National Centre for Classification in Health

PROFESSIONAL RELATIVITIES STUDY

RESOURCE MATERIAL J

Clinician Consultant documentation

Background documentation and instructions provided to the Clinician Consultants to assist with their task to provide preliminary rankings and ratings for MBS items.

prepared for

Medicare Schedule Review Board
December 2000

Professional Relativities Study

Clinician Consultants

Documentation - Phase 1

October 1997

National Centre For Classification In Health

Professional Relativities Study (PRS)

Clinician Consultants Documentation - Phase 1

CONTENTS

1. Overview of PRS

1.1 Introduction
1.2 Methodology
1.3 Study Phases
1.4 Project Management and Committee Roles
1.5 Process of selecting MBS items
Attachments

2. Professional Relativities Technical Committee (PRTC)

Outcomes Report (*without attachments*)

3. Guidelines for Clinician Consultants (Phase 1)

3.1 Guidelines for ranking and rating MBS procedural items
3.2 List 1 - MBS items selected for Speciality Group (sorted by MBS item number)
3.3 List 2 - MBS items selected for Specialty Group (sorted by Anaesthetic time)
3.4 Disc containing a copy of List 1 and List 2 for optional use (excel sheet)
3.5 Worksheets for ranking and rating MBS items

4. Abbreviations and Glossary

4.1 Abbreviations
4.2 Glossary of terms and PRS definitions

5. Literature

5.1 Measurement and analysis of intraservice work (Hsiao, W.C. et al, 28 October 1988)
5.2 An overview of the development and refinement of the Resource-Based Relative Value Scale (Hsiao, W.C. et al, November 1992)
5.3 Assessing the implementation of physician-payment reform (Hsiao, W.C. et al, 1 April 1995)
5.4 Valuing medical work (Deeble, J.S, 1 July 1996)

1. Overview of PRS

1.1 Introduction

1.2 Methodology

1.3 Study Phases

1.4 Project Management and Committee Roles

1.5 Process of selecting MBS items

Attachments

1.1 INTRODUCTION

The Professional Relativities Study (PRS) is being conducted by the National Centre for Classification in Health (NCCH) for the Medicare Schedule Review Board (MSRB). The PRS is one of three projects being conducted under the direction of the MSRB and the Medicare Schedule Review Task Force (MSRTF). The other two projects, Remuneration Rates Study and the Practice Costs study, are being undertaken as separate consultancies. An overview of the projects and terms of reference for the Remuneration Rates and Practice Cost Studies are provided as *Attachment 1*.

The PRS definitive study follows on from a feasibility study carried out in 1996 and early 1997 by the NCCH for the MSRB to examine the potential for mapping the professional components of services described in overseas schedules with the Medicare Benefits Schedule (MBS).

The overall aim of testing the mapping between the MBS and CPT was to see if the resource based relative value units developed in the United States during the 1980s and applied to the American Medical Association's Current Procedural Terminology (CPT) could be applied to mapped MBS items.

Only the Therapeutic Procedures in Category 3 of MBS were in scope for the feasibility study. That study demonstrated that it is possible to map between MBS and CPT and to gain consensus from expert clinicians on relative intraservice work (time and intensity) for items in the MBS. However, the maps are not sufficiently robust on their own to determine the relative values of the mapped MBS items.

The PRS requires Australian clinician input to develop Resource Based Relative Values for all specialties. Data to be used includes clinicians estimates of time and ratings of intensity and maps between MBS and CPT. The relative value units determined for core items will be used to establish relative values for all items within a specialty and to establish link items between specialties. The study covers over 34 specialties (*see Attachment 2*) and the following categories within the MBS:

Category 1 - Professional attendances
Category 2 - Diagnostic Procedures and Investigations
Category 3 - Therapeutic Procedures
Category 4 - Oral and Maxillofacial Services

As stated in the introductory letter from the NCCH, the study requires a complex organisational effort to bring together specialty groups of clinicians and technical advisers in a series of meetings which are interrelated and which will result in advice and reporting to the MSRB at regular intervals.

1.1.1 Clinician Consultants involvement

The role of Clinician Consultant involvement in the PRS is the development of Relative Value Units for core items selected within each specialty group. RVUs will subsequently be reviewed by specialty Consensus Groups and confirmed by the Advisory Panel on Professional Relativities in Medical Services.

Clinician Consultant involvement in this Study is as follows *(see also sections 1.2 and 1.3)*:

PHASE 1 (via correspondence)

- Review the appropriateness of items allocated (Category 2-4) to the relevant specialty by the NCCH
- Rank MBS procedural items in terms of the total work value (i.e. time and intensity) of each item
- Estimate times for component parts of each MBS item (preservice, intraservice and postservice)
- Rate the intensity of each MBS item

These activities will be used for formula development and selection of core items. *See Section 3.1 "Guidelines for ranking and rating MBS procedural items"*.

