ALBERTA
MEDICAL
ASSOCIATION

A Physician's Guide to the Physician Compensation Committee and Individual Fee Review Process

December 2015

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APPENDICES

INTRODUCTION

The AMA Board of Directors asked for this document to provide physicians with an overview of the Physician Compensation Committee (PCC) Fee Review Process. This initiative has raised many questions about how PCC works and the decisions it has made. We hope you will find the answers to any questions that you may have in these pages.

If you have further questions or comments to share, please email us at:
president@albertadoctors.org

What is the role of the PCC?

The PCC was established via the 2011-18 AMA Agreement. Its role is defined within the AMA Agreement and many of its priorities are identified by the provincial strategic requirements established by Alberta Health (AH) in consultation with the Alberta Medical Association (AMA) and the Management Committee (see Appendix A). This includes without limitation:

- Aligning physician compensation with goals of delivery-based initiatives such as primary care, strategic clinical networks and alternative relationship plans (ARPs).
- Restructuring physician compensation to provide the optimal support to those delivery models which are selected to deliver health care in Alberta.

Within this role, the Agreement directed PCC to manage all elements of physician compensation, plans and programs (excepting grant programs), including:

- Allocation.
- Reviewing and managing the distribution of funding among insured medical services, plans and programs.
- Reviewing and potentially adjusting selected rates for insured medical services and ARP rates, including those for the clinical medical services component of academic alternative relationship plans (AARPs).
- Reviewing and determining prices for Rural, Remote, Northern Program (RRNP), Physician On-Call Program (POCP) and Business Costs Program (BCP).
- Reviewing and recommending changes to RRNP, POCP and BCP.

Included in the above list of PCC tasks is the job of reviewing and potentially adjusting rates for a small number of insured medical services and ARP clinical services. This document explains in detail (i) how PCC operates and (ii) how the PCC Individual Fee Review has been conducted.

How does PCC operate?

What are the rules for PCC?

The AMA Agreement established certain rules for the PCC with respect to any fee adjustments the committee might recommend in the course of its various activities and including the Fee Review:

- Any fee adjustments that the PCC might make must be expenditure neutral. For example, if a fee adjustment results in an expenditure reduction in the physician budget, then the amount of that reduction must be returned to the physician budget through a reallocation. However, the value of the expenditure reduction need not necessarily be reallocated within the same area (e.g., a section) where the reduction was realized; the funds could be returned anywhere within the budget that the PCC directs.
- The PCC has no jurisdiction over prices, etc., related to physician support and physician assistance programs managed through grant agreements between Alberta Health (AH) and AMA.
- AH maintains responsibility for setting annual budgets and defining what is or is not an insured medical service.

How are decisions made – and by whom?

The two parties to the AMA Agreement, AMA and AH, each hold one vote. An independent chair, chosen by mutual agreement, holds a third vote. AMA and AH each designate three members and by mutual agreement, have agreed to designate an additional support person. The current members are:

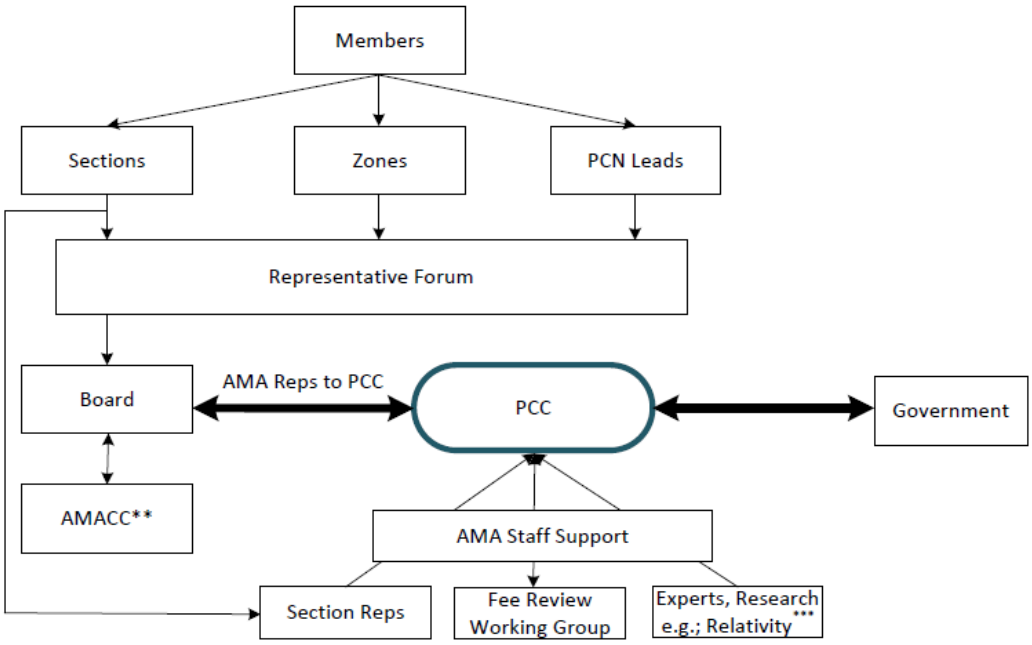
Mr. Chris Sheard, Chair
Dr. Gerry Keifer, AMA
Dr. Linda Slocombe, AMA
Mr. Jim Huston, AMA (staff)
Mr. Allan Florizone, AMA (support)
Mr. Bernard Anderson, AH
Ms. Maryna Korchagina, AH
Mr. Chris Sargent, AH
Ms. Ashley Stacewicz, AH (support)

How does the AMA participate in PCC?

The AMA is a party to the PCC under the Agreement. We do not control decision-making there, which is achieved by voting. A number of groups within the AMA contribute to what is said at the table on behalf of the AMA:

- **Representative Forum (RF)**
  - Provides broad policy direction to the AMA Board of Directors.
  - Brings forward concerns from membership and provides section and zonal feedback.
- **AMA board**
  - Develops a policy framework and provides general direction to PCC representatives.
  - Receives regular reports from PCC representatives.
  - Ensures decisions are consistent with AMA compensation strategy.
- **AMA committees**
  - Provide feedback and advice to AMA representatives on PCC.
- **AMA representatives to PCC**
  - Represent the interests of the medical profession and the board in PCC decision making.
  - Make decisions/proposals to PCC within confines of a policy framework.
  - Seek direction from board and report regularly to the board, RF and AMA committees.
- **AMA staff**
  - Provide analytical support to AMA representatives on PCC.
  - Assist in reporting PCC activities and seeking input from committees, board and RF.

The graphic below shows what this looks like in practice, e.g., in the current PCC Individual Fee Review process.



The next section of this document explains the process that PCC has followed during the Individual Fee Review.

PCC Individual Fee Review

The Individual Fee Review is a PCC initiative to address over-valued or under-valued fees. It was identified as part of the Provincial Strategic Requirements (PCC work plan) in 2013 and work progressed over 2014 and 2015.

From the AMA perspective, the review was intended to promote (but not yet achieve) fee relativity.

Under the PCC's terms (governed by the AMA Agreement), any changes to fees are to be revenue-neutral (reductions must be matched by increases elsewhere in the physician services budget).

Direction and feedback provided by the AMA Board of Directors to the AMA representatives on PCC helped establish the Individual Fee Review fundamentals, process and criteria.

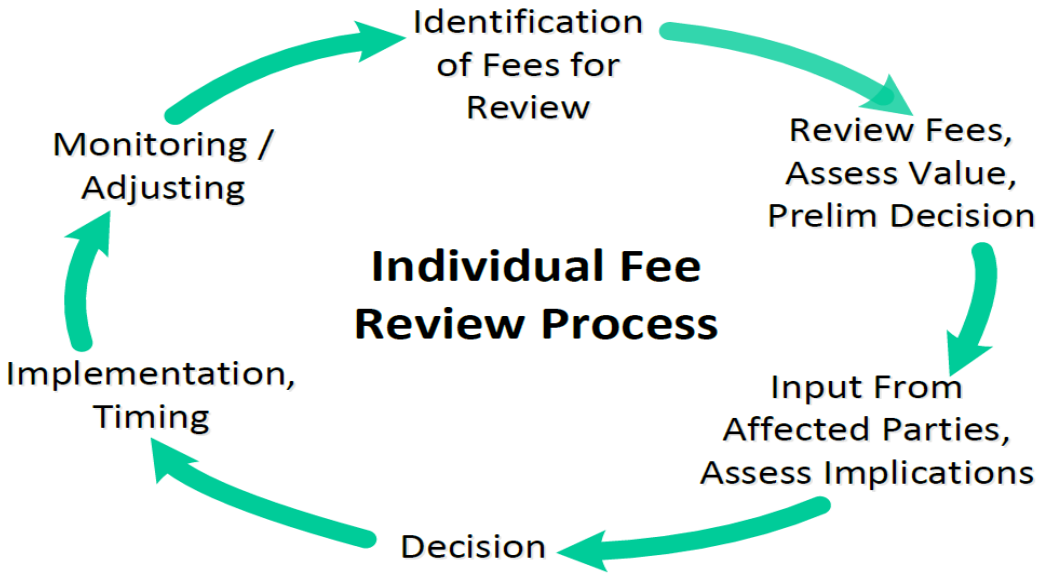
Individual Fee Review Fundamentals

The PCC established several fundamentals to guide the Individual Fee Review exercise:

- A well-defined process should be developed and communicated by PCC.
- Criteria for review should guide the fee selection process. These criteria will be established by the PCC.
- Input is to be provided by stakeholders; impacted sections should have an opportunity to provide input.
- The PCC should demonstrate legitimacy by articulating what the PCC will do, as well as how it will do it and the rationale for any decisions.
- The PCC should demonstrate credibility by using an informed process, researching and building knowledge, and involving experts to make a decision using best available information.
- The process should be transparent with clear communication lines.

