Impact of the Medicare physician fee schedule

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Impact Of The Medicare Physician Fee Schedule
by David C. Colby

In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress reformed Medicare’s methodology for paying physicians with the adoption of the Medicare fee schedule. The previous methodology—customary, prevailing, and reasonable charges—based Medicare-allowed amounts on past payments for the service. This method created distortions and inequities in payments for different services and for the same service provided by different specialties and in different geographic areas. In contrast, the Medicare fee schedule rationalizes payments, basing them on the resource costs necessary to provide the service.

Thus, with the adoption of the Medicare fee schedule, the basis for physician payments shifted from charges to relative values that reflect resource costs. As shown by the simulations here, the fee schedule has significant redistributive effects on payments for individual services, for families of services, and for physicians in different specialties. This DataWatch describes and analyzes those effects.

Although previously published analyses predicted that the fee schedule would produce significant redistributive effects, these analyses were based on differing assumptions about payment policies and on incomplete information. For example, those analyses that were based on the earliest phase of the resource-based relative value scale (RBRVS) study used relative value units (RVUs) for only about 1,400 procedure codes, which represented about 67 percent of Medicare-allowed charges. In contrast, this analysis uses relative values for all covered physician services and incorporates the final payment rules.

With one exception, these simulations compare payments under the Medicare fee schedule with baseline payments under the customary, prevailing, and reasonable charge methodology in the same year. The baseline represents payments prior to the implementation of changes specified in OBRA 1989 and OBRA 1990. Since these changes were
early transitional steps toward the fee schedule, they are retained in the baseline. These changes include (1) reductions in payments for radiology, anesthesiology, pathology, and designated overvalued procedures, and (2) differential updates for primary care versus other services. Since future updates in the conversion factor (and therefore in payments for services) are unknown at this time, this analysis does not include them. The exception is in the simulations of the change from 1991 to 1992, which show the impact on payments for that year only. These simulations use estimated 1991 allowed charges as the baseline. Payments for 1992 reflect the fee update of 1.9 percent. This analysis compares payments that physicians are receiving from Medicare in 1992 with the actual rates they received in 1991.

These simulations will differ from those generated by the Health Care Financing Administration (HCFA) and the American Medical Association (AMA), for several reasons. First, the HCFA and AMA simulations have not included earlier legislative changes. As a result, the simulations in this DataWatch tend to indicate larger changes in relative payments. Also, these simulations assume no change in the behavior of physicians and beneficiaries in response to the fee schedule. No calculation is made for possible shifts in physician assignment rates or participation decisions, or for possible changes in the volume or mix of services. By contrast, HCFA assumes that volume and intensity will increase but that assignment and participation rates will stay the same. In these simulations internal medicine is divided into two categories, procedurally oriented and nonprocedurally oriented internists. What is reported in data files as services provided by internists includes those by general internists and those by some medical subspecialists. Some subspecialties of internal medicine are not recognized by HCFA, so physicians in those are listed as internists. For a few subspecialties that are recognized by HCFA (such as cardiology), some carriers nevertheless classify those physicians as internists. As a result, the category of internist is quite heterogeneous. To obtain a better sense of the implications of payment reform for general internists and for internists who perform specialized procedures, these simulations divide internists into two groups based on the services they provide.

Impact Of The Fee Schedule Transition

OBRA 1989 authorized a five-year transition to the fee schedule. Services with average local historical charges between 85 percent and 115 percent of the fee schedule payment amounts are paid at the fee schedule in 1992. Payments for other services will be a blend of histori-
cal charges and fee schedule amounts from 1992 through 1995, reaching the fee schedule level in 1996. The average historical charges in the transition period do not continue previous specialty differentials.

In 1992, the first year of the transition to the fee schedule, physicians will experience noticeable changes in their payments for services from Medicare. From 1991 to 1992 total payments to physicians will decline by 1.2 percent. This includes the 3 percent reduction that is due to the baseline adjustment and the 1.9 percent update. Exhibit 1 shows the breakdown of payments by specialty. In the first year, payments to family and general practitioners increase by 17 percent, while payments to most other specialties change by much smaller amounts. A large component of this increase for family and general practice results from complete elimination of specialty differentials in 1992.