PHASE 2 (face to face meetings)

a) Clinician Consultant Meetings

- Review maps between MBS and CPT
- Review **attendance** items and incorporate into procedural item rankings
- Undertake ratings of intensity for attendance items
- Confirm estimates of time and ratings of intensity for procedural items
- Estimate time and rate intensity of items not already reviewed
- Confirm core and link items
- Draft relative value units (RVUs) for core items
- Make recommendations to the Consensus Groups regarding the above

Note: New attendance item documentation will be forwarded to Clinician Consultants prior to meetings

b) Consensus Group Meeting

Attend Consensus Group meeting where core item and remaining item RVUs will be determined.

Note: Consensus Groups will be provided with feedback on rankings, time estimates and intensity ratings developed by the Clinician Consultants and core item selection during Phase 1 and 2. They will review these in collaboration with the Clinician Consultants.

1.1.2 Selection of Clinician Consultants

The NCCH has used its network of Clinician Consultants and representatives from the professional groups to invite your participation as a Clinician Consultant on this project in accordance with the specialty groups approved by the MSRB. In some specialty areas we have invited more than one Clinician Consultant to participate in the study (*refer to Attachment 2 showing participating clinicians*). We have provided the addresses and phone numbers of the Clinician Consultants for your specialty where applicable (*see Attachment 3*). It is hoped that agreement on the rankings and initial ratings (Phase 1) can be managed via phone or fax.

The NCCH also encourages consultation with other colleagues in your specialty for Phase 1 of the project.

Where Clinician Consultants (particularly Physicians) are reviewing fewer procedural items (eg <20 items), the NCCH recommends that they meet as a larger CC group to combine their rankings and ratings. This will ensure that RVU development is statistically meaningful for these specialties (refer to section 1.5 for details).

1.1.3 Attendance items

The MBS attendance items have been revised by the Medicare Schedule Review Board. It is intended to develop RVUs for these newly developed attendance items.

A Consensus Group has been formed to review the attendance items. This group will meet twice. The PRTC recommended that the first meeting of this group be held prior to the Clinician Consultants' meetings to establish guidelines for developing attendance RVUs.

All Clinician Consultants will be asked to rank and rate the new attendance items with their procedural items in Phase 2 of the PRS.

1.2 METHODOLOGY

The ultimate outcome of the PRS project is a set of work related Relative Value Units (RVUs) for each item in Categories 1-4 of the MBS. These RVUs will be formula based to:

(a) make explicit the basis for the Resource Based Relative Value Scale (RBRVS)
(b) maximise acceptance by the medical community, and
(c) facilitate future updates

The methodology is outlined by the following stages (*refer also Attachment 4*):

1.	**Establish rules and regulations for study**	**PRTC**
2.	**Map MBS/CPT items**	**NCCH**
3.	**Sort MBS items by specialty for RVU development**	**NCCH**
4.	**Rank items based on total work value, estimate times and rate intensities for selected items**	**CCs**
5.	**Regress rankings against times and intensity ratings to develop formula. Estimate efficacy of formula and its' consistency with rankings**	**NCCH (Statistician)**
6.	**Choose core and link items based on MBS item ranks, good maps, and frequencies**	**NCCH/ CCs**
7.	**Provide RVUs for core items based on the US RVUs from good maps and information on times and intensity ratings**	**CCs**
8.	**Complete estimates of times and ratings of intensity**	**CCs**
9.	**Project core RVUs to remaining items using rankings**	**NCCH (Statistician)**
10.	**Re-evaluate formula and test application to RVUs for all items**	**NCCH (Statistician)**
11.	**Confirm draft RVUs and link items**	**CGs**

The study stages are discussed in more detail over page.

1. Establish rules and regulations for study (PRTC)

The PRTC is responsible for recommending definitions, rules and criteria for application throughout the study.

2. Map MBS/CPT items (NCCH)

The MBS items are being mapped to CPT codes in order to inform about appropriate CPT RVUs for use in the Study. Mapping is being undertaken from MBS items to CPT codes (forward maps) and from CPT codes to MBS items (backward maps). The 'good' maps will be used as a major criterion for the selection of core items for which RVUs will be developed. "Good" maps will be determined from the map ratio and rating and consistency of terminology of MBS items and CPT codes.

3. Sort MBS items by Specialty for RVU development (NCCH)

It is important to the outcome of the project that item numbers are categorised according to the Speciality in which clinicians provide their services. Information received from the Medicare Benefits Branch (i.e. frequencies of services provided by MBS item numbers for Specialty groups) will be analysed in order to categorise each item to a specialty. Where MBS items are performed by several specialists they will be reviewed by those Specialty groups which provide the highest proportions of services; preferably a maximum of two specialty groups per item. A list of Specialty Groups approved by the MSRB is provided in *Attachment 2*.