Individual Fee Review Process

PCC identified a six-step process for the Individual Fee Review. These are outlined below:



1. **The identification of fees for review** ***(complete as of November 2015)***

   - Given the criteria, the PCC will give consideration to how fees will be identified for the fee review process.
   - A working group is identified for this purpose. The group will need to determine support required, e.g., analytical, economic, research, clinical expertise, section representation.
   - The group will present a final set of fees for review for approval by the PCC.
   - Initially, the Individual Fee Review process would focus more on outliers and over time, with repeated cycles, could look more like the American fee review process as we further develop policy around fees.

2. **Review fees, assess value and preliminary decision** ***(complete as of November 2015)***

   - Following the gathering of the information referred to above, the PCC will consider whether it will make a preliminary decision to change the fee associated with the identified code. In doing so, it will give consideration to, among other things, the relative valuation methodologies, considerations, and decisions made by the AMA section related to the identified code. The PCC may assign the valuation to a working group.
   - Once the metrics for assessing fees are developed, these metrics should be communicated broadly.
   - A substantial amount of information will be required. Health economists with

experience in fee relativity exercises should be engaged.

- A draft set of rates will then be approved by PCC for presentation to affected groups.
- A preliminary decision will be made by PCC on the fees for review including an assessed value.

3. Input from all parties ***(in process as of November 2015)***

- Appropriate input and due process.
- The PCC needs to determine how it will receive input from interested/affected groups (e.g., specialty sections or physician sub-groups – physicians feel strongly about this – resolution at RF passed).
- The PCC will discuss proposals with affected sections or sub-groups and consider changes.
- The PCC will consider the potential impact that a fee change may have such as access, and will consider market implications for recruitment/retention purposes.

4. Decision

PCC will have the final decision on which fees will be adjusted and by how much.

5. Implementation timing

- Will occur, ideally in sync with allocation cycles to minimize implementation challenges.
- Will consider phasing implementation over time to mitigate and allow for practice change planning.
- Will occur with consideration given toward the changes recommended by the section for April 1 adjustments and future years (e.g., including INRV analysis).

6. Monitoring/Adjusting

- The PCC will monitor changes made and consider future amendments.

Once a fee review cycle is completed, it is anticipated that a new cycle would begin.

Individual Fee Review Criteria

The intent of selecting codes for review should address both those that are over-valued as well as under-valued. In order to assess which codes are going to be reviewed, the PCC adopted the following five criteria:

1. **Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work.**

    - May include codes with the fastest growth (or decline) in terms of utilization (e.g., greater than 10% per year over three years).
    - May include codes where the patient demographic has changed (e.g., to be more [or less] complex).
    - May include codes identified for changes to physician work through consultation with sections or through the consultation groups: the Provincial EMR Strategy Consultation Agreement; the Primary Medical Care/Primary Care Networks Consultation Agreement; and the System-Wide Efficiencies and Savings Consultation Agreement.

2. **Codes that have undergone substantial changes (up or down) in practice expenses.**

    - May include, for example, codes that contain bundled payments (including overhead) where the typical model of practice (>50%) is in a facility.
    - May include codes that are intended for procedures where technology requirements have changed.
    - May include examples where a procedure has been moved out of AHS facilities into the community.

3. **Evidence technology has changed physician work.**

    - May include codes where technology has changed and, as a result, the time to perform the service has changed.
    - May include codes that have been recently established for new technologies or services.
    - Important to consider relative impact on the code where time is reduced but overhead is increased.

4. **Data analysis on time and effort (intensity or complexity) measures.**

    - May include all codes with historic time allotments (>8 hours).
    - May include codes that have seen recent changes in time, intensity or complexity.

5. **Utilization extremes.**

    - May include codes that are often used.

- May include codes that lead to billing outliers within a section or within the profession.
- May include situations where individual codes have multiple layers of billing potential.
- May include situations where individual codes are seldom, if ever used or could easily be provided within an equivalent existing code.
- May include codes that may be used for the same or similar service but are valued differently across multiple sections, e.g., hospital visits.

The first year/round of the review focused on #5, identification of utilization extremes. A working group was appointed by the PCC to develop a methodology to identify codes that created billing outliers within sections. The working group studied health service code (HSC)/provider role combinations based on utilization and pricing from 2012-13 fee-for-service (FFS) physician claims. The analysis concentrated on procedural codes for higher expenditure services. The analysis also concentrated on pure FFS physicians. Physicians with annual claims in more than one specialty were assigned to the specialty in which they have the highest annual claims.

Applying Filters

All Schedule of Medical Benefits (SOMB) fees, with the exception of visit services and after-hours payments, were run through **three distinct filter screens identified by the working group**:

➡ **Filter Screen 1: HSCs with different claims' shares on high-claim outlier days**

This screen identified HSC/provider role combinations with significantly different percentages of claims on high-claim outlier days. Definitions and assumptions used for this analysis were as follows:

- A high-claim outlier day was defined as a day with claims greater than either three times (or $10,000 over) the average daily claims for the section. Overall, 2.1% of days were identified as high billing outliers.
- HSC with significantly different percentages were identified as HSC/provider role combinations where absolute difference in the percentage of section total claims varies by more than 2% between high-claim and all days.
- After-hours time premiums (03.01AA) and time surcharges were removed from the claims data to focus on service basket rather than time when the services were performed.
- All days with less than $1,000 in claims (net of above time premiums/surcharges) were excluded as these were not considered to be full-time days.

136 unique HSC/provider role combinations were identified. Several of these HSCs were identified in multiple sections.

➡ **Filter Screen 2: Top HSCs for highest-billing physicians in each section**

This screen identified the two HSC/provider role combinations with the highest claims for physicians claiming more than twice the average annual claims for pure FFS physicians in their section. Assumptions used for this analysis were as follows:

- Although not conclusive, physicians with high claims may be billing relatively over-valued HSCs.
- In order to capture an appropriate annual billing amount for a full-time physician, all physicians with annual claims <= $150,000 were excluded in the calculation of the average annual claim.
- HSC for physicians with <= $700,000 in annual claims were not included even if these physicians claim more than twice their section average.

There were 213 physicians identified within this relatively high-billing group for which 79 unique fee code/provider role combinations were also identified.

➡ **Filter Screen 3: Top 5 HSCs on high-claim days**

This screen identified the five HSC/provider role combinations with the highest FFS expenditures on days where FFS claims were at least double the section's daily average. Assumptions used for this analysis were as follows:

- After-hours time premiums (03.01AA) and time surcharges were removed from the claims data to focus on service basket rather than time when the services were performed.
- All days with less than $500 in FFS claims were excluded from the analysis as these were considered non-typical.
- All visit codes and codes with less than $100,000 in annual FFS billings were excluded.

There were 83 unique HSC/provider role combinations found. Several of these HSCs were identified in multiple sections.

Combining Screens

The three screens were combined and each fee code that appears on all three screens was identified. The resulting 22 HSC/provider role combinations were owned or co-owned by 13 economic sections.

The codes are identified in the table below.

Table 1: Codes Identified for Individual Fee Review

HSC	Description	Owner	Second Owner
16.91G	Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient	ANES 100%	
01.01A	Sinus endoscopy	OTOL 97%	
01.22	Other nonoperative colonoscopy	GAST 53%	GNSG 32%
03.38C	Other nonoperative respiratory measurements {Spirometry}	RSMD 69%	
03.38F	Other nonoperative respiratory measurements {Flow-volume loop measurement before and after bronchodilator only, technical}	RSMD 76%	
03.41A	Cardiovascular stress test using treadmill {Maximal stress electrocardiogram, technical only}	INMD 46%	CARD 43%
03.41C	Cardiovascular stress test using treadmill {Continuous, personal physician monitoring}	INMD 48%	CARD 47%
09.13F	Ultrasound study of eye {Optical coherence tomography, technical}	OPHT 100%	
13.59J	Injection with local anaesthetic of myofascial trigger points	GP 93%	
16.89D	Percutaneous facet joint injection - Lumbar/Sacral	DIRD 70%	
27.72	Insertion of intraocular lens prosthesis with cataract extraction, one-stage	OPHT 100%	
28.79B	Other operations on vitreous {Injection or aspiration of vitreous cavity for purposes of diagnosis or drug delivery}	OPHT 100%	
98.51A	Flap or pedicle graft, unqualified {Major flap of single tissue (e.g. fasciocutaneous or muscle) with axial blood supply}	PLAS 70%	
98.51B	Flap or pedicle graft, unqualified {Composite compound flap using two or more of the following: skin, muscle, bone: with axial blood supply}	PLAS 64%	
98.89E	Skin test, airborne allergens, intradermal or prick, per test	INMD 58%	
98.99D	Other operations on skin and subcutaneous tissue NEC {Initial cut, including debulking} <Moh's microscopically controlled excision>	DERM 91%	
98.99F	Other operations on skin and subcutaneous tissue NEC {Special overhead and technical component, additional benefit} <Moh's microscopically controlled excision>	DERM 91%	
X107A	Fluoroscopy performed by a radiologist during special diagnostic or therapeutic procedures, including biopsy, endoscopy, intubation, pacemaker insertion and bougienage, etc.	DIRD 85%	
X171	Thallium myocardial perfusion imaging (rest and exercise)	DIRD 63%	CARD 37%
X306	Ultrasound, heart, echocardiogram, complete study	CARD 60%	DIRD 36%
X319	Ultrasound, obstetrical, first trimester/early fetal screening	DIRD 62%	OBGY 38%
X320	Ultrasound, obstetrical, second or third trimester, general fetal assessment	DIRD 73%	

Limitations and Considerations for Next Steps

There were some data limitations and next steps identified by the working group:

- All data used for the analysis were from 2012-13.
- Fees for some of the identified HSCs had already been reduced by the relevant AMA section in Allocation 2014.
- In previous allocations (prior to Apr 2014), there had been rules in place to constrain fee adjustments, thus slowing relative value alignment within sections.
- It was considered important to align PCC recommendations with changes that occurred in Allocation 2014 [and 2015] as well as most recent INRVs.
- For a variety of reasons, visit codes and alternative payment plans were excluded from the analysis performed and were recommended for further review.
- The service code identification methodology needed to be evaluated for future phases of the Individual Fee Review process.