The impact on individual practices may differ from the change reported for their specialties, with some practices experiencing significantly larger changes than reported for their specialty. The largest decline for a specialty is 9 percent, whereas 26 percent of all individual practices will experience decreases of more than 10 percent. While over

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**Exhibit 1**
Change In Medicare Payments, By Specialty, 1992 Payments Compared With 1991 Payments

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent change, 1991-1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Family/general practice</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>Internal medicine</td>
<td></td>
</tr>
<tr>
<td>Other medical</td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td></td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Other surgical</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Physician Payment Review Commission simulations, using 1988 Medicare Part B Annual Data (BMADI). Payments in 1992 include the 1.9 percent update.

**Note:** Medical specialty payments rose 3 percent; surgical specialty payments fell 4 percent; and radiology and pathology (RAPS) payments fell 9 percent.

*a* Medical specialty.

*b* Surgical specialty.
half of practices will experience changes (up or down) in payments of 10
percent or less in 1992, 11 percent will gain more than 20 percent, and
2 percent will lose more than 20 percent. A large proportion of general
and family practices will experience substantial increases in payments.
If OBRA 1989 and OBRA 1990 are seen as the beginning of the
transition to the fee schedule, 62 percent of the total change in payment
rates will be accomplished by 1992. After 1992 the remaining change
will be spread evenly over the next four years. Evaluation and manage-
ment services and other services will move toward the fee schedule at
fairly similar rates.

Impact Of Final Fee Schedule Payments On Selected Services

When fully implemented, the Medicare fee schedule will increase
payments substantially for some services and reduce payments for others,
compared with allowed charges (Exhibit 2). Payments for office visits
with an established patient will increase 32 percent, while payments for
subsequent hospital care visits will increase 25 percent. On the other
hand, payments for most of the listed surgical and diagnostic procedures
will decrease more than 25 percent.

Changes in payments for specific procedures occur because relative
charges for many procedures under customary, prevailing, and reason-
able payment are different from relative values under the Medicare fee
schedule. This can be shown by calculating ratios of allowed charges to
RVUs assigned under the fee schedule for different services. For example,
under the earlier methodology, physicians were paid $55 per RVU
for performing a coronary artery bypass graft but received $23 per RVU
for an intermediate office visit with an established patient. In contrast,
under the fee schedule, all services are paid at a rate of $31 per RVU in
1992. Additional insight into the pattern of changes in payment by
service can be gained by grouping the thousands of services into families
(Exhibit 3). While there are substantial increases in payments for
evaluation and management services, there are decreases in payments
for all other families of services.

Impact Of Fee Schedule On Specialties

Under the Medicare fee schedule, payments to groups of specialties
and specialists who largely provide evaluation and management services
will increase, and those to others will decrease (Exhibit 4). Payments to
medical specialties as a group will increase slightly, and payments to
surgical and hospital-based specialties will decrease significantly. Within
Exhibit 2
Change in Medicare Payments for Selected Procedures, Fully Implemented Medicare Fee Schedule Compared With Baseline

<table>
<thead>
<tr>
<th>Description</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management</td>
<td></td>
</tr>
<tr>
<td>Eye exam, established patient</td>
<td>32%</td>
</tr>
<tr>
<td>Office visit, new patient</td>
<td>49</td>
</tr>
<tr>
<td>Office visit, established patient</td>
<td>32</td>
</tr>
<tr>
<td>Initial hospital care</td>
<td>33</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>25</td>
</tr>
<tr>
<td>Office consultation</td>
<td>20</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>18</td>
</tr>
<tr>
<td>Follow-up inpatient consultation</td>
<td>31</td>
</tr>
<tr>
<td>Confirmatory consultation</td>
<td>10</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Total hip replacement</td>
<td>-30</td>
</tr>
<tr>
<td>Repair femur fracture</td>
<td>-13</td>
</tr>
<tr>
<td>Insertion of pacemaker</td>
<td>-47</td>
</tr>
<tr>
<td>Coronary artery bypass</td>
<td>-44</td>
</tr>
<tr>
<td>Partial removal of colon</td>
<td>-26</td>
</tr>
<tr>
<td>Repair inguinal hernia</td>
<td>-40</td>
</tr>
<tr>
<td>Transurethral prostatectomy</td>
<td>-30</td>
</tr>
<tr>
<td>Remove cataract, insert lens</td>
<td>-40</td>
</tr>
<tr>
<td>Diagnostic</td>
<td></td>
</tr>
<tr>
<td>Upper gastrointestinal endoscopy</td>
<td>-31</td>
</tr>
<tr>
<td>Diagnostic colonoscopy</td>
<td>-38</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>-3</td>
</tr>
<tr>
<td>Chest x-ray (global)</td>
<td>-4</td>
</tr>
<tr>
<td>Chest x-ray (professional component)</td>
<td>-27</td>
</tr>
<tr>
<td>Contrast computed tomography (CT) scan of head (global)</td>
<td>-15</td>
</tr>
<tr>
<td>Contrast CT scan of head (professional component)</td>
<td>-46</td>
</tr>
<tr>
<td>All services</td>
<td>-6.5</td>
</tr>
</tbody>
</table>