4. Rank items based on total work value, confirm time estimates and rate intensities for selected items (Clinician Consultants)

In order to choose core items, test the validity of a formula and ensure the ability to replicate RVUs for MBS items, it is necessary to rank the items within each Specialty (total N) in terms of the **total work value.** Ranking is necessary to enable the relative value determinations for the core items to be projected to the remaining items and will serve as the focal point in the development of the formula. Ranking means the ordering of items from 1-N where 1 is the item of most value to the specialty and N is the least. Where items are of equal value, these can be ranked together.

Clinician Consultants will be provided with MBS items. Printouts will be produced for each Specialty and sorted by MBS item number and overall rankings. *Table 1 over page is an example*:

TABLE 1
Ranking of MBS items

MBS Item Number	Desc.	Freq.	Overall Rank
XXXX	Radical	23	1
YYYY	Removal of	735	2
ZZZZZ	Biopsy.....	2745	3

Some confirmation of time estimates and ratings of intensity will also be undertaken in stage 4.

The CC groups will be asked to:

a) **Estimate** pre, intra, post direct and indirect times as agreed by the PRTC
b) **Rate** within specialty
   i cognitive skill, clinical judgement and communication skills
   ii technical skill and physical effort, and
   iii stress due to risk.

This has been illustrated in Table 2 below.

TABLE 2
Time Estimates and Ratings of Intensity

MBS Item Number	Desc.	Freq.	Rank	Quality of map	Component ratings			Time		
					Effort	Skill	Stress	Pre	Intra	Post
XXXX	Radical	23	1	2	10	9	8	60	120	30
YYYY	Removal of	735	2	1	8	7	8	30	60	30
ZZZZZ	Biopsy.....	2745	3	4	4	2	3	5	25	5

At this stage, estimates of time and ratings of work components for at least 20% of MBS items within each specialty would be necessary for preliminary testing of the formula.

5. Regress rankings against times and intensity ratings. Estimate efficacy of formula and consistency with rankings (NCCH Statistician)

Regression analysis will be used to explain the ranking of total work value in terms of times and intensity. This will have two purposes:

a) to test possible formulae
b) to provide feedback to the CCs about their rankings and ratings

6. Choose core/link items based on MBS item ranks, good maps, and frequencies (NCCH/Clinician Consultants)

Core item selection will be based on the rankings provided by the CCs, the 'good' maps and frequency data. Both core and link items should ideally be high frequency items which have good maps and are evenly distributed throughout the rankings.

7. Provide RVUs for core items based on the US RVUs and the time and intensity ratings data (Clinician Consultants)

RVUs for CPT items for good quality MBS maps will be provided to the CCs to review, using time estimates, intensity ratings and other information. Note that while the ranking of items and the estimation of times and the ratings of effort, skill and stress are significant data for the estimation of a formula, **they do not link this formula to relative value.** This step is accomplished by the RVU estimation for the core items. In this light the estimation of RVUs for the core items can be viewed as a calibration.

8. Complete estimation of times and ratings of intensity (Clinician Consultants)

This work needs to be completed for validation of extrapolation/interpolation and ultimately so that all relative values can be formula based so that the final outcome of the project is based on a credible and defensible methodology. The attendance items will be ranked and rated with procedural items at this stage.

9. Project core RVUs to remaining items using rankings (NCCH Statistician)

This will initially be accomplished via interpolation using the rankings and later revised on the basis of time estimates and ratings of intensity.

10. Re-evaluate formula and test application to RVUs for all items (NCCH Statistician)

The regression analysis of step 5. will be repeated using the full data and interpolation of non core RVUs refined accordingly.

11. Confirm draft RVUs and link items (Consensus Group)

To assist them in their review, the CGs will be provided with ordered lists of all items within each specialty. These will contain the draft times, intensity ratings, RVUs and a comparison of the RVUs with the rankings previously provided by the CCs.