Section Presentations (August-November 2014)

Following the identification of the 22 codes, affected sections were asked to present further information to the PCC regarding their current fees. To help guide the presentation, they were asked to provide the following:

1. A description of the procedure, any equipment used and the standard methods used to conduct the procedure.
2. A description of the standard of care applicable to the procedure.
3. Changes in the way the procedure was conducted that had occurred over time or with new technology.
4. The relative value assigned to the HSC, the methodology used to arrive at the relative value assigned and changes in relative value over time, if any.
5. Any other matter the section wished the PCC to know about the HSC.

Sessions were scheduled between August and November of 2014. PCC members were impressed by the general thoroughness and preparedness of the presentations.

Of the original list of 22 codes, 11 codes were removed from the review following consideration of section presentations. These codes included:

HSC	Description	Why Removed
16.91G	Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient	$16.25 fee per 5 minutes not considered overvalued ($168/hr after 14% overhead costs removed)
01.22	Other nonoperative colonoscopy	Not considered overvalued after removing 30% overhead costs and considering section estimate of 45 minutes. Fee in line with other provinces
03.38C	Other nonoperative respiratory measurements {Spirometry}	PCC satisfied with section's reported costs associated with this technical fee
03.38F	Other nonoperative respiratory measurements {Flow-volume loop measurement before and after bronchodilator only, technical}	PCC satisfied with section's reported costs associated with this technical fee
03.41A	Cardiovascular stress test using treadmill {Maximal stress electrocardiogram, technical only}	PCC satisfied with section's reported costs associated with this technical fee
03.41C	Cardiovascular stress test using treadmill {Continuous, personal physician monitoring}	Fee of $61.09 appeared not overvalued based on Cardiology and IM time estimates (30 mins) for procedure (low even if time estimates off).
09.13F	Ultrasound study of eye {Optical coherence tomography, technical}	$20 fee considered to be in line with other provinces
13.59J	Injection with local anaesthetic of myofascial trigger points	Appeared to be a single physician problem (potential audit issue) Section INRV at $12.57 (1/2 current rate). Section was constrained in moving to full functional INRV (10%/yr)
98.51A	Flap or pedicle graft, unqualified {Major flap of single tissue (e.g. fasciocutaneous or muscle) with axial blood supply}	PCC satisfied that $741.68 fee not overvalued given 135 minute time estimate and 45% overhead cost
98.51B	Flap or pedicle graft, unqualified {Composite compound flap using two or more of the following: skin, muscle, bone: with axial blood supply}	PCC satisfied that $1175.98 fee not overvalued given 270 minute time estimate and 45% overhead cost
98.89E	Skin test, airborne allergens, intradermal or prick, per test	PCC satisfied that $2.17 fee not overvalued after accepting section's overhead estimate of 87 cents
98.99F	Other operations on skin and subcutaneous tissue NEC {Special overhead and technical component, additional benefit} <Moh's microscopically controlled excision>	PCC satisfied with section's reported costs associated with this technical fee

Development of Fee Valuation Methodology (December 2014-August 2015)

Development of the valuation methodology occurred over the subsequent eight-month period. Several iterations of the methodology were considered and refined based on feedback received from the AMA board, AMACC, PCC and the RF. Appendix H contains a timeline of these consultations.

At the Spring 2015 RF meeting, the AMA's PCC representatives enunciated the following objectives:

The PCC should:

1. Continue to pursue judicious, objective and unbiased process to validate fees.
2. Communicate frequently with physicians regarding process and results.
3. Make decisions based on best available information.
4. Recognize estimates not perfect and establish thresholds based on confidence in numbers.
5. Foster transparency by fully communicating rationale behind decisions.
6. Carefully implement to avoid unintended consequences.
7. Be open to constructive criticism and flexible to make adjustments/improvements over time.

PCC representatives also indicated there was also an obligation to "do something." The AMA Agreement and the Provincial Strategic Requirements identified the need to demonstrate progress on modernization of the fee schedule, and there were potentially very serious consequences of not acting (e.g., future imposition of fee cuts by government, unmet expectations among members who want action on overpaid fees, etc.).

The following methodology was ultimately adopted by the PCC:

1. An average payment rate per hour, net of overhead, for all physicians (the "reference rate") was determined as follows:

    a. Average daily billings for typical days of all physicians, net of overhead. For 2015, this worked out to $170.86 per hour, based upon an analysis of all physician claims for the 2013-14 year, adjusted for 2014 and 2015 fee increases. See Appendix B for a detailed explanation of the reference rate calculation.
    b. An average physician work day was considered to be eight hours.
    c. An average physician intensity/complexity/education ratio was considered to be 1.0.
    d. Average overhead costs were determined by the Physician Business Costs Model. An explanation of the Business Costs Model is provided in Appendix D.

2. For any fee, the reference rate was adjusted as follows:

    a. Multiply by the intensity factor (0.8 – 1.6) of the code of interest
    b. Multiply by complexity factor (0.78 – 1.65)
    c. Multiply by the time it takes to perform

3. All multipliers were based on the judgement of PCC after collecting and reviewing best available information, including information provided by affected and unaffected sections, and literature regarding other provincial and international experiences.

4. Time represents the average amount of physician time estimated to perform the procedure. Depending on the procedure or service, this may or may not include pre and post follow-up. In some cases, time estimates were validated against daily claims data. This approach worked better in circumstances where daily billings were restricted to one or two codes under review. An example of this analysis is provided in Appendix E. Data was also validated against American Medical Association estimates (recognizing that fees are not always directly comparable, as they may contain different levels of pre- and post-operative care, etc.). Appendix F contains a brief explanation of the American Medical Association (Medicare) approach and provides a sample of the data that the PCC reviewed.

5. Intensity was associated with the stress of performing a procedure or service due to potential risk to a patient. For example, some factors considered were:

    a. Invasive vs. non-invasive
    b. Exposure of vital organs
    c. Risk of hemorrhage
    d. Risk of airway compromise

6. Complexity of a procedure or service was the degree of complicated interrelationships that must be mastered to complete the procedure or service successfully. Some factors considered:

    a. Additional skill sets required
    b. Exceptional mental effort
    c. Judgement
    d. Experience and education

Based upon the above noted methodology, the PCC made its preliminary decision to value each code as follows:

				Factors							
a	b	c	d	e	f	g	h	i	j	k	l
	Fee Code	2015/16 Price (fee) per Procedure	Reference Code Provincial Hourly Rate Net of OH	Physician Time to Perform Procedure (Mins)	* Intensity Factor 1,2,3,4,5 (0.8-1.6)	** Complexity Factor 1,2,3,4,5 (0.78-1.65)	*** PBCM Estimate % Overhead Cost per Section or Modality	Professional Fee Component	PBCM Estimate Overhead Fee Component	Preliminary Decision Valuation	Prelim Suggested Action
Cardiology											
X306 (owner 1)		250.31	170.86	15.0	1.00	1.21	40%	51.77	99.25	151.02	Amend
X171 (owner 2)		445.13	170.86	35.0	1.00	1.00	89%	99.67	396.17	495.83	No change
Dermatology											
98.99D		306.32	170.86	90.0	1.20	1.43	0%	439.18	-	439.18	No change
Obstetrics & Gynecology											
X319 (owner 2)		202.83	170.86	30.0	1.00	1.21	77%	103.37	156.18	259.55	No change
Ophthalmology											
27.72A		482.36	170.86	30.0	1.20	1.21	25%	124.25	120.84	245.09	Amend
28.79B		147.78	170.86	10.0	1.20	1.00	38%	34.17	56.01	90.18	Amend
Otolaryngology											
01.01A		83.82	170.86	15.0	1.00	1.00	31%	42.72	25.98	68.70	Amend
Radiology											
16.89D		104.82	170.86	20.0	1.00	1.21	57%	68.91	59.75	128.66	No change
X107A		250.52	170.86	17.5	1.00	1.21	44%	60.40	110.87	171.27	Amend
X171 (owner 1)		445.13	170.86	35.0	1.00	1.00	89%	99.67	396.17	495.83	No change
X306 (owner 2)		250.31	170.86	15.0	1.00	1.21	40%	51.77	99.25	151.02	Amend
X319 (owner 1)		202.83	170.86	30.0	1.00	1.21	77%	103.37	156.18	259.55	No change
X320		154.77	170.86	10.0	1.00	1.21	44%	34.51	68.49	103.01	Amend

* The intensity factor is applied as follows: 1 (80%), 2 (100%), 3 (120%), 4 (140%), 5 (160%)

** The complexity factor is applied as follows: 1 (78.4%), 2 (100%), 3 (121.2%), 4 (142.8%), 5 (164.8%)

*** For Radiology, the PBCM estimated on average 44% of total claims are overhead. Based upon information presented by Radiology overhead expenditures are higher in certain modalities. The overheads have been adjusted to reflect these exceptional expenses (see 57% 89%, and 77%). Similar adjustments were also made for Otolaryngology and Retinal Surgery (see 31% and 38%).

Next Steps in Fee Review

As was stated above, the PCC is only partway through the Individual Fee Review process. Next steps will include:

Gathering input from affected parties

Sections have been provided an opportunity to comment on the valuation from the perspective of the expected impact to their sections and the delivery of services in Alberta. The PCC held informal workshops with sections throughout October and November, and sections formally presented their cases to the PCC in late November and mid-December. Sections of Ophthalmology (including Retinal Surgery), Otolaryngology, Cardiology and Diagnostic Imaging are currently working with AMA staff to refine overhead cost estimates for the consideration of PCC in late January.