the category of medical specialties, those specialties that provide more procedures (for example, cardiology and gastroenterology) will have decreased payments. Those that provide predominantly evaluation and management services (for example, family practice and general practice) will have substantial increases.

This pattern holds even within internal medicine. When physicians identifying themselves as internists are divided into two groups based on the services that they provide, those who did not perform any specialized procedures will receive 16 percent more under the fee schedule than under customary, prevailing, and reasonable payment. In contrast, payments to procedurally oriented internists will remain about the same.
Exhibit 3
Change In Medicare Payments For Families Of Services, Fully Implemented Medicare Fee Schedule Compared With Baseline

<table>
<thead>
<tr>
<th>Evaluation and management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic procedures</td>
</tr>
<tr>
<td>Global surgical procedures</td>
</tr>
<tr>
<td>Pathology</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Therapeutic procedures</td>
</tr>
</tbody>
</table>


Exhibit 4
Change In Medicare Payments, By Specialty, Fully Implemented Medicare Fee Schedule Compared With Baseline

<table>
<thead>
<tr>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
</tr>
<tr>
<td>Family/general practice</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Internal medicine</td>
</tr>
<tr>
<td>Other medical</td>
</tr>
<tr>
<td>General surgery</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
</tr>
<tr>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Other surgical</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Pathology</td>
</tr>
</tbody>
</table>

Notes: Anesthesiology's change is calculated as the change in the conversion factor. Total payments to anesthesiologists were further reduced as a result of other provisions of the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990. Medical specialty payments rose 9 percent; surgical specialty payments fell 15 percent; radiology, anesthesiology, and pathology (RAPS) payments fell 28 percent.  
\( ^a \) medical specialty.  
\( ^b \) surgical specialty.
Effects within specialties. Within the same specialty, some practices will receive increased payments; others will receive decreases (Exhibit 5). This is true in varying degrees for all specialties. Whereas payments to family and general practices will rise on average, payments to about 6 percent of practices in those specialties will fall. Yet while general surgeons will lose revenue on average, about 23 percent of general surgical practices will gain revenue. These variations exist because of differences in the mix of services practices provide, their previous charges relative to those of their peers, and comparisons between local charges and payments adjusted by the geographic adjustment factor.

The impact of service-mix differences on a specialty is also demonstrated in the contrast between the two categories of internists. Compared with nonprocedurally oriented internists, a larger number of procedurally oriented internists will have losses. An example of the differential change within specialties associated with the geographic aspects of reform is that fewer than 1 percent of family and general

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent change in payments</th>
<th>Gain</th>
<th>Percent with gains</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loss 0-10 11-25 26-50 &gt;50</td>
<td>0-10 11-25 26-50 &gt;50</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>0%  2%  3%  5%</td>
<td>1%  2%  4%  5%</td>
<td></td>
</tr>
<tr>
<td>Family/general practice</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0%  0%  1%  2%</td>
<td>0%  0%  1%  2%</td>
<td></td>
</tr>
<tr>
<td>Internal medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonprocedurally oriented</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Procedurally oriented</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Other medical</td>
<td>0%  0%  1%  2%</td>
<td>0%  0%  1%  2%</td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>0%  1%  2%  3%</td>
<td>0%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>8%  1%  2%  3%</td>
<td>8%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>0%  0%  1%  2%</td>
<td>0%  0%  1%  2%</td>
<td></td>
</tr>
<tr>
<td>Other surgical</td>
<td>1%  2%  3%  4%</td>
<td>1%  2%  3%  4%</td>
<td></td>
</tr>
<tr>
<td>Radiology/pathology</td>
<td>1%  2%  3%  4%</td>
<td>1%  2%  3%  4%</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>0%  0%  1%  2%</td>
<td>0%  0%  1%  2%</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>5%  1%  2%  3%</td>
<td>5%  1%  2%  3%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1%  2%  3%  4%</td>
<td>1%  2%  3%  4%</td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>1%  2%  3%  4%</td>
<td>1%  2%  3%  4%</td>
<td></td>
</tr>
</tbody>
</table>

