:

You will recall during the development of the 1974 revisions of the RVS that Doctor Bell requested each physician who supervised a specific RVS section to provide CMA with evidence to support the charge data submitted on which resulting relativities were based. Such data could consist either of survey material or of a general statement from you concerning the numbers of physicians contacted and the types of information which they supplied. In any case, we do need some evidence to maintain in our files that the charges which you submitted as reflecting practice in California do indeed represent what physicians are charging, rather than what might be considered "appropriate" relativities.

Now that the RVS revision has been completed and approved by the CMA Council, I am writing to request that you send us some information for the files. Should you already have done so, please let me know and I will look more closely at the material already in my possession, since I would like to have this type of information from all subcommittees stored in one specific place. If you have not sent in any such information or statement, I would appreciate your doing so at your earliest convenience.

In advance, please accept my thanks for your assistance in this matter, as well as for all the help you provided the committee and me during the revision process. Please feel free to call me if there is any question as to the nature of this request.

Sincerely,

Michael W. Jones, Staff Coordinator
Committee on Relative Value Studies

cc: Leo S. Bell, M.D.

MWJ:mcm/wpc

APPENDIX B

MEDICINE

PERITONEAL DIALYSIS

90963 excluding cannula and/or catheter insertion, per dialysis.....

HEMODIALYSIS

(Each of the following code numbers 90970-90981 is for a single therapeutic hemodialysis treatment.)

90970 Acute renal failure and/or intoxication, initial hemodialysis.....

90974 third through end of sixth week, per treatment.....

90981 seventh stabilization through end of first month of chronic hemodialysis therapy per treatment.....

90982 Hemodialysis service for a hospitalized chronic renal failure patient who is hospitalized because of an inter-current illness or for a problem related or unrelated to chronic renal failure.....

90986 Monthly physician fee for patient dialysis in a facility.....

HOME HEMODIALYSIS

A physician may elect to report his services on an itemized or monthly basis, but not a combination thereof. The initial method of reporting per patient may not be changed during that calendar year.

90991 Home hemodialysis care, outpatient, per month. (This descriptor applies only to those services either provided by the physician primarily responsible for total hemodialysis care or under his direct supervision. It includes on-call coverage and at least one office visit per month, but excludes complicating, nonhemodialysis related illnesses).....

MEDICINE

OFFICE VISITS

ESTABLISHED PATIENT

90040 Brief examination, evaluation and/or treatment, same or new illness.....

90050 Limited examination, evaluation and/or treatment, same or new illness.....

90060 Intermediate examination, evaluation and/or treatment, same or new illness.....

90070 Extended re-examination and/or re-evaluation

HOSPITAL VISITS

NEW OR ESTABLISHED PATIENT

90220 Initial hospital care, comprehensive history and examination including intiation of diagnostic and treatment program and preparation of hospital records.....

ESTABLISHED PATIENT, FOLLOW-UP CARE

90240 Brief examination, evaluation, and/or treatment, same illness.....

90250 Limited examination, evaluation, and/or treatment, same or new illness (characteristic of the usual hospital visit).....

90260 Intermediate examination, evaluation and/or treatment, same or new illness.....

90620 Consultation requiring comprehensive history and examination and/or evaluation.....

93000 Electrocardiogram, with interpretation and report.....

MUSCULOSKELETAL SYSTEM

GENERAL

EXCISION

20220 bone, trochar, superficial (e.g. ilium, spinous process).....

INTRODUCTION or REMOVAL

20550 Injection, tendon sheath, ligament or trigger points.....

20600 Arthrocentesis, aspiration or injection, small joint (e.g., fingers,toes).

20605 intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle joint; olecranon bursa).....

20610 major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).....

REPAIR, REVISION or RECONSTRUCTION

27130 acetabular and proximal femoral prosthetic replacement ("total hip").....

FRACTURES and/or DISLOCATIONS

27236 closed or open, open reduction, internal dixation or prosthetic replacement.....

27244 closed or open, open reduction, with internal fixation.....

AMPUTATION

27590 Thigh, through femur, any level, with primary closure.....

SURGERY
Cardiovascular (Heart, Pericardium)

PACEMAKER

33200 Insertion of permanent pacemaker, with epicardial electrode by thoracotomy.....

33205 with transvenous electrodes.....

33212 Insertion or replacement of pulse generator only.....

33216 Insertion, replacement or repositioning of permanent transvenous electrodes only (15 days or more after initial insertion).....

33240 Insertion of temporary transvenous electrode (independent procedure)..

CARDIAC VALVE

Aortic Valve

33410 Replacement (for multiple valves, see next column.....

33430 Replacement (for multiple valve procedure, see next column).....

Cardiovascular (Heart, Pericardium; Arteries and Veins)

35070 Abdominal aortic aneurysm, with or without ileo-femoral.....

THROMBOENDARTERECTOMY-with or without patch graft

35300 Carotid or vertebral.....

35610 Femoral-popliteal, autogenous, unilateral.....

Intra-arterial - Intra-aortic:

36200 aorta (arch, abdominal, mid-stream renal, aorto-iliac runoff, etc.....

Venous

36410 adult, necessitating physician's skill (independent procedure) (not to be used for routine venipuncture).....

36480 Central venous pressure catheter placement, subclavian, external jugular or other vein, percutaneous.....

36485 by cutdown.....

Arterial

36601 Arterial puncture, withdrawal of blood for diagnosis, infant or child under age five.....
(For adult, see 99014)

36620 Arterial catheterization for monitoring.....

Intervascular Cannulization or Shunt

36810 Arterio-venous, external (Scribner type).....

SURGERY
Digestive (Intestines; Rectum)

Intestines (except rectum)

Excision

44005 with acute bowel obstruction.....