Decision

After hearing from sections, the PCC will make a final decision regarding which fees will be

adjusted and by how much. Decisions will be made by majority vote (i.e., 1 for AMA, 1 for AH, and 1 for the Chair). In rendering its decision, the PCC will be guided by the following set of principles and factors:

a. **Equity:** Fees should be valued in an objective and consistent way using factors such as time, intensity, complexity and the costs of providing a service. Relativity in this context should be considered at both an intra-sectional level (compared to other fees in the same specialty) and an inter-sectional level (compared to fees paid in other specialties).

b. **Quality of care:** Fees should support quality care for Albertans, where possible reflecting best practice and supporting an appropriate level of medical service to patients with health system improvement as an overall intent. Furthermore, the assessment of a fee should consider any potential of adversely impacting patient care or health outcomes.

c. **Access to care:** Fees should support timely access to care for Albertans, ensuring:
    - An appropriate number and mix of physicians by specialty (include general/family practice) and geography.
    - An appropriate level of services to ensure that Albertans can access care in the province without unduly long waiting times.

d. **Strategic health system goals:** Fees should align with strategic health system goals such as:
    - Better health for Albertans, by working to create the social and economic conditions for good health, to prevent people from becoming ill and stay as healthy as they can be.
    - Better experiences for Albertans, by making sure the care that they receive is available to them in a way that is respectful and responsive to their needs and expectations.
    - Better quality of care, by making sure health interventions are evidence-based, cost effective and safe to ensure Albertans experience the best care outcomes possible.
    - Better value for investment, so that the health system has the resources needed to meet Albertan's present and future health needs.
    - Effective stewardship of the health system by setting strategic directions, monitoring performance, establishing standards, providing funding and supporting research.

e. **Productivity:** Fee should support efficiency and cost effectiveness in the use of physician time and skills.

f. **Zero sum game (financially):** Any adjustments in fees are to be expenditure neutral and, therefore, all savings and/or reductions arising from or through the individual fee review cannot be transferred or used outside of the physician services budget.

g. **Simple/transparent:** Fee codes and the rules around billing them should be as simple, consistent and transparent as possible, to minimize physician billing errors and Alberta Health audit issues.

h. **Market and benchmarking:** Fees should be valued in a way that considers national and international benchmarking, balancing our concerns for inter-provincial relativity and Alberta's ability to recruit and retain physicians.

Implementation timing

The PCC will consider phasing implementation over time to mitigate any potential unintended consequences and allow for practice change planning.

Monitoring

The PCC will monitor changes to help avoid any potential unintended consequences and will consider future amendments if necessary.

Feedback Received

The AMA and PCC have received a significant amount of negative feedback from affected physicians and sections following the publication of the initial valuation. See Appendix G for all PCC-related resolutions from Fall 2015 RF. See Appendix H for the Individual Fee Review communications timeline.

Feedback can be summarized as follows:

1. PCC processes and methodology are not transparent (RF15F-07, RF15F-10, joint letter from sections).
2. PCC appeared to ignore information presented (joint letter).
3. Overhead figures are incorrect (RF15F-06, RF15F-15, joint letter).
4. The hourly base rate is inappropriate (RF15F-12).
5. Fee reductions will negatively impact intra-sectional relativity (RF15-F11, joint letter).
6. Fee reductions will negatively impact patient access (joint letter).
7. Fee reductions will negatively impact competitiveness with other jurisdictions (joint letter).
8. Fee Review Methodology should be approved by the AMA Representative Forum (RF15F-04, RF15F-05).
9. AMA representatives to PCC not sufficiently representative of, and accountable to, board and membership (RF15F-08, joint letter).
10. Fee reductions should be carefully monitored for adverse effects (RF15F-09, RF15F-14).

Appendix A – Provincial Strategic Requirements provided to PCC

1. PCC will determine appropriate rates to be paid to physicians in new compensation models that are developed by the parties and approved by the Ministry.

2. Complete a relative value guide review process that results in fee relativity between sections of medicine in Alberta. This process will consider evidence external to Alberta and include a focus on improved patient care, patient outcomes, and to the changing needs and circumstances in Alberta.

3. Develop a fees review process that can identify and address necessary changes in existing codes. This would address codes that are found to be over-priced and those that are under-valued. Criteria to be used by PCC to select which codes to review will take into account evidence of changes in physician work, codes that have undergone changes in practice expenses, evidence that technology has changed physician work, data analysis on time and effort measures and utilization extremes.

4. Enhance the physician business costs/overhead model by reviewing physician expenditures in both hospital and community settings. This will include the examination of splitting out compensation for overhead and professional services.

5. Redevelopment of the AARP clinical draw rates.

6. When necessary and appropriate, establish rates for identified new codes approved to facilitate innovative physician access and communications (e.g., e-codes).

7. Unbundle pre-and post-operative care from surgical rate.

8. Redevelop rules and rates for minor surgical procedures and visits provided for the same encounter and carried out in physician offices.

Appendix B – Fee Review: Hourly (reference) rate calculation

The PCC has determined an average hourly net physician billing rate with data from the physician claims database using a five-step approach. This approach is described below and shown graphically in Figure 1 (next page):

1. Total physician claims (FFS and ARP for all sections) are projected to 2015-16 using historical claims data and the negotiated fee increases.

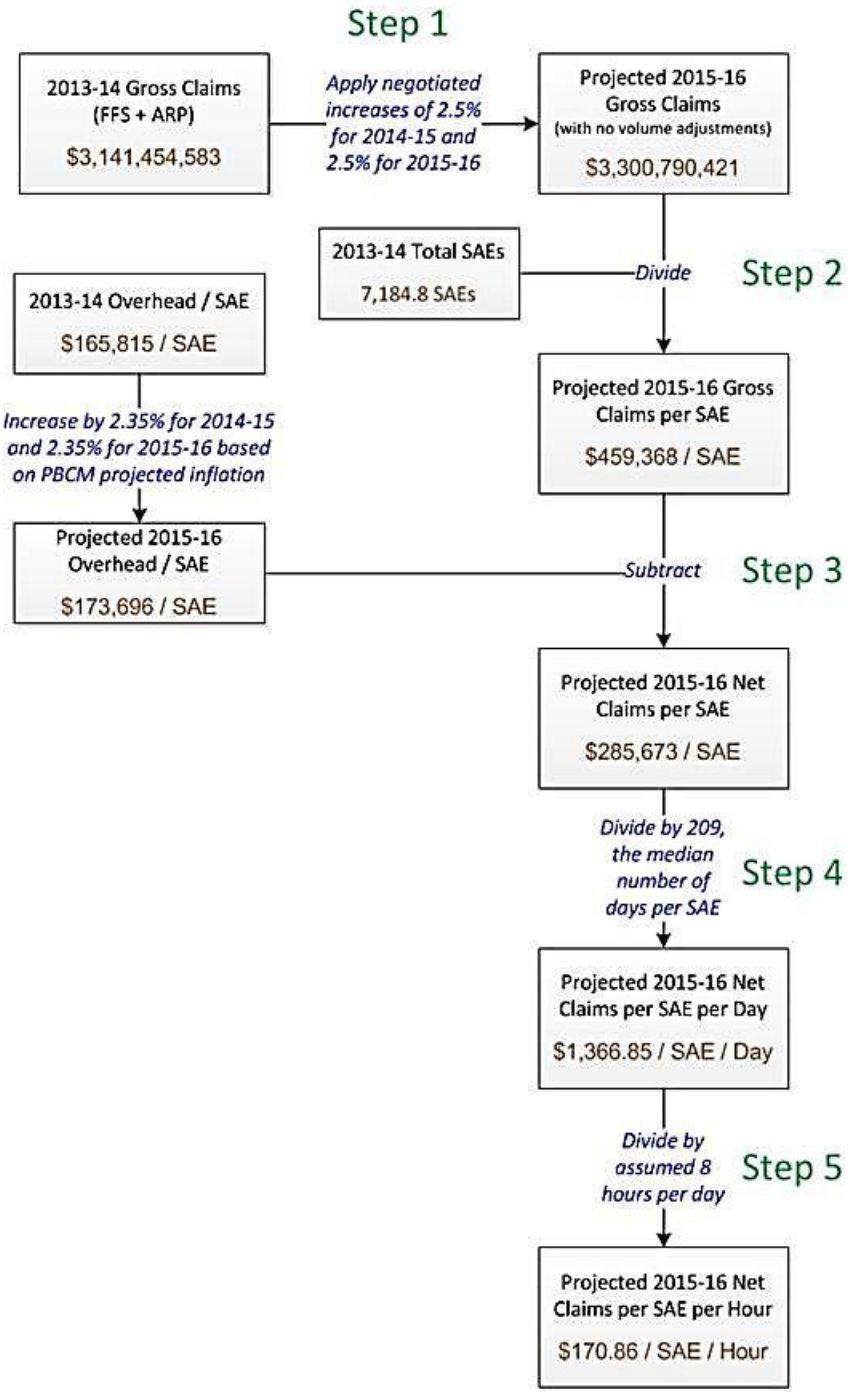
2. Result from step 1 is divided by the total number of sectional allocation equivalents (SAEs) to get average gross annual claims per SAE. (The SAE methodology is presented in Appendix C.)

3. Result from step 2 is then reduced by the amount of overhead per SAE (all sections) to obtain the net annual claims per SAE.

4. Result from step 3 is divided by 209 to obtain net daily claims per SAE. 209 is the median number days worked of a physician considered as full-time using the SAE methodology.

5. The result from step 4 is divided by an assumed 8 clinical hours per day to arrive at the average net hourly claims of $170.86.

Figure 1: The Five Steps to Calculate the Hourly Rate



Appendix C – Sectional Allocation Equivalent description

Background

Prior to 2014-15, AMA used the Canadian Institute of Health Information (CIHI) methodology to calculate full-time equivalent (FTE) physicians. The CIHI approach estimates FTEs using annual claims payments. Since 2014-15, the AMA has adopted the Sectional Allocation Equivalent (SAE) as an enhanced measure of FTE physicians. This new SAE methodology takes into account section billings as well as number of days worked per year.