practices in rural areas will have losses, while nearly 9 percent in extremely large metropolitan areas (more than three million persons) will have losses.

Implications for geographic areas. Payments under the fee schedule are adjusted by the geographic adjustment factor so that payments for the same service reflect only differences in physicians’ costs of furnishing the service. The Medicare fee schedule will redistribute payments from urban to rural areas, especially those counties with the smallest populations (Exhibit 6). Most of the redistribution across geographic areas is due to the previous level of charges relative to national average charges and the geographic adjustment factor. Part is also attributable to the mix of services provided in an area. Rural counties, especially the smallest ones, have a higher proportion of evaluation and management services than urban areas do.

Within each geographic category, some practices will lose revenue, and others will gain (Exhibit 7). While the typical practice in the largest metropolitan areas will lose revenue under the fee schedule, about 43 percent will gain. By contrast, the typical practice in the small rural areas (those with populations of less than 25,000) will gain revenue, but about 17 percent will experience a decline in payments. This variation is due to differences in historical charges and the mix of services provided by physicians practicing within each type of area.

Understanding The Impact Of Payment Reform

The total impact of payment reform on a specialty is the sum of the impacts of three different aspects of payment reform—the elimination of

| Exhibit 6 |
| Change In Medicare Payments For Geographic Areas, Fully Implemented Medicare Fee Schedule Compared With Baseline |

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 3 million people(^a)</td>
<td></td>
</tr>
<tr>
<td>Between 1 and 3 million people(^a)</td>
<td></td>
</tr>
<tr>
<td>Under 1 million people(^a)</td>
<td></td>
</tr>
<tr>
<td>Over 25,000 people(^b)</td>
<td></td>
</tr>
<tr>
<td>Under 25,000 people(^b)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Metropolitan area.
\(^b\) Rural county.
### Exhibit 7
Distribution Of Physician Practices By Change In Payment, By Geographic Area, Fully Implemented Medicare Fee Schedule Compared With Baseline

<table>
<thead>
<tr>
<th>Area</th>
<th>Percent change in payment</th>
<th>Percent with gains</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;50</td>
<td>26–50</td>
</tr>
<tr>
<td>Metropolitan &gt;3 million</td>
<td>2%</td>
<td>18%</td>
</tr>
<tr>
<td>Metropolitan 1–3 million</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Metropolitan &lt;1 million</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Rural county &gt;25,000</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>Rural county &lt; 25,000</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>


specialty differentials, the relative value scale, and the geographic adjustment factor—and the baseline adjustment for volume changes. Since OBRA 1989 required that the Medicare fee schedule be implemented in a budget-neutral fashion, HCFA reduced the conversion