44110 Excision of one or more lesions of small or large bowel, not requiring anastomosis, exteriorization or fistulization, single enterotomy.....

44120 Enterectomy; resection of small intestine with anastomosis.....

44140 Colectomy, partial, with anastomosis.....

ENTEROSTOMY-External fistulization of intestines (independent procedure):

44320 Colostomy or skin level cecostomy (independent procedure).....

EXCISION

44950 Appendectomy.....

ANUS EXCISION

46255 internal and external, simple..

46320 Enucleation or excision of external thrombotic hemorrhoid.....

INTRODUCTION

46500 Hemorrhoids, injection of sclerosing solution.....

LIVER

Incision

47000 Needle biopsy of liver, percutaneous

Excision

47100 Wedge biopsy (independent procedure).....

BILIARY TRACT

47420 Choledochotomy or choledochostomy with exploration, drainage or removal of calculus, with or without cholecystotomy.....

EXCISION

47600 Cholecystectomy.....

47605 with cholangiography.....

47610 with open exploration of common duct.....

Abdomen, Peritoneum and Omentum

INCISION

49000 Exploratory laparotomy; exploratory celiotomy (independent procedure) (see Surgery ground rule 9b).....

49020 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal.....

49080 Peritoneocentesis; abdominal paracentesis, initial.....

SURGERY Eyeball

EYEBALL, ANTERIOR SEGMENT, CORNEA

Excision.

65420 Excision or transposition of pterygium without graft.....

EYEBALL, ANTERIOR SEGMENT,
IRIS, CILIARY BODY

66625 peripheral, for glaucoma (independent procedure).....

66630 sector, for glaucoma (independent procedure).....

66635 optical (independent procedure).

REMOVAL of LENS (cataract)

66915 Expression of cataract, linear, one or more stages.....

66920 Extraction of lens, with or without iridectomy, intracapsular, with or without enzymes.....

66930 for dislocated lens.....

66940 extracapsular (other than 66840, 66850, 66915).....

66945 in presence of fistulization bleb, intracapsular or extracapsular....

EYEBALL, POSTERIOR SEGMENT,
RETINA, CHOROID

67107 by scleral buckling, with or without external implants (may include procedures 67102-67106).....

67108 with vitrectomy, with or without air tamponade, procedures 67102-67107 and/or removal of lens by

67142 Prophylaxis, retinal detachment, one of more stages, without drainage (e.g., retinal break, lattice degeneration), diathermy.....

67143 cryotherapy.....

67144 photocoagulation, xenon arc.....

67146 laser.....

67212 Destruction of localized lesion of retina or choroid (e.g., choroidopathies), one or more stages, diathermy.....

67214 photocoagulation, xenon arc.....

67216 laser.....

EXCISION or REMOVAL OF LESION

67800 Excision, chalazion, single.....

PROBING and RELATED PROCEDURE

68800 Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral.....

68820 Probing of nasolacrimal duct, with or without irrigation, unilateral.....

68840 Probing of lacrimal canaliculi, with or without irrigation.....

APPENDIX C

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE
50 FULTON STREET
SAN FRANCISCO, CALIFORNIA 94102

February 20, 1975

SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEALTH INSURANCE
MERCIA LETON KAHN
REGIONAL REPRESENTATIVE

Refer to:
IHI-R912

Mr. Willis W. Babb
Executive Director
California Medical Association
731 Market Street
San Francisco, CA 94103

Dear Will:

You will recall that at the last council meeting, I sent a letter about our concern over introduction of the 1974 revision of the California Relative Value Studies. Since then, our Office of Research and Statistics has made available to me the results of a summary review of the revision. I want to share this with you and express my desire to have it available to the reference committee considering resolutions relating to the RVS.

The findings reflected in this review raise grave concern on our part that the new publication will impact heavily on the cost of the Part B Medicare program in California. While California accounts for less than nine percent of total SMI enrollment, the California carriers (Blue Shield and Occidental) account for over 14% of the total SMI reimbursements.

While we have not been able to fully assess what would appear to be a considerable fee escalation resulting from use of the 1974 revision, the summary review of the Medicine section indicates a strong possibility of fee escalation. The visit Unit Values, when applied to the frequency distribution of visits billed to Medicare in 1972, suggest an increase of about 12% due to the new unit value relationships. This 12% is the indication before taking into account any shifts in the mix of previously established visit levels, or the impact of the newly created levels and categories, or any change in conversion factors. One of the more costly additions is likely to be the code which suggests a higher value for the discharge day.

We certainly recognize that the California Medical Association has devoted enormous resources and efforts in producing this revision and that there is no intention to cause fee escalation through the use of the revised RVS. However, the impact on the Medicare beneficiaries in California could be substantial and we would like to see publiçation and distribution delayed until further analysis and study can be completed.

Sincerely,

Mercia Leton Kahn
Regional Representative

Attachment

cc:
Charles Stewart
California Blue Shield
John Fulton
Occidental

A SUMMARY REVIEW OF THE 1974 REVISION OF THE 1969 CALIFORNIA RELATIVE VALUE STUDIES

GENERAL

According to the Introduction, the 1974 revision lists "about 30 percent more procedures than did the 1969," essentially 1,000 more procedures. Relative values were again re-scaled in all sections except Anesthesiology. A new expression for value, RNE--Relativity Not Established, is used "in instances when relativity could not be determined, but the procedural technique was reasonably standardized." (Interestingly, about 40 of the RNE items had specific unit values in the 1969 CRVS, as did some 75 items that are now designated BR--By Report.) The expression BR is now limited to procedures for which techniques vary widely. The codes and terms for "Special Services and Billing Procedures" (sometimes referred to as the two-digit modifier codes) have been expanded, most notably for Pathology, and relative value expressions have been referenced to appropriate sections.

