

CRITICAL CARE NEWS

The Newsletter of the Section on Critical Care of the American Academy of Pediatrics

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Physician Assistants in Critical Care

By Debi Gerbert, PA-C
Wolfson Children's Hospital
Jacksonville, Florida

With the trend towards declining physician residency and fellowship training programs nationwide, how intensive care units will provide physician staffing in the next decade is often discussed. The time may be right to begin to look to another profession to enter and make an impact upon this work force.

For over thirty years physician assistants in the United States have practiced medicine with physician supervision. From the first four graduates in 1967, the profession has grown to over 32,000 in 1997. There are now 106 accredited PA programs that graduate more than 3500 students annually. Between 1991 and 1996, the number of new PA graduates produced each year increased 83 percent, the cumulative number of PAs increased 38 percent, and the estimated number of PAs in clinical practice increased 41 percent. Physician Assistants practice in all practice settings, in communities of all sizes and provide a wide range of medical services.

In the 1997 census survey conducted by the American Academy of Physician Assistants, 37.8 percent of respondents report that they spend more of their work time in the hospital than outpatient setting. In another question, 28 percent of the respondents report that they are employed by a hospital. 2.4 percent report that they work full time in an intensive care unit.

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Fall Issue Guest Editor:

Niranjan Kissoon, M.B.B.S., FAAP
Professor, Critical Care Medicine
University of Florida HSC/Jacksonville

Welcome to The Newsletter

Critical Care News is the newsletter of the Section on Critical Care of the American Academy of Pediatrics. We hope to keep you abreast of activities and opportunities in Pediatric Critical Care. We plan to run current news, advertisements for positions, and other articles of interest to you. Please let us know how we are doing.

Submissions to *Critical Care News*

Members of the Critical Care Section may submit announcements and articles to *Critical Care News*. Priority will go to articles of current interest to pediatric critical care practitioners. We hope to run announcements for available critical care staff positions in future issues.

American Academy of Pediatrics

141 Northwest Point Boulevard
Post Office Box 927
Elk Grove Village, Illinois 60009-0927
1-800-433-9016
or (847) 228-5005
Fax: (847) 228-5097

<http://www.aap.org>

Physician Assistants in Critical Care*Continued from page 1*

Physician Assistants are qualified by training and experience to perform many of the procedures that are commonly required in the intensive care setting. They are well trained in history taking and physical examinations. Their education in the medical model provides the background for the critical thinking and problem solving which faces the medical providers in this setting. One advantage to the full time presence of a physician assistant in the unit is the provision of continuity of care to the many chronically ill patients that are there for extended periods of time or readmitted on a frequent basis. As the fellows and residents rotate in and out of a unit on a weekly or monthly basis, a PA on staff is there providing medical care on an ongoing basis from year to year. The nursing staff relies on their presence and familiarity with patient care routines to facilitate care of the patient.

Physician Assistants believe strongly in the team concept of practice. This model works well in the ICU where patient care is complex and requires many different types of services. They practice in a dependent role with physician supervision. The supervising physician need not be physically present at all times, but must be immediately available by phone when necessary.

The recent trends seen in workforce composition reveal increasing numbers of nonphysician providers, both nurse practitioners and physician assistants. The NPs and PAs are available to begin work sooner than physician graduates. The 1997 Balanced Budget Act passed by Congress realized the value of care provided by Physician Assistants and provides for a Medicare reimbursement rate of 85 percent of the physician fee in all practice settings.

The reimbursement is paid to the employing physician or institution, not the physician assistant.

There will always be a need for physician presence in the intensive care unit.

They will remain the "captain of the ship" in regards to decisions on patient care. But who supports that physician may be changing. Residents and fellows may not be there in the numbers they once were, thereby leaving a gap in patient care. The physician assistant profession has been growing at a brisk rate for the past seven years. No shortage of employment opportunities has been seen. Physician assistants may be the answer to many physicians and hospitals when faced with the dilemma of medical staffing of the ICU.

For more information on the education, licensure and employment of physician assistants please contact the American Academy of Physician Assistants 950 North Washington Street, Alexandria, VA 22314. Telephone: (703) 836-2272 E-mail: <http://www.aapa.org>.

The Relative Value System and the Pediatric Intensivist

By Stephen T. Lawless, M.D., M.B.A
The Alfred I. duPont Hospital for Children

I. INTRODUCTION

A rephrasing of an old light-bulb joke could result in the following: "How many intensivists would it take to perform a hypoplastic left heart repair?" The potential answers may not be as potentially humorous as before since there currently exists a measurement tool that equates the work activities of physicians across specialty boundaries.

Over the past 15 years, HCFA in collaboration with the Harvard School of Public Health and various medical societies developed the Resource-Based Relative Value System (RBRVS).