1.3 STUDY PHASES

The methodology has been presented in terms of the study phases in Table 3 below. At the end of each phase, results will be reported to the MSRB so that subsequent phases can be redirected if necessary. *See also flow chart in Attachment 5.*

TABLE 3
PRS Study Phases

PHASE 1

Step 1	**PRTC**	Recommend definitions, rules and criteria for application throughout study
Step 2	**NCCH**	Map all items in MBS Categories 2 - 4 (as of May 1997 - undertaken concurrently with steps 1-5) Evaluate quality of maps using criteria established by PRTC.
Step 3	**NCCH**	Sort all MBS items (Categories 2-4) into specialty groups - separating attendance items from diagnostic and procedural items.
Step 4	**CCs**	• confirm MBS procedural items selected by the NCCH for study within each specialty group • rank all MBS procedural items within their specialty in terms of total work and in accordance with criteria set by the PRTC (the NCCH will have pre-sorted items in terms of anaesthetic times or proxy time to assist with this process) • **estimate** pre, intra and post times and **rate** effort, skill and stress for at least 20% of items *Note:* this work would be undertaken by correspondence
Step 5	**NCCH (Statistician)**	Develop preliminary formula on the basis of the information assembled through step 4.
Step 6	**PRTC**	Present results of formula testing, and mapping to second meeting of PRTC.
Step 7	**APPRMS**	Provide information to Advisory Panel on Professional Relativities for Medical Services (APPRMS) on definitions, rules and criteria
Deliverables	**NCCH**	First Interim Report to MSRB - Board to approve definitions, rules and criteria.

PHASE 2

Step 8	**NCCH**	Assemble additional data including frequencies for CPT mapped items, actual theatre times from hospital operating theatre systems, information from Department of Health and Family Services operating theatre service weight study, anaesthesia times for MBS items and MBS relativities using existing fees.
Step 9	**CG**	CG on attendance items to hold first meeting
Step 10	**NCCH**	Draft core and link items (for each specialty covering a representative range of activities based on quality maps with CPT, ratings of MBS items, volume, the cost of services and attendance items).
Step 11	**CCs** **NCCH**	Meet with CCs to establish RVUs for MBS core items and to complete the estimation of pre, intra and post times and the rating of effort, skill and stress for procedural items. Rank and rate attendance items. The CCs will: • check query maps • check maps of all core items • review attendance items and incorporate into procedural item rankings • undertake ratings of intensity of attendance items • confirm estimates of time and ratings of intensity for procedural items • estimate time and rate intensity of items not already reviewed • confirm core and link items on which inter and intra professonal relativities will be established • develop RVUs for core items (based on CPT RVUs**)** • make recommendations to the Consensus Groups regarding the above.
Step 12	**NCCH (Statistician)**	Project core RVUs to remaining items using rankings. Re-evaluate formula and test application to RVUs.
Step 13	**NCCH**	Distribute and present results of CC core RVUs to Consensus Groups (CGs) for confirmation of RVUs (all steps in the development of the RVUs by CCs will be presented).
Step 14	**CGs**	Meet with the CGs to ratify the draft RVUs and link items.

PHASE 2
(Cont'd)

Step 15	**CGs**	Meet with CG for attendance items for a second time to determine attendance item RVUs and provide those RVUs to MSRB for consideration with relativities of therapeutic items.
Deliverables	**NCCH**	Second Interim Report to MSRB - Board to approve work to date

PHASE 3

Step 16	**NCCH**	Revise RVUs based on CG recommendations.
Step 17	**APPRMS**	Meet with APPRMS to advise members of outcome of CG meetings, review and confirm RVUs for core, non core and link items.
Deliverables	**NCCH**	Third Interim Report to MSRB - Board to approve work to date.

PHASE 4

Step 18	**NCCH**	Assemble results and prepare final report
Deliverables	**NCCH**	Final Report to MSRB

1.4 PRS PROJECT MANAGEMENT AND COMMITTEE ROLES

Title	Members	Role
1. Project Management		
MSRB Medicare Schedule Review Board	DHSF: Dr Louise Morauta (Chairperson) Ms Gail Batman Dr Bill Coote Mr Terry Slater AMA: Dr Stephen Clarke Dr Bill Coote Dr Geoffrey Metz Dr Col Owen	Responsible for directing the Professional Relativities Study.
MSRTF Medicare Schedule Review Task Force	Mr Col Bailey Mr John Popplewell Mr David Reddy	Responsible for the management of the Professional Relativities Study
NCCH National Centre for Classification in Health		The NCCH is responsible for the day to day project management.
Director	A/Prof Rosemary Roberts	Attend meetings with MSRTF and MSRB. Assist with preparation of reports to MSRB. Liaise with members of MSRTF.
Project Manager Assistant Manager	Ms Lauren Jones Ms Sheelagh Noonan	Oversee the day to day management of the project for the NCCH. Become familiar with criteria, rules and definitions for development of RVUs. Communicate with MSRTF concerning organisation of meetings, preparation of data and reports to project groups and MSRTF. Supervise NCCH project officers. Ensure time lines are followed. Prepare interim and final reports for MSRB. Manage NCCH project budget. Attend meetings of PRTC, APPRMS, CCs and CGs when possible.
Meeting Facilitators	Ms Kay Bonello Ms Kerry Innes Ms Lauren Jones Ms Sheelagh Noonan A/Prof Rosemary Roberts Ms Sue Walker	Become familiar with criteria, rules and definitions for development of RVUs. Assist in preparation of material for CG meetings. Run CG meetings. Assist in preparation of reports from CG meetings.