MEDICINE

On average, each 1969 Medicine unit value equals between .25 and .30 in 1974 units. The definitions provided to describe Levels of Service for visits were slightly revised. A new Level of Service, "Unusually Complex," was added. There are now five levels and variants for office visits by New Patients, and eight choices for office visits by Established Patients. For hospital visits, a new code was added for initial Unusually Complex visits, and another follow-up visit code was provided for services rendered on the discharge day. Special new codes were also provided for hospital visits to patients in Critical Care areas. For Skilled Nursing Facility visits, a new code for Transfer Patients has been added representing the same kinds of services that would otherwise be provided on the discharge day from the hospital, to be used only when that new hospital visit code is not used. Also, for both SNF and other nursing home visits to established patients, Brief visits have been separated into one patient and more than one patient, while Limited and Intermediate visits have been split into new illness and same illness.

For follow-up hospital visits and SNF visits for same illness, the Limited visit has been designated to be "characteristic of the usual visit." If so, and if physicians generally tend to hold their present fee for limited hospital visits but adjust all other visit fees in accordance with the new relative values, overall fees would rise substantially. A test of 15 directly comparable kinds of office and hospital visits which have been accounting for about 75% of all medicine services suggests an increase in unit values per visit of about 18% for office visits and 4% for hospital visits, or a composite 12%. Except perhaps for the new codes for nursing

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home, brief visits to more than one patient, the new visit codes and terms seem to invite fee escallation, i.e., to justify higher fees than would be applicable from the unit values established for the more generally described visit of comparable level.

Because of the plethora of potentially applicable codes, evaluation of "emergency" visits would seem most difficult. As in the 1969 CRVS, codes (formerly two, now three) are provided to add units to any visit level if a physician is called to the Emergency Room from some other place. Also, a schedule of Emergency Care Facility visits is provided for MDs assigned to that department or using these facilities as a substitute for his office. These have higher values than office visit values at similar levels. Finally, while the Critical Care area codes are not valued, the descriptive tone implies that still higher fees than for 'ordinary' emergency room services are warranted.

For consultation, the "Unusually Complex" level was added. Provision has also been made for the reporting of follow-up visits by consultants. Certain preventive health services for infants and children are now listed. To some extent, these may be viewed as replacements for the age-differentiated Comprehensive visits that were in the 1969 CRVS, but no longer appear.

Many new psychiatric procedures have been added. Dialysis terminology was substantially expanded. New separate listings are provided for Gastro-enterology specific diagnostic services and for otorhinological services. Opthalmologic non-surgical procedures were expanded from 12 items to 51 items.

Physicians' behavioral responses to the 1974 revisions in Medicine terminology seem likely to increase Medicare SMI costs, even if physicians do not strictly adopt the new relative value indications. There is strong inducement provided in the new terminology to charge above-usual fees for the discharge day of a medical admission, to charge relatively higher fees for care provided to patients in critical care areas, to consider some visits as "Unusually Complex" and/or "complicated by a chronic disabling condition."

ANESTHESIOLOGY

Since the minimum basic value is still 3 units, apparently no change in anesthesia basic unit values was intended. However, for non-obstetrical services, the time factor begins as one unit per 15 minute interval, then changes after the first four hours to become one unit per 10 minute interval. In the 1969 CRVS, all time intervals were 15 minutes to equal one unit. Also, 5 minutes has now been designated as a sufficient term for the final time unit. (Thus, 45 minutes = 3 time units, 50 minutes = 4 time units, 270 minutes = 19 time units, 275 minutes = 20 time units.) The basic values were increased, usually

by one unit, for a number of procedures. A quick test of 12 procedures which occur frequently and require anesthesia showed five unchanged, and seven (mastectomies, tonsillectomy, cholecystectomy, inguinal hernia, vaginal hysterectomy and caesarean sections) increased by one unit. This suggests an increase of about 14% in basic values or 7% overall.

SURGERY

Surgical relative values were re-scaled so that on average one 1969 unit equals between 0.6 and 0.7 1974 units. There were substantial terminology and coding changes in most sub-sections. Over 300 new codes were provided in the Musculoskeletal section, and over 100 each in the Cardiovascular, Digestive, Nervous and Eye sections. Also, a code for unlisted procedures was provided in most sub-sections. Each section is separately summarized and discussed below.

To keep track of the seventy-nine 1969 CRVS surgery codes which in 1972 were paid at an annual rate of $100,000 or more for SMI by California Blue Shield, one must consider at least 115 of the 1974 codes, and perhaps 13 or more others. Although terminology was not significantly changed for forty-six of these seventy-nine important items, and two procedures were compressed into a single 1974 code, there are now between sixty-five and seventy-eight 1974 codes which stand for the other thirty-one important 1969 surgical codes.

This increase in codes reflects the "split" of previous terminology for these thirty-one important items (and for about 180 surgical items overall) into two or more codes differentiated by such things as place of treatment (viz., hospital versus office for transurethral surgery), or approach (viz., cervical versus thoracic versus lumbar for spinal surgery) or age (viz., under age one versus age one to twelve versus age twelve or over for inguinal hernia repairs). In the relatively few instances where compressions of 1969 coding occurred, they can usually be attributed to combining the descriptions of two equally valued operations of the same broad type, or the elimination of lower-valued descriptions for 'subsequent' procedures. While not all of these "splits" and "compressions" resulted in alteration of relative value indications, these kinds of adjustments can severely impede the application of controls like the Physician Index required by Section 224 of PL 92-603.