The SAE measure is preferred to the CIHI measure for several reasons, including:

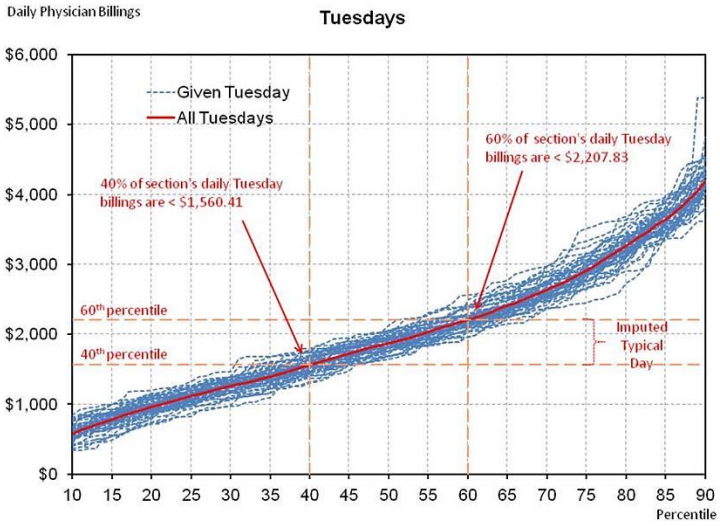
- Better comparability between sections and across jurisdictions, particularly when considering significant differences in gross billing.
- CIHI methodology bases its estimate of FTEs on the 40th to 60th percentile of annual billings. Over the past two decades physician demographics have changed resulting in an increase to the percentage of part-time physicians and this increase is more prevalent in certain specialties than others. CIHI methodology tends to overestimate FTE counts for certain sections with high proportions of part-time physicians. Rather than estimating FTE using gross billing, the SAE methodology levels the playing field between sections in Alberta by also measuring days worked. Furthermore, the SAE calculation allows an adjustment when physicians work more than the 209 days.
- The CIHI definition was developed for fee-for-service (FFS) physicians and is considered inappropriate for comparison of physicians on salary or sessional payments. The SAE definition can be adapted to alternative payments by consideration of days worked.
- The board appointed, AMA Compensation Committee (AMACC) sees the methodology as a substantial improvement over the previously available CIHI methodology for measuring FTEs for the purpose of performing allocation.

Methodology

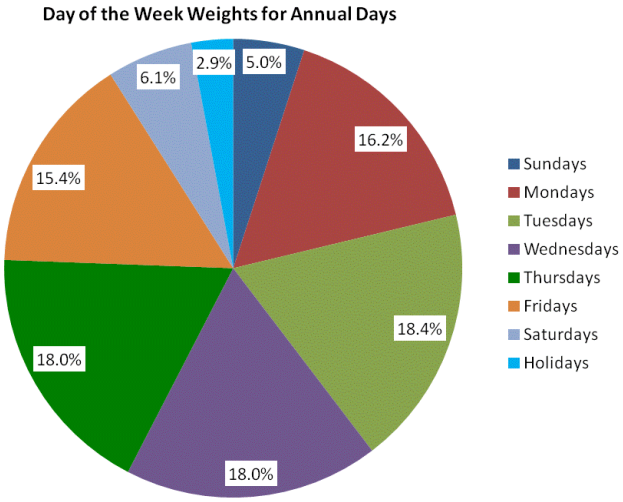
The SAE calculation involves the development of a benchmark range to define a full-time equivalent FFS physician. The quantification of a section's SAE uses all FFS records in a year. The specific steps to calculate benchmarks include:

1. Gather annual claims data from Alberta Health (non-identifiable daily claims).
2. Place every physician into an economic section based on their highest annual assessed claims.
3. Remove all physicians with shadow-billed services.
4. Aggregate paid claims by date of service for each physician, group by day of the week. In addition a "holidays" group is created from all statutory holidays, single days between statutory holidays and weekends, and days between Christmas and New Year's.

5. Trim all physician service dates in which daily paid claims represent less than 5% of the mean section paid claims for that day of the week.
6. Include physicians who submitted (non-trimmed) claims in at least 11 months of the year.
7. Calculate the 40th and 60th percentiles for each day of the week and for holidays, within each section. The example below shows what a section's "Tuesdays" distribution might look like. The dashed blue lines represent percentile distributions based on all physicians within the section that bill on a Tuesday. The solid red line is the percentile distribution across all Tuesdays within a year for that section. A day with claims between the 40th and 60th percentile is considered typical ($1,560 to $2,208 in the example).



8. Calculate the total working days of an SAE physician, based on the 70th percentile of section- specific non-trimmed working days to a maximum of 209 days.
9. Allocate the total working days by weekday based on the percentage of total section paid claims by workday.



10. **Calculate the benchmark range**

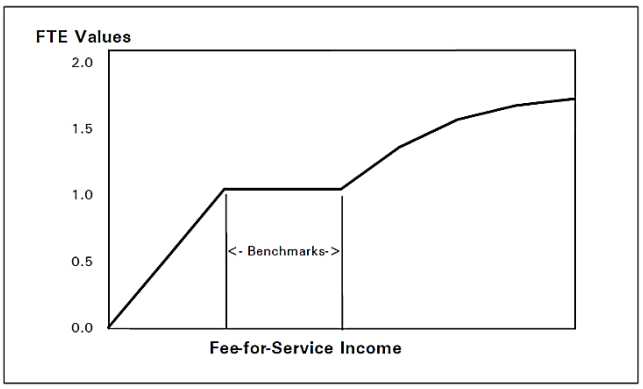
The table below shows a numerical example of the SAE methodology for a section under the assumption of 209 working days per SAE per year.

The claims per typical day are obtained as above for each day of the week with the lower and upper claims set to the 40th and 60th percentile of claims. The claims per day are then multiplied by the number of typical working days (based on the 70th percentile of days worked to a maximum of 209). For example, if Mondays represent 16.2% of working days for physicians in the section, then claims from 209x16.2% = 33.9 Mondays are considered typical of a SAE physician. The annual claims per day of the week are then calculated by multiplying the typical days and the claims per typical day. Summing over the days of the week, yields the annual benchmark range for 1.0 SAE of $293,007 to $430,457.

	Claims per Typical Day		% Days	Typical Days Worked per SAE per Year	Annual FFS Claims Benchmark	
	40th Percentile	60th Percentile			Lower Claims	Upper Claims
Sunday	$827	$1,547	5.0%	10.5	$8,678	$16,232
Monday	$1,618	$2,292	16.2%	33.9	$54,888	$77,726
Tuesday	$1,560	$2,208	18.4%	38.4	$59,932	$84,798
Wednesday	$1,507	$2,159	18.0%	37.6	$56,609	$81,124
Thursday	$1,534	$2,171	18.0%	37.6	$57,645	$81,561
Friday	$1,291	$1,983	15.4%	32.2	$41,600	$63,901
Saturday	$627	$1,205	6.1%	12.7	$7,933	$15,246
Holidays	$929	$1,603	2.9%	6.2	$5,723	$9,869
Total			100.0%	209	$293,007	$430,457

11. **Calculate physicians' FTE amounts based on the benchmarks**

Once the upper and lower benchmarks are calculated, the SAE contribution for each physician is computed based on the comparison of the physician's total annual claims to the benchmark billing range, using CIHI's FTE formula:



Total Payments Below lower threshold:
FTE=payments/lower threshold

Total Payments Between lower and upper threshold:
FTE=1.0

Total Payments Above upper threshold:
FTE=1+natural log (payments/upper threshold)

Source: CIHI National Physician Database, 2013-14

Appendix D – Physician Business Costs Model

Gathering and maintaining overhead cost estimates is a key activity for managing physician compensation. Overhead data is typically required for negotiations, allocation and policy analysis.

In 2008, the AMA, Alberta Health and Alberta Health Services initiated development of a new model for measuring overhead costs. The previous model from 2000-01 was considered out of date and unrepresentative by certain section. The new model was based on the concept of a model medical office. This was defined as a modern, reasonably efficient electronic medical office that reflected the typical space, personnel, equipment and supplies that a physician would require for patient care.

The model development was facilitated by consultants and involved extensive physician and clinic staff input through the use of various consultations/workshops and surveys to gather input requirements and costs.

The starting point was to define the characteristics for a base set of model offices. Office types were broken into several categories: solo office, group office, hospital office, and office only (non-clinical) settings.

Cost categories within the model included:

- Staff - salaries and benefits for supporting resources. Also includes the employers' share of CPP and EI.
- Office Space – office lease or rental rates, common area costs, operational costs (e.g., utilities, maintenance) and parking.
- Capital – annual amortization of medical equipment and non-medical equipment and furniture (e.g., chairs, computers, etc.).
- Operational – two categories:
    - Medical – medical supplies, memberships/dues, medical insurance, medical equipment maintenance, and professional development.
    - Administrative – telephone, computer maintenance, professional services, office supplies, licensing, insurance, interest, bad debts and bank charges, advertising and promotion, vehicle, travel and other.

Section-specific modifiers were created to account for varying characteristics of 39 different sections. Geographical modifiers were developed to account for the cost of operating a model office in 19 different Alberta locations.

This type of cost model has a number of desirable features:

- The model permits a better understanding of components and variations in costs to maintain a medical practice.

- Model office costs can be viewed by cost category for a given office type, office size, section and location.
- The AMA can examine the impact of a change in specific office characteristics (e.g. equipment, space), or a change in unit costs (e.g., prices, rent, wages).
- The AMA can explore how changing technologies or changing practice styles impact costs.
- Sources of practice expenses can be isolated and quantified.
- The AMA can update baseline costs based on changing market conditions using a wide range of economic indices.

During development, it became apparent that the generic survey tool was not effective for modelling Diagnostic Imaging (DI) operating modalities. A different survey tool was developed specifically for DI, which followed similar methodology but collected info on office characteristics for 11 different modalities. Costs were calculated by modality, then converted to per full-time physician costs. Costs were also validated by comparing with billing data on the number of tests by modality in Alberta.

The initial model was launched in 2009. It was first incorporated into the April 1, 2014 macro allocation, as there were no increases in the first three years of the Agreement. It was subsequently used for Allocation 2015 and is currently being employed for Allocation 2016.