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1997 Pediatric Critical Care
Physician Salaries

This survey is not available on the web
edition of this newsletter

The Relative Value System

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Since the initial publication of the specific Relative Value Units (RVUs) in 1992, modifications have occurred to individual RVU assigned values. The resulting RBRVS system, initiating on 1/1/98 and mandated by Federal law, is the basis upon how HCFA reimburses physicians for work performed with Medicare patients.

The RBRVS system was initially developed utilizing time and cost studies of the adult primary and specialty services. There has been input from the American Academy of Pediatrics and some modifications to adjust for pediatric patient care. There is also a recognition by HCFA that further modifications to accommodate pediatrics "may" (but not necessarily) occur if there is adequate and quantifiable justification for the alteration. While the Medicare percentage of patients in any pediatric practice is minimal, all primary care and specialty pediatricians should become knowledgeable of the RBRVS methodology. Over 90% of Blue Shield plans and 30% of other private payers utilize the RBRVS system as the basis for all physician reimbursement (*American Medical News*, 12/1/97) and these percentages are increasing yearly. In addition, the RBRVS system is the primary methodology utilized as a productivity and efficiency assessment tool both within a division and across specialties.

What follows is a brief primer of the RBRVS system and an example of its potential application to a Pediatric Critical Care division.

II. RBRVS METHODOLOGY

There are over 12,000 CPT-4 codes for

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which physicians can bill for their services. Each CPT-4 code has a specifically assigned Relative Value Unit (RVU) which is a numerical value with 2 decimal places.

Each RVU is actually made up of three components: a work RVU (RVU_w), a practice RVU (RVU_p), and a malpractice RVU (RVU_m). Each of these components has been specifically assigned to each CPT-4 based upon the past 15 years of study and review. As initially proposed, an uncomplicated office visit for evaluation of an upper respiratory illness to a primary physician office would be assigned a RVU of 1.00. All other procedures and evaluations have been assigned an RVU value in relation to that number depending upon the effort, cost, and risk associated with the delivery of a specific service.

The RVU_w represents physician work (salary expense). The RVU_w is a quantification of physician time, technical skill and physical strength, mental effort and judgement, physician stress, and total work. The RVU_p is a quantification of the practice expense (non-physician salary) required and allotted to each CPT-4, included in this expense allotment is overhead expense. The RVU_p represents rent, support staff, and supplies, which may vary by practice location (within a hospital or independent of a hospital). The RVU_m represents the degree of liability risk with the performance of each CPT-4. Because areas of the country vary in terms of cost of living expenses and malpractice "climate", each of the three components should be adjusted by a specific geographic adjustment factor (GAF).

A complete list of CPT-4 Codes and their assigned RVU values along with their component values and the geographic adjustment factors for each region of the country can be found in the issues of the *Federal Register* (http://www.access.gpo.gov/su_docs/).

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Proposed 1999 RVU Values for CPT-4 Codes

CPT-4	Description	RVUw	RVUp	RVUm	RVU Total
99291	E/M, 1 st hr	4.00	1.50	0.11	5.61
99292	E/M, Addl 30 minutes	2.00	0.79	0.04	2.83
31500	Intubation	2.33	0.62	0.14	3.09
36488	Central Line, <2yrs	1.35	0.54	0.14	2.03
92950	CPR	3.80	0.91	0.17	4.88

The trend in RVU valuation has been a progressive increase in value for those services that involve “evaluation and management” (E/M) and a devaluation of those services which are “procedure-oriented”. Though a particular CPT-4 code may have a relatively high RVU assignment, it is also the number of times that CPT-4 is billed which results in the major reimbursement impact. In the pediatric ICU at the Alfred I. DuPont Hospital for Children in Wilmington, Delaware, the breakdown of RVUs from E/M activity is 94% versus only 6% from procedure related activity.

Determining the total RVUs produced by an individual or a group simply involves applying the following formula:

$$\text{Total RVU} = ((\text{Total RVU value of a CPT-4 Code}) * (\text{Number of times CPT-4 billed}))$$

The total RVU value can then be used to compare relative productivity of physicians (RVU/FTE), relative cost behavior (patient care cost/RVU), or in determination of reimbursement, and development of pro formas for divisional activity and budgeting.

III. CONVERTING THE RVU TO ACTUAL REIMBURSEMENT

There is a simple formula which converts

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The Relative Value System

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Since first published in 1992, there have been various updates to the RVU valuation process both in number of CPT-4 codes assigned an RVU and in the specific value of each component. The following table lists the proposed 1999 RVU values for CPT-4 codes utilized by a typical pediatric intensivist:

The Relative Value System

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the RVUs produced into potential reimbursement. In order to perform this, the concept of the Cost Factor (Cf) enters into the equation. This Cf is the dollar amount that every RVU is worth. Prior to 1998, the Cf for Medicare varied by specialty (primary care, specialist, or surgeon). As a result of the Balanced Budget Amendment, a single cost converter for the Medicare system has been implemented. This value is \$36.68/RVU.