Integumentary System

Forty-seven "new" terms were added. Measurement categories for wounds, grafts, excisions and repairs were changed to be exclusively the metric system. This resulted in numerous splits of former codes. A separate listing for "Intermediate" (between 'Simple' and 'Complex') repairs has been added. Among the 13 higher-cost procedures in this section,

only one was definitely sub-divided, and this was attributable to the change to metrics. The coding and terminology changes in this sub-section do not appear price escallatory. From a coverage viewpoint, "Tattooing" is probably the most questionable new listing.

Musculoskeletal System

Of the approximately 365 additional codes in this section, about 265 represent "new" procedures. The remainder are the net result of the deletions, compressions and numerous splits. Sixty-four of the "new" terms describe tendon surgery. Thirty-two of the new terms describe fractures. Thirty-one times, the expression "with suction irrigation" was given a separate code to modify an orthopedic procedure. Eighteen new codes result from "age" splits, while 36 new codes are from 2 for 1 splits of other types and 26 additonal codes are from 3 to 1 splits of former codes. Among the nine higher-cost procedures, one was age split, two fractures were provided with new modifiers (with values 0.5 to 1.0 units less than the former term), and two amputations were provided new modifiers (valued at 0.7 units more in one case and RNE in the other). The other four higher-cost procedures' terminology was not significantly modified.

Respiratory System

There are 42 "new" terms and codes added to this section. Ten of these were endoscopic, primarily laryngoscopy. Six were for "Introduction" procedures (incision, catheterization, etc.), primarily tracheo-bronchial. Many of the added procedures and new terms appear to reflect Maxillo-facial surgery. A previously BR procedure was split into five codes, and there were four 2 for 1 splits of 1969 codes. Two of the 4 higher-cost codes were split 2 for 1, but their relative value indications remained identical.

Cardiovascular System

The number of listings in this section rose from 203 to 310. About half of these increases involved the Heart and Pericardium. In this subsection, the "standard" headings (incision, excision, etc.) were eliminated and replaced by headings for particular valves or disease categories. Direct cross-referral from the 1969 codes is possible for only 53 of the 119 entries. In the Arteries and Veins subsection, 14 "new" terms are added. Twenty-eight new codes are the results of splits. In the Arterio-venal Introduction subsection there was comparatively little change--4 new terms, 4 deletions and one 2 for 1 split. In the remaining CV subsections (cannulization, shunts, repairs) there are twenty "new" terms, three 2 for 1 splits and three deletions. Among the 9 higher-cost cardio-vascular codes, two (which had identical 1969 unit values) were compressed into one code, and three were not significantly altered. Three of the 9 were subjected to 2 for 1 splits, and one was split 3 for 1.

Hemic and Lymphatic System

There are now 33 listings instead of 22. Seven "new" terms were added, two 1969 codes were split 2 for 1 and two procedures were relocated from the Mediastinum/Diaphragm section. There are no higher-cost procedures in this section.

Mediastinum and Diaphragm

This section has three new terms. Procedure terminology for the only higher-cost code was not significantly changed.

Digestive System

This section was increased by 163 terms. All endoscopic procedures were grouped into a new sub-section. In the process, 47 new codes were added, reflecting 41 "new" listings and 8 new codes from splits and 2 deletions of 1969 codes. Maxillo-facial influence is also evident here. A new 17 code section was created for "Vestibule of Mouth," and there are 6 new Lip codes, 11 new Tongue and Floor of Mouth codes (8 of which are actually new terms), 10 new Dental-Alveolar Structure codes, 11 new Salivary codes and 10 new Pharnyx codes. There were also alterations in all of the other Digestive System subsections, except the Liver and the Meckel Diverticulum and Mesentary. Thirteen of these net 46 additional codes are in the Abodomen subsection, and 10 involve Intestines, Except Rectum. There are 22 higher-cost digestive system codes. Four of these higher-cost codes were clearly split into two or more codes, most notably Appendectomy (2 of the 3 1974 codes are RNE), Partial Colectomy with Coloproctostomy, Complete Proctectomy (but same unit value for both 1974 codes) and Unilateral Femoral Herniorrhaphy. The provision of numerous additional endoscopic listings could affect Procto-sigmoidoscopy. Two new codes were added under Gallbladder with Duct Exploration and three new listings appear under Partial Colectomy. Thus, although 15 of the 19 higher-cost codes did not have significant terminology modification, the amount of change centering on the above seven procedures raises concern for immediate and future escallation in this section.

Urinary System

There are 76 "new" terms encoded in this subsection. New endoscopy listings account for 36 (with most valued at or near similarly described Cystourethroscopy) and 10 are transurethral surgery. Nine new codes result from 2 for 1 splits (4 of which are separations of 'hospital' versus 'office' for transurethral surgery). There are eight higher-cost procedures in this section, four of which did not have significant terminology change. One procedure was subjected to the 'hospital versus office' split (with 'hospital' valued 2.75 times

higher than 'office'). The other three codes are diagnostic cystourethroscopy. Since most values for the newly listed endoscopies are near those for cystourethroscopy, it is not likely that resulting coding shifts would be immediately escalatory.

Male Genital System

Twelve of the 13 "new" codes are either penile or testicular procedures. There were also two 2 for 1 splits. Three sub-systems had no significant change. The two higher-cost codes were not substantively changed. A new 2-code Intersex Surgery section is noted here.

Female Genital System

There are 34 new terms, 10 of which are vaginal procedures and 6 of which comprise a new Endoscopy, Laparoscopy subsection. While there were no obvious direct terminology changes in the 4 higher-cost Female Genital codes, three of them (all hysterectomies) have had new coded modifier terms added (i.e., new codes were provided to represent the hysterectomy plus a repair of the bladder).