Limitations

A number of limitations have been identified with the current Physician Business Costs Model:

1. The model is designed to measure total costs (or modality-based costs with DI) of a model medical office, which represents a weighted average cost of performing various procedures. There is currently no method to map costs to individual procedures/fees (other than using this average). As such, it is not ideally suited as a micro/fee costing model.

2. The model presents model office costs as measured at a point in time (2009). While costs are inflated each year using a number of cost indices (CPI, etc.), it doesn't currently account for changing costs when physician output either increases or decreases. In this respect, the model treats all costs as fixed on a per FTE basis.

3. Overhead for hospital-based physicians may be overstated, as AHS may be paying more of these costs than is reflected in the current data.

4. There may be some slight variation in estimates due to differences in the way that FTE physicians are measured. Costs are measured on a per FTE basis (reflecting the measure that was in place when the model was constructed), while output is measured using the AMA's Sectional Allocation Equivalent measure, which takes into account daily claims data. See Appendix C for an explanation of how SAE is calculated. The PCC has adopted the AMA methodology on this item.

5. A variety of other minor issues have also been identified.

Section-Based Initiatives

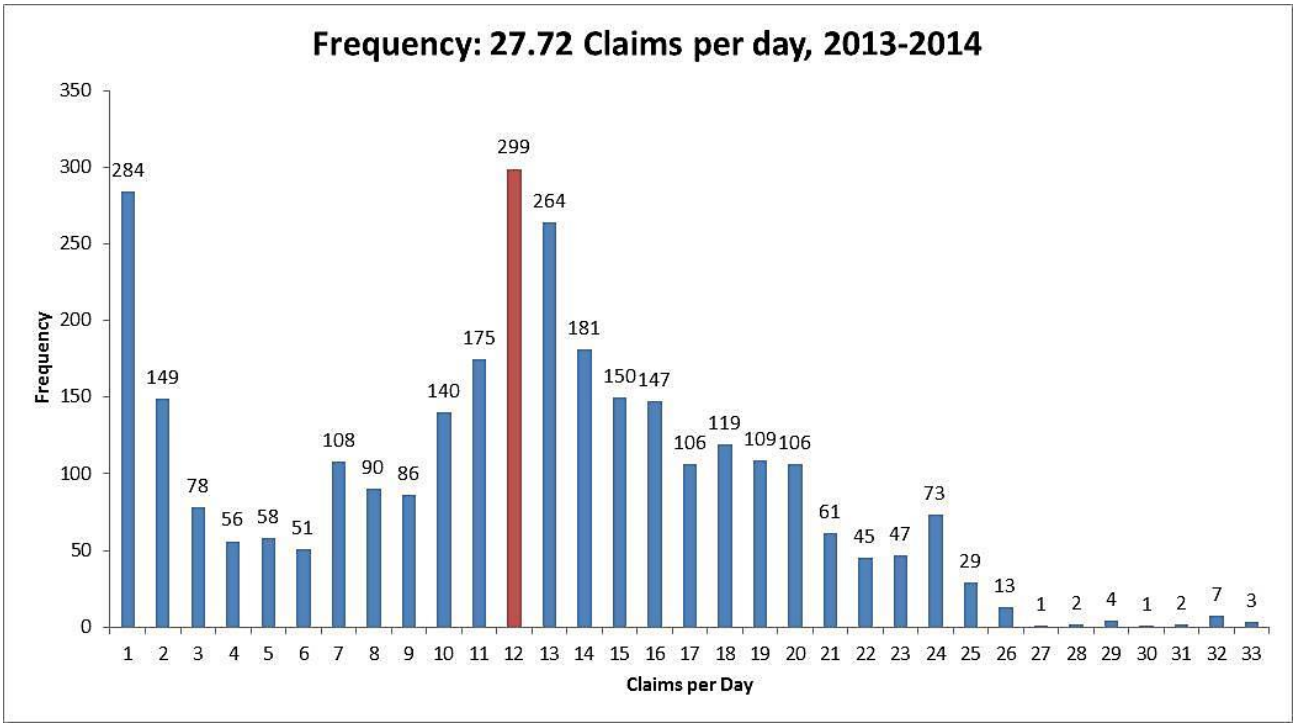
Sections of Ophthalmology and Diagnostic Imaging have undertaken their own overhead studies independent of the AMA. While commendable, these studies create some difficulties in terms of validation of estimates. In reviewing the DI model, AMA staff have noted some improvements over the AMA model (e.g., handling of certain office builds requiring lead or copper lined walls, etc). Staff have also noted some methodological problems, such as an inconsistent base used to count physicians (in some cases, FTE is used, in others a simple headcount).

Model Review and Update

Last year, the PCC commissioned an independent review/evaluation of the Physician Business Costs Model. The report recommended continuing with the model office approach rather than moving towards either a traditional overhead study or tax return approach. The report listed some potential areas of improvement that the PCC will consider when it updates the model next year.

Appendix E – Analysis of time estimates using claims data

- Data was gathered from the 2013-14 FFS claims file to determine the number of services that could be delivered in one day.*
- Data included 72 ophthalmologists who billed 36,273 cataract extractions (27.72A) on 3,044 physician-service days.
- Results showed the count of physician-service days on which 1 to 33 (data maximum) cataract extractions (27.72A) were billed.
- The median and mode were 12 services per day.
- 18 or more services per day were billed on 20% of physician-service days.



* Some possible explanations for high claims per day could include use of more than one Operating Room (O/R) and O/R Team or long O/R days in a non-hospital surgical facility.

Appendix F – American Medical Association approach

Overview of the RBRVS (from the American Medical Association)

In 1992, Medicare significantly changed the way it pays for physicians' services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services). Payments are also adjusted for geographical differences in resource costs.

The physician work component accounts, on average, for 48 percent of the total relative value for each service. The initial physician work relative values were based on the results of a Harvard University study. The factors used to determine physician work include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice. Also, the legislation enacting the RBRVS requires the Centers for Medicare and Medicaid Services (CMS) to review the whole scale at least every five years.

The practice expense component of the RBRVS accounts for an average of 48 percent of the total relative value for each service. Practice expense relative values were based on a formula using average Medicare approved charges from 1991 (the year before the RBRVS was implemented) and the proportion of each specialty's revenues that is attributable to practice expenses. However, in January 1999, CMS began a transition to resource-based practice expense relative values for each CPT code that differs based on the site of service. In 2002, the resource-based practice expenses were fully transitioned.

On January 1, 2000, CMS implemented the resource-based professional liability insurance (PLI) relative value units. The PLI component of the RBRVS accounts for an average of 4 percent of the total relative value for each service. With this implementation and final transition of the resource-based practice expense relative units on January 1, 2002, all components of the RBRVS are resource-based.

Annual updates to the physician work relative values are based on recommendations from a committee involving the AMA and national medical specialty societies. The AMA/Specialty Society RVS Update Committee (RUC) was formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised codes in Current Procedural Terminology (CPT®). Nearly 8,000 procedure codes are defined in CPT, and the relative values in the RBRVS were originally developed to correspond to the procedure definitions in CPT. Changes in CPT necessitate annual updates to the RBRVS for the new and revised codes.

The *Affordable Care Act* in 2010 added some further requirements to the review process, as the Act directed the AMA to examine seven different code categories at an ongoing frequency. The seven categories were as follows:

1. Codes or families of codes with the fastest growth.
2. Codes or families of codes with substantial changes in practice expenses.
3. Codes that are recently established for new technologies or services.
4. Multiple codes that are frequently billed together for a single service.
5. Codes with low relative values, billed multiple times for a single treatment.
6. Codes which have not been subject to review since the implementation of the RBRVS.
7. Other codes determined to be appropriate by the Secretary.

The Relativity Assessment Working Group, which has re-reviewed codes since 2006, now carries out this ongoing review. Since its formation, the working group identified over 1,500 code re-evaluations through its 12-point screening criteria, a $2.5 billion redistribution within the Medicare Physician Payment Schedule[1].

(See the following pages for 'Echocardiography with Doppler' example.)

[1] RVS Update Process, Relativity Update Committee, AMA, 2013

Echocardiography, with Dopp

RBRVS DataManager

AMA AMERICAN MEDICAL ASSOCIATION

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- GENERAL INFORMATION
- LOCAL PAYMENT SCHEDULES
- VIGNETTE/SERVICE
- RUC RATIONALE
- PHYSICIAN TIME
- PE INPUTS
- FREQUENCY DATA
- SEARCH

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Overview Welcome, alflorz

General Information

93306 - ECHCRDGRPHY, TRNSTHRCC, RL-TM WTH IMG DCMNTTN (2D), INCLDS M-MD RCRDNG, WHN PRFRMD, CMPLT, WTH SPCTRL DPPLR ECHCRDGRPHY, AND WTH CLR FLW DPPLR ECHCRDGRPHY

Long Descriptor

Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

	Global (Combined Prof & Tech)	26 (Professional)	TC (Technical)
Work RVU/Base Units:	1.30	1.30	0.00
Non Facility Practice Expense RVU:	5.04	0.45	4.59
Facility Practice Expense RVU:	NA	0.45	NA
Professional Liability Insurance RVU:	0.06	0.04	0.02
Non Facility Total RVU:	6.40	1.79	4.61
Facility Total RVU:	NA	1.79	NA
Medicare Non Facility National Payment:	$229.97	$64.32	$165.65
Medicare Facility National Payment:	NA	$64.32	NA
Medicare Status*:	A	A	A
Medicare Policy Indicators*:	A+	A+	A+ GS

*** Please refer to the help file for definitions and explanations.**

RBRVS DataManager

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- GENERAL INFORMATION
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- VIGNETTE/SERVICE
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Overview Welcome, alflorz

Vignette/Service

93306 - TTE W/DOPPLER COMPLETE

Vignette	A 67-year-old man with a history of coronary artery disease and hypertension presents with exertional shortness of breath and progressive exercise intolerance. On clinical evaluation, blood pressure is 140/90 mmHg, heart rate is regular at 90 bpm, and respirations are elevated at 20 per minute. Examination is notable for rales in the lung fields, and a systolic murmur is heard. Cardiomegaly and pulmonary congestion are noted on chest X-ray, and LVH is noted on ECG.
Pre-Service	The physician reviews existing information (e.g. request for an echocardiographic evaluation) and relevant clinical records to clarify the indications for the procedure and to determine the clinical questions that need to be answered.
Intra-Service	A sequence of real-time tomographic images of cardiac structure and dynamics is obtained from multiple views and recorded on videotape or digitally. Selected M-mode (time-motion) recordings may be made to facilitate dimensional measurement. Using color Doppler flow imaging, blood flow velocity patterns are viewed and recorded across the cardiac valves and along the atrial and ventricular septae, as well as in the great arteries and veins. When abnormal findings indicate valvular regurgitation or an intracardiac or extracardiac shunt, additional views are recorded. Using spectral Doppler (by means of pulsed and/or continuous wave techniques), flow velocities are recorded across the cardiac valves, and abnormal flow
Post-Service	A report is then prepared, reviewed and corrected if necessary, and signed. The study findings may be reviewed in detail with the requesting physician in order to facilitate appropriate patient management decisions.