Title	Members	Role
1. Project Management		
Project Officers	Ms Andrea Groom Ms Paula Hallang Ms Jennifer Shepheard Ms Joy Smith	Become familiar with criteria, rules and definitions for development of RVUs. Carry out mappings between MBS and CPT. Retrieve and assemble data on actual theatre times for Australian procedures, MBS relativities, CPT mapped item relativities and frequencies, anaesthesia times (in conjunction with MSRTF). Attend meetings of PRTC, APPRMS, CCs and CGs. Keep minutes and prepare reports of meetings.
Statistician OR Systems Pty Ltd	Mr George Rennie	Play a major role in PRTC in assisting with decisions on: definition of time - total service time, intra, pre and post, definition of direct/indirect time & effect on MBS relativities, effect of using existing MBS item relativities for RVUs, formula for calculating time and intensity to establish RVUs, methods for RVUs for consults, therapeutic and anaesthesia items, criteria for choosing core and link items, method for translating RVUs from core to remaining items, criteria for accepting a good map. Test PRTC decisions on above definitions and criteria. Supervise database manager. Attend meetings of PRTC, APPRMS. Liaise with NCCH and MSRTF.
Database Manager OR Systems Pty Ltd	Mr Andrew Brion	Prepare and maintain mapping data bases and reports. Prepare data bases with additional data on theatre & anaesthesia times, frequencies, MBS relativities. Enter results from CC and CG meetings on time and intensity estimates. Establish e-mail links with other project staff.
Administrative Assistant	Ms Ruth Rinot	Arrange meetings, travel. Disseminate material to meeting participants. Prepare reports. Liaise with interstate staff. Prepare and maintain data bases of group membership, contact addresses, phones, faxes, email. Liaise with MSRTF re meeting organisation.

Title	Members	Role
2. Committees		
PRTC Professional Relativities Technical Committee	7 Clinicians: 1 GP rural 1 GP metropolitan 1 General Surgeon 1 Specialist Surgeon 1 General Physician or Paediatrician 1 Specialist Physician 1 Anaesthetist NCCH Director NCCH Project Manager Statistician Meeting Facilitators (5) MSRTF (3) MSRB (1)	Recommend definition of time - total service time, intra, pre and post. Recommend effect of using existing MBS item relativities for RVUs. Recommend formula for calculating time and intensity to establish RVUs. Recommend methods for RVUs for consults, therapeutic & anaesthesia items. Recommend criteria for choosing core & link items. Recommend method for translating RVUs from core to remaining items. Recommend criteria for accepting a good map.
APPRMS Advisory Panel on Professional Relativities in Medical Services	Clinicians from specialty craft groups NCCH Director NCCH Project Manager Statistician MSRTF (3) MSRB members	Note and comment on PRTC rules, definitions, crtieria, formulae. Confirm RVUs for core and remaining items from CCs and CGs. Confirm link items. Provide communication to and from craft groups.
CCs Clinician Consultants	Clinician Consultant representatives of specialty craft groups Attendance item Consensus Group NCCH Project Manager NCCH Project Officer	Decide 20 core items in specialty. Review data on core items. Establish times & intensity for core items. Establish link items. Make recommendations to Consensus Groups.

Title	Members	Role
2. Committees		
CGs Consensus Groups	Consensus Groups on Procedural Items: Up to 4 representatives of each specialty nominated by Colleges & Societies Clinician Consultants NCCH Meeting Facilitator NCCH Project Officer 1 MSRTF representative Consensus Group on Attendance Items: 2 General Practitioners General Surgeon Specialist Surgeon General Physician or Paediatrician Specialist Physician (Cardiologist or GE) NCCH Meeting Facilitator NCCH Project Officer 1 MSRTF Representative	Agree RVUs for core items and confirm link items

1.5 PROCESS OF SELECTING MBS ITEMS

Data from the Medical Benefits Branch of the Department of Health and Family Services were used to determine the frequencies for providers of each item. MBS items were allocated to specialties based on criteria recommended by the PRTC. The principle of using MBS data is to ensure that specialist providers of items are involved in the development of RVUs. Reliance on the MBS classification only would limit the allocation of items to some speciality groups.

Using 1996/97 claims data, MBS Items in Categories 2-4 were initially allocated to Specialties for ranking and for the estimation of times and intensities on the following basis:

1 Provided the specialty had performed a sufficient number of services (>3 and >12.5% of the total services), MBS items were first allocated to the specialty which provided most services for the item in proportion to the total number of services provided by that specialty.