Maternity Delivery

There are 29 "new" terms. Twelve are modifications of "normal" deliveries, and 6 are new fetal evaluation tests. There was no net change in Caesarean delivery codes and a net reduction (from compressions of 1969 codes) of Abortion codes. While for Medicare there are no higher-cost procedures in this section, maternity and delivery are the highest cost Medicaid "surgery." The 12 new normal delivery codes (all valued RNE) portend a risk of future escallation opportunity.

Endocrine System

Only one new term was added. There are no higher-cost codes in this section.

Nervous System

Overall, 109 new codes were added, 87 of which represent "new" procedures. In the Skull sub-section, 15 of the 34 net additions including 10 of the 31 "new" procedures are in the excision or destruction category. The only higher-cost code has been split 3 for 1 (but at the same relative value) and a coded modifier (valued 15% higher) also was added. Spine and Spinal Cord surgery had 45 net additions, 30 representing "new" procedures. Eleven of the "new" procedures are injections, while 10 are new laminectomy/laminotomy items. The only higher-cost procedure was effectively split by changing from the 1969 value and description covering one or two segments, to a 1974 approach valuing one segment in

the basic code, and each additional segment in another. Nerve surgery has 30 new codes, including 26 representing new procedures. Twelve of the new procedures are in a new sub-section "Neurorrhaphy with Nerve Graft." Other "Nerve Repair" has five "new" codes and 4 additional codes resulting from splits. The only higher-cost code had no significant terminology change.

Eye

The number of listings has more than doubled, growing from 115 codes to 252 codes. Only 11 of the 1969 codes and terms were totally unrevised, and only 11 of the 1969 codes and terms were totally unrevised, and only 38 other 1969 codes were re-used after terminology modification. Among the five higher-cost codes, only one had no significant terminology change. The other four (Cataract, Iridectomy, Keratoplasty, Photocoagulation of Retina) now each have 4 or 5 counterpart 1974 codes. Thus nineteem 1974 codes must be followed to track the trends in the five 1969 higher-cost codes. This degree of revision seems to invite price escallation.

Ear

Eighteen "new" procedures and a net of 17 more codes from splits are now listed. Nine of the new procedures are Inner Ear surgery, including a new 6-code category headed 'Operations on Temporal Bone, Middle Fossa Approach'. All but one of the split codes were for Middle Ear surgery, most notably the separation of Tympanoplasty with Mastoidectomy into 8 codes, and the split of Revision Mastoidectomy into five codes. There was no significant terminology change in the only higher-cost Ear surgery code.

RADIOLOGY

Radiology relative value scales were adjusted in roughly the same proportion as those for Surgery, with each 1969 unit averaging slightly over 0.6 1974 units. The most obvious terminology change is the addition of a 35 code section for Diagnostic Ultrasound procedures. The 1969 CRVS had only three Medicine Section codes for such procedures. (Although the California Blue Shield SMI claims data on hand suggest only about 200 reimbursable ultrasound procedures in 1972, 24 of the 35 1974 codes have relative value unit designations at 4 different 'Total' levels and 5 different 'PC' levels.) It should be noted that the 1974 revision shows 'PC' (Professional Component) unit values and 'Total' unit values for each radiology test, and suggests that different conversion factors be used for each type. In the 1969 CRVS, only one radiology unit value scale was presented.

There are 56 "new" Diagnostic Radiology (i.e., x-ray) procedure codes. There was one 1 for 3 compression and three 1 for 2 compressions of 1969 codes. Two 1969 codes were deleted. Eighteen of the new procedures are

examinations of listed bones or joints. Most of these involve films after using contrast media. Twenty-eight of the new diagnostic x-ray procedures are Vascular system exams, and most concern sialography studies. Most of the splits are also in this category. Four of the new items involve the G-I tract, one is for the G-U tract, and seven are miscellaneous. Among the fourteen higher-cost procedures, there was one 2 for 1 split and one 1 for 2 compression.

The Radiation Therapy (and Oncology) teletherapy treatment class strengths were re-defined. The former 'Superficial' and 'Orthovoltage' classes were combined, 'Supervoltage' was unchanged, and 'Megavoltage' strength was split into two codes. Also, the per treatment schedule was separated into "simple" and "complex" categories. Thus, in 1974's CRVS, there are 11 per treatment teletherapy code counterparts to the six 1969 CRVS per treatment codes, and there was some revision, but no net increase, in the number of codes for the treatment week schedules. Three radium treatment codes were added, and the Adjunctive Studies category now lists 11 codes rather than two. There were no terminology changes for the three higher-cost radiation therapy codes.

PATHOLOGY

The Pathology relative value unit scales were changed so that on average, one 1969 unit is equivalent to between 0.4 and 0.5 1974 units. In all there were several hundred additions to terminology and many previously separated listings for blood versus urine tests were compressed. The net increase was about 235 codes.

The "B" Test" listing that was published in the 1972 Interim Pathology Supplement to provide lower values for certain tests when three or more items were performed at the same visit has been eliminated. In their place, three grouping codes (but no relative values) are provided. Panel test reporting codes were re-grouped and Phosphotase, Acid deleted from the panel list. (In the Supplement, Globulin was added to the original 1969 CRVS panel list and Cephalin Flocculation and Thymol Turbidity were deleted. The 1974 version does likewise.)

The largest number of additions were in the Chemistry & Toxicology section. At least 37 of the new tests are for the detection of drugs, usually specific drugs. At least 28 of the new tests are Radio-Immuno-Assays. About 100 other new tests were also added.

About 43 new Hematology tests were added. About 60 Immunology procedures were added, many of them blood-handling procedures. Most of the 22 code increase in Microbiology listings are separations of 1969 codes. Eleven new Autopsy procedure codes were added and 2 were deleted. Nine specific Karotyping codes were added. Four Cytopathology codes were added, and 2 deleted. Gross and Microscopic exams were split into 3 basic groupings,

and 'complex' into two. Four additional Consultation codes are provided and 4 additional test codes for surgical pathology procedures are shown. There are four new Miscellaneous tests, and one 1969 code was separated into 6 1974 codes.