Other than Medicare, there is no obligation for any payer to reimburse either the \$36.68/RVU or to have a uniform Cf for specific RVU values. For example, a commercial insurer may reimburse some CPT-4 codes at \$40/RVU and other at \$30/RVU depending upon negotiations with specific physician practices. However, the Medicare \$36.68/RVU can be used as a guide to relative reimbursement of physician activity. In addition, some practices may or may not negotiate for inclusion of the GAF into the RVU dollar conversion. Individual practices must decide whether this extra "manipulation" is actually beneficial.

The specific formula for converting produced RVUs to potential dollars is:

$$\text{Dollars} = \text{Cf} * ((\text{RVU}_w * \text{GAF}_w) + (\text{RVU}_p * \text{GAF}_p) + (\text{RVU}_m * \text{GAF}_m))$$

If not already in place, hospital information systems should be upgraded to track accurate RVU activity by specialty. Simple spreadsheets can also be designed to perform these calculations and track the impact of various market changes on physician perceived performance as the next section illustrates.

IV. PRACTICAL EXAMPLE:

A Critical Care division of 4 intensivists generates 30,000 RVUs/year (50% are RVU_w, 40% are RVU_p, and 10% are RVU_m). Their divisional operational budget is \$900,000 (70% of this expense covers physician salaries and benefits) and their overhead expense is \$250,000. The geographic adjustments are GAF_w = 1.003, GAF_p = 1.005, and the GAF_m = 0.786. Their practice plan has negotiated a reimbursement rate of 110% of Medicare. Their divisional revenue should be \$1,188,773, and their net revenue (revenue – all expenses) is \$38,773. This divisional relative productivity would be 7,500 RVU/FTE. This compares to a desired goal of 7,000 RVU/FTE for their entire group of practice specialists. The next year the reimbursement rate decreases to 90% of Medicare but their clinical activity increased by 10%. The divisional net income changes to (\$80,104). Their practice administrator threatens to decrease divisional salaries because "productivity has obviously decreased!" How can the intensivists respond?

The RBRVS calculations (and a little cost accounting) can assist this division in their time of need. Productivity has activity has actually increased to 8,250/FTE. If the reimbursement rate had stayed at the previous year level, overall net income would have been \$157,650. In addition, the RVU summation also gives an indication of whether certain expenses are proportionally too high from what would have been predicted based on the actual RVU breakdown. The percent of total expenses allocated to physician salaries is about right (50% as predicted by the RVU results compared to an actual 55%). The non-physician total expenses are about 45% of total expenses, again not far off from the RVU predicted of 40%. Perhaps the problem is with the contracting department!

V. CONCLUSION

The RBRVS system has become the standard by

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which physician productivity and reimbursement are being based on even in pediatric specialties. Knowledge of the RBRVS system can result in a stronger negotiating position with third party payers, practice plan administrators and department chairman. Further information about the RVU system and practical applications are available from the author, e-mail: slawless@nemours.org.

Final note: the answer to the initial riddle is, "it depends on the assigned value of the RVU!"

1997-98 Executive Committee

Joseph R. Zanga, M.D.
(President)
23 Mariners Cove, West
New Orleans, LA 70124
(504) 568-4567
Fax: (504) 568-6330
Jzanga@aap.org

Joel J. Alpert, M.D.
(Vice President)
224B Allendale Road
Chestnut Hill, MA 02167
(617) 534-5938
Fax: (617) 534-7087
Jalpert@aap.org

Joe M. Sanders, Jr., M.D.
(Executive Director)
American Academy of Pediatrics
141 Northwest Point Boulevard
Post Office Box 927
Elk Grove Village, IL 60009-0927
(847) 228-5005

Fax: (847) 228-5097
Jsanders@aap.org

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1998 AAP Annual Meeting

October 17-21, 1998
Moscone Convention Center
San Francisco, Marriott

What's new this year at the 1998 Annual Meeting!

Educational Formats: Audience Response Systems and Case Studies:

The Audience Response System (ARS) is unique in that it allows audience participation through the use of individual keypads. This format affords

the opportunity for faculty/attendee interaction through a series of questions with multiple choice answers where attendees can anonymously indicate their choices. Results are tabulated and explanations about the correct answer will follow.

The Case Studies format allows the audience to set the agenda through discussion of cases and problems brought from the attendees' practices.

Benefits of attending the 1998 Annual Meeting:

1. Earn valuable CME credits.
2. Update your skills and techniques
3. Network with your colleagues, from the US and abroad.
4. Hear the latest from experts in the field of pediatrics.
5. Discover why San Francisco is one of the best locations in the world.

We are expecting one of our largest meetings ever so to avoid long lines on-site, please return your Registration and housing forms now, to ensure your best selection of courses and to lock in your hotel reservation.

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