RUC Rationale

93306 - TTE W/DOPPLER COMPLETE
RUC Rationale

Background For the 2005 Five Year Review, CMS originally requested review of CPT Code 93325 Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) (work RVU = 0.07, ZZZ global) as it had not been reviewed by the RUC. The American College of Cardiology (ACC) surveyed the code and recommended an increased work RVU to the RUC. During that meeting, the RUC reviewed the specialty's survey results and rationale and noted that code 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work RVU = 0.92, XXX global period) was almost always billed with 93325. The RUC recommended code 93325 be referred to the CPT Editorial Panel for consideration for bundling with 93307. During the October 2006 RUC meeting, the RUC was informed that CPT code 93325, had not yet been reviewed by the CPT Editorial Panel following the most recent Five-Year Review. The specialty society had indicated to CPT that it did not intend to submit a CPT code proposal. Although the RUC indicated an interest in bundling the service with other cardiology services, ACC argued that bundling is inappropriate due to the services varied utilization pattern with a wide variety of other services. Since ACC did not develop a bundled coding proposal and the CPT Panel Executive Committee did not discuss it, the RUC would need to examine the code again. The specialty presented their 2005 survey data results for 93325 at the February 2007 RUC meeting. The RUC also reviewed data from the 2005 Medicare Utilization files for 93325 and other services in this family of codes. The RUC discussed the inherent nature of providing the services described in 93325, 93307, and 93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete on the same day by the same physician, as illustrated in the following table: Same Day Occurrences for 93325 with Codes Billed Together at Least 90% of the Time Produced from the 2005 5% Sample File CPT Code 1 CPT Code 2 Code 1 Services Same Day Billed Occurrences % of Time Code 1 Billed with Code 2 93325 93320 138,398 136,433 98.58% 93325-TC 93320-TC 23,039 22,645 98.29% 93325-26 93320-26 211,640 206,755 97.69% 93325 93307 13,8398 130,949 94.62% 93325-TC 93307-TC 23,039 22,298 96.78% 93325-26 93307-26 211,640 197,093 93.13% The RUC discussed its policy for other services that are inherent in the provision of physician services. For example, when conscious sedation is inherent to procedures it is included within the valuation of the procedure and not reported separately. Likewise, the CPT Editorial Panel has moved to an approach of including radiological guidance within a new CPT code if it is inherent to the procedure. The RUC understood that the American College of Cardiology is taking a long-term, broad review of their services and welcomed this approach. However, the data for 93320, 93325, and 93307 is clear and the RUC recommended a coding proposal be prepared by the specialty society to immediately address this as one service versus three distinct services. In June 2007, the CPT Editorial Panel edited four codes and created a new code that reflects the work of CPT codes 93307, 93320 and 93325 when performed together. The panel created new code 93306 Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if prerformed, with spectral Doppler echocardiography, and with color flow Dopper echocardiographty which combined the following three codes into one service: 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work RVU = 0.92) 93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete (work RVU = 0.38) 93325 Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) (work RVU = 0.07) This CPT code revision was in response to changes in clinical practice that have generally made the performance of spectral and color flow Doppler an integral part of a complete transthoracic echocardiogram. The introduction of the new code serves to maintain 93307 (two dimensional echocardiography) and to preempt coding confusion for the instance when imaging without color flow or velocity information is requested. In addition, the CPT Editorial Panel made necessary editorial changes in the introductory language of Echocardiography to accommodate the new code. RUC Review and Recommendation In September 2007, the RUC reviewed the specialty societys survey results of the physician work for new code 93306 from a random sample of 597 physicians. The specialty received a response rate of 16.4% (nearly 100 respondents) that indicated the physician work was believed to approximate the sum of its inherent procedure codes (93307+93320+93325). The median survey results indicated a work RVU of 1.44 which is slightly more than the sum of its parts (0.92+0.38+0.07 = 1.37). The specialty society indicated that the majority of echocardiography laboratories have shifted from image recording on videotape to digital image recording. While the physician is now able to review recorded images and associated flow velocity waveforms in a shorter period of time due to the use of digital technology, the interpreting physician actually reviews more

data (and provides more complex analyzes) in a shorter period of time. The specialty societys RUC Advisory Committee believed that the intensity of the physician work had increased, and compared the work to several other codes as reference points, including: 76485 Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification (Work RVU = 1.46, 2005 Five Year Review Code) 78708 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing (Work RVU = 1.19, RUC Multi-specialty Points of Comparison Listed) 93975 Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report (Work RVU = 1.48, 2000 Five Year Review Code) 70551 Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material (Work RVU = 1.48) The specialty societys RUC Advisory Committee understood that although the intensity of the service had increased with imaging technological advances, the overall physician work may have decreased. This same committee reviewed the distribution of the survey results and noted that survey median physician time (31.50 minutes) is less than the building block time of 43 minutes and that there was a tight spread between the 25th and 75th percentiles (1.30 1.76). The specialty acknowledged that although the survey respondents indicated the physician work was slightly more (1.44) than the sum of its parts (1.37), the total physician time was lower by 11.5 minutes. The specialty therefore acknowledged that there are economies of scale when these services are provided together and recommended the 25th percentile survey results (Work RVU = 1.30) would provide the proper valuation of this new code. The RUC reviewed the specialty recommendation for new code 93306 and believed that the specialty survey results provided an accurate depiction of the typical patient. The RUC reviewed the new bundled code in relation to code 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. (Work RVU = 1.34, 20 minutes of intra-service time). The RUC believed that the rationale provided by the specialty was consistent with efficiency gains associated with performing these services together and their proposed physician work value of 1.30 is appropriate in relation to other services among and across specialties. The RUC recommends a physician work relative value of 1.30 for code 93306.

Physician Time

93306 - TTE W/DOPPLER COMPLETE
Physician Time as Published by Medicare (All time is displayed in minutes)

Pre-Service Evaluation Time: 5.0
Dress, Scrub, and Wait Time:
Other Pre-Service Time:
Intra Service Time: 20.0
Same Day Post-Service Time: 6.5
ICU Time After Day of Surgery:
Post Operative Hosptial Visit Time After Day of Surgery:
Office Visits Time:

Total Time: 31.5
Source: RUC

99211 99212 99213 99214 99215 99231 99232 99233 99238 99239 99291 99292

The physician time included with this product has been collected from various sources and is posted on the Centers for Medicare and Medicaid Services website www.cms.hhs.gov each year. These time estimates should only be used to determine the relativity of physician work allocated between various services. The RBRVS is based on the "typical" patient for the service, and individual circumstances will vary. The time data and the number of post-operative visits should not be construed to be absolute.

PE Inputs

93306 - TTE W/DOPPLER COMPLETE
Direct Practice Expense Inputs For 2015

		Clinical Labor Inputs			Clinical Staff Time				CMS Profiled As	
Staff Type	Description	Compensation Per Minute	Pre Non Facility	Intra Non Facility	Post Non Facility	Pre Facility	Intra Facility	Post Facility	In Office	Out of Office
L037D	RN/LPN/MTA	0.37	5	7	0				Y	N
L050A	Cardiac Sonographer	0.5	3	63	4				Y	N

Medical Supply Direct Inputs

Supply Code	Description	Quantity In Office	Quantity Out of Office	Cost In Office	Cost Out of Office
SA048	pack, minimum multi-specialty visit	1		$1.14	
SB006	drape, non-sterile, sheet 40in x 60in	1		$0.22	
SD053	electrode, ECG (single)	3		$0.27	
SJ062	ultrasound transmission gel	180		$2.34	
SM022	sanitizing cloth-wipe (surface, instruments, equipment)	3		$0.14	

Medical Equipment

Equip Code	Description	Equip In Use In Office (Min)	Equip In Use Out of Office (Min)	Equip Cost In Office	Equip CostOut of Office	Equip Useful Life (Yrs)	Purchase Price
ED021	computer, desktop, w-monitor	63		$0.6200		5	$2,501.00
ED036	video printer, color (Sony medical grade)	63		$0.6700		4	$2,295.00
ED034	video SVHS VCR (medical grade)	10		$0.0400		5	$1,250.00
ED050	PACS Workstation Proxy	63		$0.6200		5	$2,501.00
EF018	stretcher	63		$0.3200		10	$1,915.00
EL016	room, ultrasound, vascular	63		$111.3500		5	$466,492.00

Appendix G – Representative Forum resolutions regarding PCC

Fall 2015

RF15F-04 Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang
THAT the AMA develop with Sections and present to RF for approval the actual methodology it will use to determine, test and validate the Intensity and Complexity multipliers applied to the physician base rate, prior to confirming the AMA's final position on this at the Physician Compensation Committee.

REFERRED TO THE BOARD

RF15F-05 Moved by Dr. Trina C. Uwiera, seconded by Dr. James N. Wolfli
THAT the AMA present to RF for discussion and approval the actual methodology it will use to determine, test, and validate the physician time assigned to different procedures prior to confirming the AMA's final position on this at the PCC.