Among the fifteen higher-cost pathology items, the five panel test 1969 codes are now effectively six codes. Terminology for the five higher-cost Chemistry exams was not significantly changed. Three of the four higher-cost Hematology procedure codes were split into two or more codes. The one higher-cost Anatomic Pathology exam code became three codes. Overall, twenty-four 1974 codes are the equivalent to the fifteen 1969 higher-cost Pathology codes.

APPENDIX D

HOWARD HASSARD
JOSEPH S ROGERS
ROBERT D HUBER
SALVATORE BOSSIO
DAVID E WILLETT
JOHN I JEFSEN
WILLIAM B STURGEON
GLENN L ALLEN
GARY A GAVELLO
JAMES N PENROD
RICK C ZIMMERMAN
A ROBERT SINGER
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HARTLEY F. PEART
(1901-1954)
GUS L. BARATY
(1910-1966)
ALAN L. BONNINGTON
(1948-1972)

November 30, 1977

Homer C. Pheasant, M.D.
2300 South Hope St., Suite 300
Los Angeles, California 90007

Re: FTC - California Relative Value Studies

Dear Homer:

I have a copy of your letter of November 21, 1977 to Kash Rose regarding the action of the California Medical Association relative to the Federal Trade Commission and the RVS.

There are several statements in your letter that I thought need comments by me.

You refer to the anesthesiologists; it is true that there is a case pending in the Federal Court in New York, brought by the Department of Justice against the American Society of Anesthesiologists. I have been in rather constant communication with Mr. John Lansdale, the attorney for the American Society of Anesthesiologists, and I can assure you that Mr. Lansdale has advised his client for many months to settle the case if that can be done with the ASA giving up its relative value program, but without giving up any rights it has under the First Amendment to the US Constitution. The Department of Justice has been waivering back and forth during the past few months and as of last weekend there was a chance (I do not know how great) that the Department of Justice and the American Society of Anesthesiologists would come to an agreement.

With respect to your comment regarding the inconsistency of government agencies, please understand that agencies of the federal government very frequently take totally inconsistent positions on any subject under the sun, and the bureaucrats couldn't care less. It may be immoral, as you say, but that has never bothered the federal bureaucracy.

As a matter of fact, the Federal Trade Commission has not attacked the relative value studies per se. What it has said (and what it intends to litigate, if necessary) is that relative value publications should not originate with the providers of service. FTC staff is on record as saying that if any consumer group, or third party payor group, public or private, wants to develop and publish relative values, such action is not a violation of the antitrust laws or the Federal Trade Commission Act..

Please recall that it was stated in Dr. Rose's letter of November 14, 1977 that the right of the California Medical Association to continue to publish descriptors and code numbers is expressly preserved.

I fully appreciate your statement regarding the use of the RVS as a guideline for new or rare procedures, however, this was related to the FTC staff time and again, without any noticeable impact.

Lastly, I should point out that the legal advice given to the CMA Council was not solely mine. At the outset, I requested and received permission to bring in an outside consultant, the antitrust department of the San Francisco law firm of Pillsbury, Madison & Sutro. It was that firm's advice that CMA had little or no chance of winning in the Federal Courts, and that, accordingly, the agreement should be accepted.

With kindest personal regards, I am

Sincerely,

Howard Hassard

HH:cw
cc: Kash Rose, M.D.
Fred Ackerman, M.D.
Will Babb
Mike Jones
Dave Willett

APPENDIX E

CURRICULUM VITAE

Name: Benson B. Roe, M.D.

Title and Department: Professor of Surgery
University of California School of Medicine, San Francisco

Date of Birth: July 7, 1918

Place of Birth: Los Angeles, California

Education:

High School:		Palo Alto High School	1931-1935
University:		University of California, Berkeley	1935-1939
Medical School:		Harvard Medical School, Boston	1939-1943
Degrees:	A.B.	University of California	1939
	M.D.	Harvard University (cum laude)	1943

Postgraduate Training:

Internship: Massachusetts General Hospital, Boston — Mar. 1943-Oct. 1944

Residency training:

Assistant Resident, Massachusetts General Hospital — July 1946-Jan. 1950

Resident in General Surgery, Massachusetts General Hospital — Jan. 1950-Mar. 1951

Other training:

1) National Research Fellow, Department of Physiology, Harvard Medical School — 1948-1949
2) Mosley Traveling Fellowship, Harvard Medical School (These five months spent at University of Edinburgh.) — Nov. 1950-Mar. 1951

Board Certification:

1) American Board of Surgery - Diplomate 1950
2) American Board of Thoracic Surgery - Diplomate 1953

Appointments:

Professor of Surgery, University of California School of Medicine, San Francisco
Chief, Thoracic and Cardiac Surgery, University of California Medical Center
Consultant, Thoracic Surgery, Veterans Administration Hospital, San Francisco
Consultant, Cardiothoracic Surgery, San Francisco General Hospital