2 Items were allocated to a second specialty if the item constituted more than 0.1% of the specialty's workload, the specialty provided more than 25% of the total services for the item, no other eligible speciality provided more services and the item had not already been allocated to the specialty under.

3 Items were also allocated if the specialty performed the second most services (these being >3, >12.5% of total services and >0.1% of the services provided by the specialty) for the item in proportion to the total number of services provided by the specialty, and the item was not already allocated under (2).

For 487 items, there were insufficient claims data to make an initial allocation according to these three rules. These items were allocated manually to a single specialty on the basis of the location in the schedule, in accordance with the allocation of similar items or using the exception report.

An exception report of major providers who missed out on allocation was produced and reviewed and submitted to the Task Force. This report was used to manually allocate items to major providers if the major provider:

- provided ≥50% of the item
- provided <50% of the item and the item was in the appropriate section of the schedule or relevant to the providers specialty.

Where groups have discrepancies over including/not including items in their Specialty area, these will be revised by the NCCH and redistributed by way of the Clinician Consultant meetings.

Attachment 6 shows the number of items allocated to each Specialty Group based on the above criteria. No MBS items were allocated to Emergency Medicine based on the above criteria, mainly because there were very few services provided by this group overall. Given that there is considerable commonality between items allocated to General Practice and items performed by Emergency Medicine Practitioners, the NCCH has recommended that Emergency Medicine be represented at the General Practice CC. Endocrinology, Geriatrics and Infectious diseases were grouped with General Medicine for the same reason.

Specialty Groups for Clinician Consultants Meetings

After analysis of MBS data and allocation of MBS items, it was found that some CC groups would not be viable on their own in terms of the number of procedural items for RVU development. It is important to the outcome of the PRS that all specialty craft groups are involved throughout the process of RVU development. Therefore, in order to make these groups viable (ie to ensure that RVU development is statistically meaningful for the specialty), the following consolidation is recommended for the **Clinician Consultant meetings and Consensus Groups**:

Combined Group	**Specialities**
Group 1	Anaesthesia ICU
Group 2	Clinical Haematology Medical Oncology
Group 3	General Medicine, Endocrinology, Geriatrics Infectious Diseases, Rehabilitation Medicine, Rheumatology, Nuclear Medicine, Immunology
Group 5	Obstetrics and Gynaecology IVF
Group 5	Paediatric medicine Thoracic medicine
Group 6	Cardiology Renal Medicine

(Please note that the final allocation of items has been made on this basis)

The above group combinations have been selected on the basis that they have some high frequency MBS items in common. This does no negate the importance of each specialty craft group being fully represented for the PRS, but ensures that groups with small numbers of procedural items are viable in terms of the study processes.

All CC groups will initially rank and rate items as allocated (refer *Attachment 6*). The above combinations are only recommended for CC meetings and Consensus Group review.

Attachments

1.
   - Overview of Projects (MSRB)
   - Terms of Reference - Remuneration Rates Study
   - Practice Costs Study

