Editorial Commentary: A Rigged Game—Surgeon Reimbursement Under the Resource-Based Relative Value Scale, Current Procedural Terminology, and the Affordable Care Act

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Abstract: The value of surgeon procedural work is currently determined through a fee-setting process controlled by the Centers for Medicare & Medicaid Services. This process relies on the Resource-Based Relative Value Scale (RBRVS) to advise the Centers for Medicare & Medicaid Services concerning surgical work reimbursement. This system and several other government policy decisions over the past 25 years have placed orthopaedic surgeons at great disadvantage in establishing and maintaining the value of orthopaedic surgical work. Continued reliance on the RBRVS will result in further reductions in surgical reimbursements and may affect patient access to orthopaedic services. Orthopaedic surgeons must consider moving away from the RBRVS and Current Procedural Terminology as a way of determining value and instead establish price as the value signal in orthopaedic medicine. Bundled-payment methodologies offer one mechanism for establishing price in the marketplace.

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Ken Kesey wrote *One Flew Over the Cuckoo's Nest* in 1962, and the book was made into a famous movie of the same name starring Jack Nicholson in 1975.[1] The story is a tale of the tyrannical control of Nurse Ratched over the inpatient psychiatry ward she manages and the efforts of the nonconformist R. P. McMurphy to break that control. When confronted with his disruptions of the ward by the hospital psychiatrist, McMurphy complains that Nurse Ratched is not honest in her dealings with the patients and deserves disruption: "She likes a rigged game." Nurse Ratched exerts total control on the ward by manipulating the rules, always to her advantage.

A rigged game. That is the way to describe current surgeon reimbursement under the Resource-Based Relative Value Scale (RBRVS) that uses Current Procedural Terminology (CPT) codes to report and adjudicate insurance claims of physician work. The excellent article "The Cost of Outpatient Arthroscopic Rotator Cuff Repairs: Hospital Reimbursement Is on the Rise While Surgeon Payments Remain Unchanged" by LaPrade, Camp, Brockmeier, Krych, and Werner[2] provides more evidence that the fix is in concerning surgeon reimbursement and that fix is a concerted effort by Medicare and insurance companies to ratchet down surgeon procedural fees. The authors studied Medicare claims data for a 10-year period and noted substantial increases in hospital reimbursement (163%) compared with static surgeon reimbursement over the same time frame. They correctly note that their study does not separate implant and equipment cost increases, which certainly contribute to some of the disparity, but the fact remains that hospitals were reimbursed 255% more than surgeons by 2014 and points to the real culprits in continued cost escalations from arthroscopic rotator cuff repair. Those increases are related to an increasing volume of procedures because of the population aging and hospital cost escalation.

LaPrade et al.[2] also correctly point to the significant growth of the hospital administrative state as a driver of increased hospital costs. The several studies they cite documenting the growth in number and overall compensation of nonclinical and administrative staff is

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The authors report no conflicts of interest in the authorship and publication of this article. Full ICMJE author disclosure forms are available for this article online, as supplementary material.

0749-8063/20788/$36.00

https://doi.org/10.1016/j.arthro.2020.05.010

especially troubling when these increases are not correlated to hospital financial or clinical performance.[3-8] So, while practicing surgeons see a flattening of fees despite inflation, hospital chief executive officers experience a 93% increase in compensation.[6] When viewed through the new lens of "value-based care," one must ask, Where is the value in such an unprecedented growth in workers not even involved in treating patients?