REFERRED TO THE BOARD

RF15F-06 Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang
THAT the AMA create a framework for discussion and agreement with Sections on office overhead data collection, calculation methodology, and verification, prior to confirming any information as the AMA's final position on this at the Physician Compensation Committee.

REFERRED TO THE BOARD

RF15F-07 Moved by Dr. Sayeh Zielke, seconded by Dr. Jennifer J. Burke
THAT the AMA require its Physician Compensation Committee appointees to honor RF resolution RF13F-25, before any fee changes are finalized by the PCC.

REFERRED TO THE BOARD

RF15F-08 Moved by Dr. Robert G. Davies, seconded by Dr. Jennifer J. Burke
THAT the AMA form a second table for negotiations conducted on behalf of Sections at the Physician Compensation Committee that includes each Section President or designate, to enhance information sharing within the process and accountability to the membership, before 2016.

REFERRED TO THE BOARD

RF15F-09 Moved by Dr. Christopher J. Rudnisky, seconded by Dr. Robert G. Davies
THAT after a Section has had fee reductions imposed by the Physician Compensation Committee, the AMA oppose additional fee reduction proposals from the PCC for the affected section for 18 months in order to assess the impact on patients.

REFERRED TO THE BOARD

RF15F-10 Moved by Dr. Jennifer J. Burke, seconded by Dr. Christopher J. Rudnisky
THAT the AMA require a full and transparent account of the assumptions and calculations made by the Physician Compensation Committee on all 22 fees reviewed, to be shared with all Sections.

REFERRED TO THE BOARD

RF15F-11 Moved by Dr. James N. Wolfli, seconded by Dr. Robert G. Davies
THAT prior to implementing Physician Compensation Committee-determined methodologies being used for fee valuation, the AMA first determine the impact this will have on intra-sectional fee relativity work, on fee schedule redevelopment work by Sections, and on new fee submissions by Sections.

REFERRED TO THE BOARD

RF15F-12 Moved by Dr. Graham M.D. Campbell, seconded by Dr. Magnus Murphy
THAT the AMA request that the Physician Compensation Committee reconsider the methodology by which they calculated the hourly base rate.

CARRIED

RF15F-13 Moved by Dr. Phillip W. van der Merwe, seconded by Dr. Stephen Wainer
THAT the AMA support the ongoing efforts of the Physician Compensation Committee to address the significant issue of fee inequity.

CARRIED

RF15F-14 Moved by Dr. Sarah L. Bates, seconded by Dr. Paul E. Boucher
THAT the AMA direct its members of the Physician Compensation Committee to advocate for a phased implementation of any substantial fee reduction resulting from the fee review process.

REFERRED TO THE BOARD DUE TO LACK OF TIME

RF15F-15 Moved by Dr. Paul E. Boucher, seconded by Dr. Sarah L. Bates
THAT the AMA direct its members of the Physician Compensation Committee to advocate for the re-evaluation of any adjusted fees as the business cost model is refined.

REFERRED TO THE BOARD DUE TO LACK OF TIME

Previous Resolutions

RF13Sp-05
THAT the AMA commits to direct consultation with sections and/or subsections affected by any proposed changes prior to recommendations by the Physician Compensation Committee.
CARRIED

There has been no further discussion with AH on relativity at this time.

It is anticipated that the Physician Compensation Committee will address the fee relativity issue early in its mandate. The AMA's proposed process for this project will include the commitment to consultation as contemplated in this resolution.

Update: August 2014
The PCC has established a process for the review of individual health service codes. This information has been communicated to all section presidents and fees representatives. All impacted sections will have the opportunity to present comments to the PCC before a final decision is made.

Update: January 2015
All affected sections have met with PCC prior to any recommendation by PCC.
Complete

RF13F-25
THAT the AMA work in conjunction with sections to clearly define Physician Compensation Committee processes that will determine fee relativity and reflect the principles of time, intensity and complexity.
CARRIED

AMA staff have prepared and presented a paper that was supported by the AMA Board of Directors on the fee relativity process. This document will be further refined and developed within the AMA Compensation Committee prior to a presentation at the Physician Compensation Committee (PCC).

PCC discussions on this topic, including how to involve sections, will occur in coming months.

Update: August 2014
In keeping with the PCC mandate to perform an individual fee review, the PCC has developed a process for the review of individual health service codes. The PCC has begun gathering information from AMA section representatives to help inform the fee review process. The PCC has recognized the importance of having a detailed methodical process that is based on fundamental principles. Criteria have been established to allow for the identification of codes to be reviewed.

All section presidents and fees representatives have been sent the individual fee review fundamentals, the fee review process and the criteria for individual fee review. Representatives from affected sections will be contacted by the PCC chair and will be given the opportunity to present to the PCC before a final decision is made.

Update: January 2015
All sections affected have met with PCC as part of the review process. A preliminary decision regarding the codes under review is pending.

RF14S-49 Moved by Dr. Christopher J. Rudnisky, seconded by Dr. Douglas B. Duval
THAT the AMA advocate, via the PCC, that changes made to the SOMB in the April 2014 update be evaluated for at least one year before undergoing individual fee review.

Not Handled – REFERRED TO BOARD

Board direction:
The proposed Physician Compensation Committee (PCC) fee relativity review does include a process for re-evaluation; changes to any specific fees will be introduced gradually so as not to introduce unintended consequences. The board does not want to micro-manage changes to the Schedule of Medical Benefits, nor would it want to commit to a process without fully investigating all aspects. As such, discussion of fee review processes will remain at the PCC level.

Update: January 2015
Complete.

Appendix H – Fee Review communications timeline

Board Involvement
President's Letter (PL)
AMA Compensation Committee (AMACC)
PCC Communications
Representative Forum (RF)
PCC Meetings with Sections

Date	Activity	Summary
July 21-22, 2011	Board	Approval of PBCM for use in Allocation
April 22, 2013	AMA and AH	AMA Agreement signed by AMA and AH
December 13, 2013	Board Presentation	PCC Update: priorities, challenges, next steps in fee review
January 3, 2014	PL	Introduction of relativity
January 20, 2014	AMACC	Review of Dec 13 Board presentation, fee relativity backgrounder, fee review process and criteria
February 7, 2014	Board Presentation	PCC relationships
February 25, 2014	AMACC	Fee relativity criteria, review of different methodologies to identify outliers
February 26, 2014	PCC Update Newsletter	Report on recent activities "relative value, including an individual fee review"
February 28, 2014	PL	PCC – overhead and relative value, including an individual fee review.
March 15, 2014	RF	PCC activity update: individual fee review criteria, process, fundamentals relationships required
March 17, 2014	AMACC	PCC update, including fee review relationships, fee review process, fast five criteria
March 19, 2014	AMA and AH	Agreement on Provincial Strategic Requirements
April 7, 2014	PCC Update Newsletter	Fee relativity criteria
April 11, 2014	Board Presentation	Relativity and Individual Fee Review process
June 6, 2014	Board Retreat	PCC Update including fee review process, identification of the codes,
June 16, 2014	PCC Letter to Sections	Process for individual fee review
June 19, 2014	PCC Update Newsletter	Process and criteria for fee review that was sent to sections
June 24, 2014	PL	PCC update; 6 stages in fee review process
July 11, 2014	PCC Meetings with Sections	Ophthalmology presentation
July 14, 2014	AMACC	PCC identification of 22 codes for review affecting 13 sections, filters and methodology development
July 16, 2014	PCC Update Newsletter	Criteria used to identify 22 codes selected for review
July 16, 2014	Board Presentation	AMA rep activities re board direction on fee review
July 30, 2014	PL	PCC has begun fee review of 20 fee codes
August 8, 2014	PCC Meetings with Sections	General Practice presentation
August 22, 2014	PCC Meetings with Sections	Obstetrics & Gyneacology, Cardiology presentations

September 3, 2014	PL	PCC priorities include fee review and RVG
September 10, 2014	Board Presentation	AMA Draft plan for PCC, including Individual fee review
September 12, 2014	PCC Meetings with Sections	Gastroenterology, Plastic Surgery presentations
September 14, 2014	PCC Letter to Section Presidents	Questions for Sections, FAQ's, Criteria for Individual Fee Review
September 17, 2014	PCC Update Newsletter	Report on initial interviews with affected sections. List of questions PCC has asked sections to answer in their presentations.
September 19, 2014	PL	PCC beginning to look at 22 codes (<1% of SOMB codes)
September 19, 2014	RF	PCC update: relationships, fundamentals, fee review status, methodology to value a code
October 3, 2014	PCC Meetings with Sections	Respiratory Medicine, dermatology presentations
October 6, 2014	AMACC	Update on PCC activities
October 17, 2014	PCC Meetings with Sections	General Surgery, Anesthesia presentations
October 24, 2014	Board Presentation	Fee review timeline, status, next steps
October 31, 2014	PCC Meetings with Sections	Diagnostic Imaging, Internal Medicine presentations
November 4, 2014	PCC Meetings with Sections	Otolaryngology
November 21, 2014	PCC Update Newsletter	Progress report on individual fee review
December 12, 2014	Board Presentation	PCC Status update – principles for fee review, factors for individual fee review, identification of 22 codes for review
January 26, 2015	AMACC	Principles and factors for individual fee review, AMACC review of fee assessment methodology
February 6, 2015	Board Presentation	PCC Review of Fee Assessment Methodology
February 12, 2015	PCC Update Newsletter	Progress update: PCC continues to analyze fee codes to ensure fee review process can carry forward to future fee work.
March 13, 2015	RF	PCC update: Individual fee review – 13 sections (owners of 22 codes presented to PCC)
July 13, 2015	AMACC	Fee review methodology
August 19, 2015	PCC Letter to Sections	Preliminary decision
August 27, 2015	PCC Update Newsletter	PCC has arrived at a preliminary decision regarding some individual HSC's
September 16, 2015	Board Presentation	Fee review timeline, fee and income relativity
September 25, 2015	RF	PCC Chair presentation re fee review and 6 affected codes

NOTE: PCC's activities were suspended April-June due to Strategic Agreement discussions.