2. Clinician Consultant Groups Recommended for the PRS

3. Clinician Consultants by Specialty - Names and Addresses

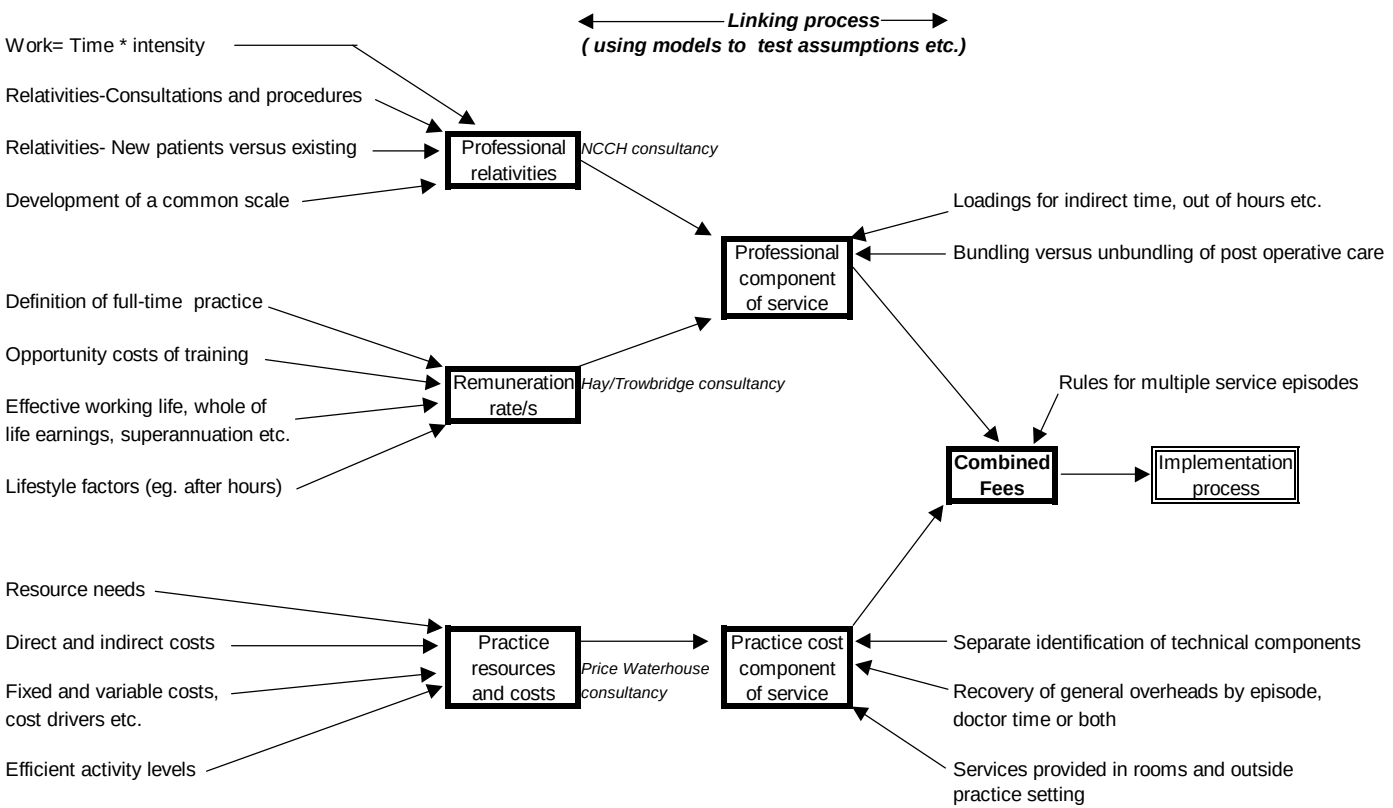
4. Methodology

5. Outline of Processes

6. Allocation of MBS items for review by Specialty Groups

Overview of Projects (MSRB)

Attachment 1



TERMS OF REFERENCE AND REMUNERATION RATES AND PRACTICE COST STUDIES

1. Remuneration Rates Study

Under the direction of the Medicare Schedule Review Task Force and within the context of a cost or resource (non market) based approach for setting fees for medical services covered by the General Medical Services Table of the Medicare Benefits Schedule the consultants shall:

a) identify the factors that are considered relevant in establishing "benchmark" and differential net earning rates for representative classes of doctors providing private medical services in Australia. Relevant factors may include issues such as income foregone in obtaining the requisite skills and experience, duration of professional working life, disruption to family life etc;

b) provide comparisons of the net earning rates and hours of work of representative classes of doctors in the public and private sectors in Australia having regard to superannuation and other "whole of life" income related matters;

c) provide similar comparisons with the net earning rates of other professionals in Australia; and

d) provide comparisons of net earning rates in Australia and in other countries with similar living standards using generally accepted benchmarks such as average weekly earnings and purchasing power equivalents.

The consultancy shall commence on Monday 4 August 1997 with a final report to be provided to the Medicare Schedule Review Board by Friday 21 November 1997.

2. Practice Costs Study

Under the direction of the Medicare Schedule Review Task Force and within a process of consultation with representative medical groups the consultant will:

a) develop the criteria to apply in the determination of resources required to operate a reasonably efficient private medical practice across a range of major specialty groups;

b) construct representative resource based models based on reasonably efficient private medical practices to assist in establishing fair and reasonable non professional medical components in private medical fees across the range of major specialty groups;

The models must:

- identify the physical resources incorporated into each practice type;
- apply reasonable efficient cost and utilisation rates to those resources;
- provide an orderly classification and allocation of costs into the following cost groups: direct costs; indirect costs; professional indemnity insurance; and working capital;

- provide sufficient flexibility to allow for inclusion of new items of service and changes of mix of services with consequent adjustments to resources allocated to other items within the model;
- provide the capacity for differential cost analysis in relation to the following practice variables:
  - location of service;
  - practice type;
  - size of practice; and
  - geographical location of practice; and
- allow for the ongoing review, evaluation and adjustment of practice costs.

c) Identify options and recommend a set of costing principles to apply to the allocation of resources and costs within the model.

d) Undertake differential cost analyses in relation to costs affected by the location where services are provided, the practice type, size of practice and geographical location of practice, and report on the policy issues arising; and

- analyse and report on the variances between groups of costs of services across a range

e) Through application of the models describe and quantify the financial impact of options for determining cost recovery rates which could represent the practice cost component for fees for items of service listed in the Medicare Benefits Schedule.

f) The consultancy shall commence by Tuesday 1 July 1997 and be completed as soon as practicable, but no later than Thursday 30 April 1998.