### Exhibit 8
Decomposition Of Medicare Fee Schedule Changes, By Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Baseline adjustment</th>
<th>Elimination of specialty differential</th>
<th>Geographic adjustment</th>
<th>Relative value scale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>-6.5%</td>
<td>0%</td>
<td>2%</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>-6.5</td>
<td>-3</td>
<td>-1</td>
<td>-10</td>
<td>-21</td>
</tr>
<tr>
<td>Family/general practice</td>
<td>-6.5</td>
<td>12</td>
<td>8</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>-6.5</td>
<td>-1</td>
<td>0</td>
<td>-11</td>
<td>-19</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>-6.5</td>
<td>-5</td>
<td>0</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Nonprocedurally oriented</td>
<td>-6.5</td>
<td>-5</td>
<td>-2</td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td>Procedurally oriented</td>
<td>-6.5</td>
<td>-6</td>
<td>3</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Other medical</td>
<td>-6.5</td>
<td>-4</td>
<td>-1</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>Surgical</td>
<td>-6.5</td>
<td>1</td>
<td>-1</td>
<td>-8</td>
<td>-15</td>
</tr>
<tr>
<td>General surgery</td>
<td>-6.5</td>
<td>2</td>
<td>0</td>
<td>-11</td>
<td>-14</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-6.5</td>
<td>-1</td>
<td>-2</td>
<td>-16</td>
<td>-25</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>-6.5</td>
<td>2</td>
<td>-5</td>
<td>-4</td>
<td>-14</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>-6.5</td>
<td>0</td>
<td>-3</td>
<td>-25</td>
<td>-35</td>
</tr>
<tr>
<td>Urology</td>
<td>-6.5</td>
<td>-1</td>
<td>0</td>
<td>0</td>
<td>-7</td>
</tr>
<tr>
<td>Other surgery</td>
<td>-6.5</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Radiology/pathology</td>
<td>-6.5</td>
<td>-1</td>
<td>-2</td>
<td>-17</td>
<td>-27</td>
</tr>
<tr>
<td>Radiology</td>
<td>-6.5</td>
<td>-2</td>
<td>-2</td>
<td>-17</td>
<td>-27</td>
</tr>
<tr>
<td>Pathology</td>
<td>-6.5</td>
<td>0</td>
<td>-3</td>
<td>-13</td>
<td>-23</td>
</tr>
<tr>
<td>Other</td>
<td>-6.5</td>
<td>-3</td>
<td>11</td>
<td>-3</td>
<td>-1</td>
</tr>
</tbody>
</table>

factor by 6.5 percent to offset projected volume increases.

Paying physicians in different specialties the same amount for the same service will increase payments for some specialties and decrease payments for others when there is significant overlap in the services provided by those specialties. Evaluation and management services are the most notable in this regard, since they are provided by physicians in most specialties. Therefore, the elimination of specialty differentials has the most pronounced effect on medical specialties. It results in higher payments for general and family practice physicians but lower payments for the other medical specialties (Exhibit 8). For most other specialties, this aspect of payment reform has only a small impact.

The geographic adjustment policy will affect specialties that are not evenly distributed across all locations. Thus, family and general practice physicians, who are more likely to be located in rural areas, will benefit from this policy, while most other specialties will experience slight decreases. Overall, the geographic adjustment is not a major factor in the redistribution of payments across specialties.

The third aspect of payment reform, the resource-based relative value scale, generates most of the change for nearly all specialties. Even for family and general practice physicians, a larger proportion of the change in payments is attributable to changes in the relative value scale than to the other factors.

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NOTES


3. Changes shown in this DataWatch are comparable to changes in the column entitled “payments per service” in the Final Rule, *Federal Register* (25 November 1991): 59612–59621.

4. Since providing some procedures requires that the physician have specialized training, the performance of one or more of these services likely indicates the type of practice. Therefore, those internists who performed at least one heart catheterization, angioplasty, pacemaker insertion, upper gastrointestinal endoscopy, colonoscopy, electroencephalogram, scan of extracranial arteries, bronchoscopy, cardiovascular imaging, thyroid imaging, pulmonary perfusion imaging, dialysis, cystourethroscopy, nerve conduction study, or electromyography were categorized as procedurally oriented internists. Other internists were identified as nonprocedurally oriented internists.

5. This transition applies to all services except radiology. OBRA 1990 provided that payments for those radiology services whose charges are between 85 percent and 109 percent (compared with 115 percent for other services) of the fee schedule be paid the fee schedule amount in 1991.

6. Since codes for visits were significantly revised for 1992, it is difficult to predict how physicians will use these new codes. Although simulations reported here are based on HCFA’s crosswalk, changes in payments will depend on the actual use of these codes.

7. For those interested in the payments for services not listed above, the national average payment can be calculated by multiplying the relative value units for the service (which are listed in the Final Rule) times the conversion factor.

8. Estimates of the impact of the fee schedule on specialties are subject to uncertainty because there may be changes in the volume and intensity of services provided. Major revisions in codes and the actual use of codes by physicians also will affect impact of the fee schedule on specialties. Estimates for changes in pathology, for example, are subject to more uncertainty than are those for other specialties because of major coding changes.