These unjust and unhelpful statistics might be attributed to the unintended consequences of 30 years of government policy, but this outcome was actually desired by the architects of all of these policies. When the RBRVS was formulated at the Harvard School of Public Health in the late 1980s, its intended goal was to restructure payment methodologies to favor primary care over "historically overvalued specialty procedures."[9] As a result, orthopaedics has experienced an absolute decrease in reimbursement levels over the past 27 years of up to 40% for some procedures. When considered relative to 1992 dollars, the reduction is as much as 68%.[10] The flawed Sustainable Growth Rate policy established in 1997 led to several value surrogates such as the Physician Quality Reporting System (PQRS) and the Merit-based Incentive Payment System (MIPS) that require large staff and overhead increases for reporting and compliance satisfaction. The HITECH (Health Information Technology for Economic and Clinical Health) Act of 2009 mandated costly electronic medical record systems and meaningful-use criteria, further increasing staffing needs and practice costs. The massive shift from patient care to nonclinical workers was also the intended consequence of the Affordable Care Act (ACA) of 2010. A significant portion of the increase in the administrative hospital workforce has taken place since the passage of that law, which favors and facilitates large bureaucratic entities to "coordinate" health care.[6] Of particular interest is that the acceleration of hospital reimbursement and the hospital charge multiplier and payment multiplier ratios created by the authors began their steep rise just after the passage of the law. The ACA has put hospitals in the driver's seat and favored them over physicians and surgeons especially when it comes to reimbursement.

The most logical question is, Why do we, surgeons, continue to play this rigged game? Organized orthopaedics including the American Academy of Orthopaedic Surgeons and Arthroscopy Association of North America remain committed to engagement with the RBRVS so that we and our patients have advocates involved in that process. It is the classic "be at the table or on the menu" approach to negotiations. The writing is on the wall, however. We will continue to see efforts to decrease procedural fees through Centers for Medicare & Medicaid Services (CMS) review processes (e.g., recent reductions in the value for total joint arthroplasty) or bundling policies designed to reduce the ability to report legitimate surgeon work (e.g., shoulder arthroscopy codes).

In 2011, CMS—through its wholly owned and controlled subsidiary, the National Correct Coding Initiative—bundled the arthroscopic debridement codes into all the shoulder arthroscopy index codes. It took 6 years, hundreds of hours of uncompensated surgeon work, and lobbying Congress to overturn that policy. This is an obviously ineffective and unsustainable way to deal with flawed reimbursement issues. With continued negative pressure on procedural reimbursement, there will come a time in the not-too-distant future when it is economically superior to spend more time in the office than in the operating room. Evaluation and management relative value units will be the same as surgical CPT codes on a per-time basis. The RBRVS is a loser for our patients and their ability to maintain access to orthopaedic procedural care.

Bundling of existing CPT codes will continue and is part of the CMS plan. Let's take recognized category I CPT procedures, all with their own separate and distinct work values. CMS identifies codes that are reported together with a frequency of 50% or higher and determines that those codes should be bundled, that is, they are really one procedure. This process simply robs surgeons of work value. If you go to McDonald's and order a Big Mac, fries, and drink, CMS not only would say should you get the fries and drink at a discount (multiple-procedure minimum discount rule) but also now says you should get the fries and drink for free with bundling. This is un-American and wrong to the core. When do we stand up? When do we create our own fee schedule?

We need to get away from CPT codes and endlessly fighting over their value. CPT is a rigged game that was designed for us to lose. We need to get back to a simple, American and market-based approach to value what we do. We must have price re-emerge as the value signal in orthopaedic medicine. Price is the original "crowdsource" approach to value that lets market players individually make decisions to determine value. It works over time and distance—no complex formulae, no bean counters, and no reporting forms or jumping through a million meaningless hoops to arrive at "reimbursement."

Can never happen, you say? Well, it's happening now with bundled payments in which surgeons decide on the price for an episode of orthopaedic care and then sell that to insurance companies. Better yet, many practices are selling their comprehensive episodic services to self-insured employers, eliminating the insurance middleman. This is gaining traction in the total

joint and spine arenas, but rotator cuff, anterior cruciate ligament, and other high-volume arthroscopic procedures with predictable costs will follow. With the price of a comprehensive episode of care established, CPT codes become irrelevant from a reimbursement standpoint and are useful only for tracking the incidence of disease and treatment volumes.

We each have practiced orthopaedics for almost 30 years without ever competing on price. Everyone we know, save public employees, has had to take price into consideration in their business calculus—everyone except doctors. Let that fact sink in for a few minutes while you consider our pandemic-injured market economy. Before our services are valued below those of the internist evaluating a sore throat, we must change our approach to procedural value in the marketplace.

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