Professional Societies

Alpha Omega Alpha
American Surgical Association - Fellow
American Association for Thoracic Surgery
Chairman, Membership Committee
Representative to American Board of Thoracic Surgery
American Board of Surgery - Diplomate
✓ American Board of Thoracic Surgery - Diplomate
✓ Board of Directors
Examination Committee
Residency Review Committee
Special Programs Committee
American College of Cardiology - Fellow
American College of Surgeons - Fellow
Advisory Council for Thoracic Surgery
SESAP II Examination Committee
Past Councilor - Northern California Chapter
American Heart Association
Public Relations Committee, Committee on Grading Coronary Arteries
Executive Committee, Council on Cardiovascular Surgery
American Medical Association
Residency Review Committee for Thoracic Surgery
American Society for Artificial Internal Organs
Chilean Society of Cardiology
California Academy of Medicine - Past President and Council
California Medical Association
Committee on Cardiovascular Diseases
Committee on Relative Value Studies
Harvard Club of San Francisco - Board of Directors
Harvard Medical Alumni Association - President, Northern California Chapter
International Cardiovascular Society - North American Chapter ✓
Chairman, Membership Committee 1968
Pacific Coast Surgical Association
San Francisco Heart Association
Past President
Past Chairman, Bay Area Research Committee
San Francisco Surgical Society
Society of Thoracic Surgeons
✓ Past President and Vice President, 1972 and 1971
Council 1971 - 74
Program Committee 1969-71
Committee on Training, Standards and Ethics, 1973 -
Nominating Committee, 1974 - 1975
Society of University Surgeons
✓ Society of Vascular Surgery
✓ Past Vice President
Council
Western Society for Clinical Research
Annals of Thoracic Surgery, Editorial Board

Benson B. Roe, M.D.

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APPENDIX F

Biography

Frederick M. Binkley, M.D.
134 San Carlos Avenue
Sausalito, California 94965

Birth Date: March 29, 1924
Selma, California

Wife: Marian T. Binkley

Children: Terry Anne Binkley
Frederick M. Binkley, III
Sharon Jean Binkley

Education: M.A. University of California 1943
M.D. University of California Medical School 1946
Internship, Surgery, University of California Hospital 1945-1946
Assistant Resident, Surgery, University of California Hospital 1946-1948
Senior House Officer, Surgery, San Francisco General Hospital 1951-1952
Senior Assistant Resident, Surgery, University of California Hospital 1953-1954
Chief Resident, San Francisco General Hospital 1954
Chief Resident, University of California Hospital 1955

U.S. Army, Surgeon, Ft. Lawton Army Hospital 1949-1951

Asst. Clinical Professor of Surgery, University of California Hospital Medical School

Diplomate, American Board of Surgery 1956

Fellow, American College of Surgeons 1957

Member: San Francisco Surgical Society
Pacific Coast Surgical Association
Western Surgical Association
H. C. Naffziger Surgical Society, President 1973
Bay Area Vascular Surgical Society
American Medical Association
California Medical Association
San Francisco Medical Association

Chief Surgical Advisor, California Blue Shield, Medicare, Medi-Cal

California Medical Association, Relative Value Study Committee 1969, 1974
Chairman Cardiovascular Surgical Committee
Consultant, General Surgical Committee

National Champion, American Medical Golf Association 1968, 1971, 1974

Bibliography - attached

Hospital Affiliations: University of California
Children's Hospital
Ralph K. Davies, Franklin Medical Center
St. Joseph's Hospital
San Francisco General Hospital

APPENDIX G

August 26, 1977

Summary of Curriculum Vitae

Name: Walter Birnbaum

Date of Birth: July 1, 1906

Education:
-A.B., University of California, Berkeley
-M.D., University of California School of Medicine, San Francisco

Post-Doctoral Training:
=Surgical Residency Program, University of California Hospitals
=Chief Resident, San Francisco General Hospital
=St. Marks Hospital, London
=Temple University Hospital, Philadelphia

Military:
=Medical Corps, U.S.Army, 1941-1946
=Chief, General Surgical Section, Hoff General Hospital, Santa Barbara, Calif.
=Executive Officer, 30th General Hospital (University of California Affiliated Unit) European Theater of Operations.
=Chief, General Surgical Section, Dibble General Hospital, Palo Alto, Calif.
=Chief, Surgical Service, Regional Hospital, Riverside, Calif.
=Ranks: Captain to Lt. Colonel
=Honorary Reserve

University Service:
=Instructor to Emeritus Clinical Professor. Classes, graduate courses, committees, residency training,etc.

Public Service:
=Lectures, radio programs,etc. American Cancer Society
=Medical Division, Disaster Council
=Commissioner, Irwin Memorial Blood Bank
=Commonwealth Club of California

Scientific Societies:
=Fellow, American College of Surgeons
=Fellow, President, American Society Colon and Rectal Surgeons (formerly American Proctologic Society)
=Member, American Medical Association
=Member, California Medical Association

Summary, Curriculum Vitae. Dr. Birnbaum. (cont.)

=Member, San Francisco Medical Society.
Numerous committees. Delegate to California
Medical Society.
=Member, President, Northern California Society
Colon and Rectal Surgeons
=Member, Naffziger Surgical Society
=Member, California Academy of Medicine
=Director, President, Bureau of Medical Economics
= Councillor, California Public Health League
=Member, Pacific Coast Surgical Society
=Member, PanPacific Surgical Association
=Chairman, Section Colon and Rectal Surgery,
American Medical Association

Hospital Appointments:

*Chief of Medical Staff, Franklin Hospital,
Ralph K. Davies Medical Center
=University of California Hospitals
=Mary's Help Hospital
=Mt. Zion Hospital
=Children's Hospital
=Southern Pacific Hospital
=Consultant, Veterans Administration Hospital
=Lecturer, U.S.Naval Hospital, Oakland,Calif.

Board Certification:

American Board of Surgery

Bibliography:

About 20 published papers. Contribution to
two textbooks. Numerous papers given at local,
national and international levels.

Private Practice:

= Colon and Rectal Surgery, San Francisco, until
August 1, 1977.
= Now Medical Advisor, Blue Shield of California
(one day a week).

APPENDIX H

CURRICULUM VITAE - KENNETH G. CAMPBELL, M.D.

BORN: San Francisco, California
July 25, 1930

HIGH SCHOOL: Burlingame High School - 1947

COLLEGE: Stanford University - AB 1951

MEDICAL SCHOOL: Stanford Medical School - M.D. 1955

POSTGRADUATE TRAINING:

Internship: New York Hospital
Cornell Medical Center - 1955-56

General Surgery Residency - New York Hospital
Cornell Medical Center - 1956-57

Orthopedic Residency - University of Michigan Medical Center
1959-1962

In the practice of orthopedic surgery at the Palo Alto Medical Clinic
300 Homer Avenue
Palo Alto, Ca. From Aug. 1962 until present.

MILITARY SERVICE: Capt. U.S. Air Force
General Surgeon in Japan

MEDICAL ORGANIZATIONS:

American Academy of Orthopaedic Surgeons
Western Orthopaedic Association
Santa Clara Co. Medical Society
Santa Clara Valley Orthopedic Club

PRESENT COMMITTEE ASSIGNMENTS:

Palo Alto Medical Clinic: Member, Executive Board
Member, Business Affairs Committee
Member, Physical Therapy Committee
Chairman, Patient Education Committee
Chairman, Medical Legal Committee

Santa Clara Co. Medical Society: Member of the Finance Committee

American Academy of Orthopaedic Surgeons: Member of Regional XI Admissions. Committee.

APPENDIX I

CURRICULUM VITAE

RALPH WALKER SCHAFFARZICK, M. D.

Home: 2837 Rivera Drive, Burlingame, California 94010
Phone [redacted]

Office: Two North Point, San Francisco, California 94133
Phone 415/445-5420

Born in White Sulphur Springs, Montana - May 20, 1922

Education

Washington High School, Portland, Oregon; graduated 1939
Stanford University, California; A. B. 1943
Stanford University, California; M. D. 1946

Member of Faculty, Stanford University School of Medicine:

Instructor in Pharmacology and Therapeutics, 1948-1950
Assistant Clinical Professor in Pharmacology and Therapeutics, 1950-1957 (one-half time)
Associate Clinical Professor, Medicine, 1957 - present

Private Practice, Internal Medicine, San Francisco, 1950-1977

Military Service

United States Navy, Lieutenant Junior Grade, Medical Corps Reserve, 1945-1948
United States Naval Hospital, Shoemaker, California, 1945-1946
Regimental Surgeon, 11th Marines, Tientsin, China and Guam, 1946-1947
United States Naval Hospital, Oakland, California, 1948

Affiliations with Professional Organizations

1. San Francisco Medical Society, California and American Medical Associations
2. San Francisco, California and American Societies of Internal Medicine
3. Northern California and American Rheumatism Associations
4. Board of Directors, San Francisco Medical Society, 1966-1972

5. Delegate to California Medical Association, 1966-1976
6. Alternate Delegate to American Medical Association, 1968-1974
7. Associate Member, American College of Physicians
8. Board of Trustees, Saint Francis Memorial Hospital, San Francisco, 1965-1971 and 1972 to present

Involvement With Peer Review

Insurance Mediation Committee, San Francisco Medical Society,
Member, 1963-1967
Chairman, 1967 and 1968
Utilization Committee, Saint Francis Memorial Hospital, San Francisco,
Chairman, 1965-1967
Ad Hoc Committee on Hospital Utilization, San Francisco Medical Society,
Chairman, 1965-1966
Blue Shield of California
Medical Advisor, 1967-1969
Chief Medical Advisor, 1969-1972
Medical Director, 1972-1974
Senior Vice President and Medical Director, 1974 to present
Bureau of Health Insurance, Ad Hoc Committee Concerning Utilization,
(Chaired by Doctor Theodore Bedwell, Chief Medical Officer, BHI)
Member, 1969
National Association of Blue Shield Plans, Blue Shield Task Force, Guidelines of Care for Common Diagnosis,
Member, 1972

BLUE SHIELD OF CALIFORNIA

APPENDIX J

INTEROFFICE MEMORANDUM

To: Felix Brunner

Date: January 17, 1979

From: Chris Danko

Subject: California Physicians and Blue Shield of California
Member Physician Statistics

Attached is a listing as you requested of California physicians and Blue Shield of California member physicians divided into surgeon and non-surgeon category and then broken down into specialities of practice.

The data for the California physicians is from the most recent files that the CMA has. They in turn get their data from the AMA so they are the same figures reported by both organizations. This data represents only physicians that are involved in patient care (as opposed to teaching and research) as does the data on member physicians of Blue Shield of California which was obtained from our provider certification and profile department.

CD:ls
Attachment

cc: Michael Ganahl
Joseph Sevall

	Total California Physicians In-patient Care (12-31-76)	Blue Shield of California Physician Members (6-30-78)
Total Physicians	36,628	18,450
Total Non-surgeon	26,108	13,919
General Practice	6,405	4,805
Allergy	243	110
Dermatology	660	335
Cardiovascular	737	226
Internal Medicine	5,583	2,292
Pediatrics	2,322	1,224
Gastroenterology	221	62
Neurology	419	157
Anesthesiology	1,679	315
Pulmonary	200	89
Pathology	958	311
Psychiatry	3,096	2,328
Radiology	1,925	764
Physical Medicine and Rehabilitation	124	77
Other and Unspecified	1,536	824
Total Surgery	10,520	4,531
General Surgery	2,949	1,308
Otology, Laryngology	653	317
Neurological Surgery	365	124

OB-Gynecology	2,341	948
Orthopedic Surgery	1,549	581
Opthamology	1,273	682
Plastic Surgery	338	124
Urology	746	297
Thoracic Surgery	214	124
Colon/Rectal Surgery	92	26