Professional Relativities Study
Clinician Consultant Groups

PHASE 1

GROUP	CLINICIAN CONSULTANT GROUPS (CCs)	CLINICIAN CONSULTANT NAMES	
	Name and specialty groups included	*Name*	*State*
1	General Practice	*Dr Brian Bowring*	*Tasmania*
		Dr Paul Dugdale	*ACT*
	Emergency Medicine	*Dr Michael Cleary*	*Brisbane*
2	Facio-max surg	*Dr Mark Moore*	*Adelaide*
3	Obstetrics and Gynaecology	*Dr Miriam O'Connor*	*Melbourne*
		Prof Roger Pepperell	*Melbourne*
4	General surgery	*Mr John Cocks*	*Melbourne*
		Dr Peter Burke	*Sydney*
	Breast Surgery	*Dr Michael Henderson*	*Melbourne*
	Colorectal	*Mr Ian Jones*	*Melbourne*
	Upper GI	*Dr Christopher Worthley*	*Adelaide*
5	Cardio-thoracic surgery	*Prof Brian McCaughan*	*Sydney*
6	Neurosurgery	*Mr Peter Bentivoglio*	*Sydney*
		Mr Graeme Brazenor	*Melbourne*
		Mr Richard Vaughan	*Perth*
7	Orthopaedic surgery	*Dr Philip McGrath*	*Sydney*
8	Paediatric surgery	*Dr Hugh Martin*	*Sydney*
9	Plastic surgery	*Mr Frank Ham*	*Melbourne*
	Hand surgery	*Mr Bruce Johnstone*	*Melbourne*
	Burns	*Dr Peter Kennedy*	*Sydney*
10	Urology	*Mr Laurie Cleeve*	*Melbourne*
		Mr DG Travis	*Melbourne*
11	Vascular surgery	*Dr Ray Englund*	*Sydney*
12	Ophthalmology	*Dr Michael Hennessy*	*Sydney*
		Dr Justin Playfair	*Sydney*
13	ENT	*Dr Robert Berkowitz*	*Melbourne*
		Mr John Kennedy	*Melbourne*
14	Anaesthesia	*Dr Greg Deacon*	*Adelaide*
		Prof Bill Runciman	
	Hyperbaric medicine	*Dr Michael Bennett*	*Sydney*
15	Dermatology	*Dr Robert Salmon*	*Wollongong*
16	IVF	*Dr Geoffrey Driscoll*	*Sydney*
17	General medicine	*Dr Peter Greenberg*	*Melbourne*
	Endocrinology	*Dr Duncan Topliss*	*Melbourne*
	Geriatrics	*Dr Terence Finnegan*	*Sydney*
	Infectious diseases	*Dr Philip Jones*	*Sydney*
18	Cardiology	*Dr Terry Campbell*	*Sydney*
19	Renal medicine	*Dr Lindsay Barratt*	*Adelaide*
		Dr Timothy Mathew	*Adelaide*
20	Gastroenterology	*Dr Finlay Macrae*	*Melbourne*
21	Neurology	*Dr Robert Hjorth*	*Melbourne*
22	Paediatric medicine	*Dr Ralph Hanson*	*Sydney*
23	Rehabilitation medicine	*Dr Lynette Lee*	*Sydney*
24	Rheumatology	*Dr David Barraclough*	*Melbourne*
25	Thoracic medicine	*Dr Chris Clarke*	*Sydney*
26**	Psychiatry	*Dr Kay Wilhelm*	*Sydney*
27	Radiation oncology	*Dr David Thomas*	*Brisbane*
28	Clinical haematology	*Dr Frank Firkin*	*Melbourne*
29	Medical oncology	*Dr Raymond Snyder*	*Melbourne*
30	Intensive care	*Dr Robert Herkes*	*Sydney*
31	Nuclear medicine	*Dr Barry Chatterton*	*Adelaide*
32	Immunology	*Dr Raymon Bullock*	*Sydney*

** Psychiatry to be reviewed with Attendance items

OBSTETRICS AND GYNAECOLOGY

Dr Miriam O'Connor
Freemasons Medical Centre
Suite 105
320 Victoria Parade Tel: 03 9416 3864
EAST MELBOURNE VIC 3002 Fax: 03 9416 2917

Prof Roger Pepperell
Professor, Obstetrics and Gynaecology
Royal Women's Hospital
132 Grattan Street Tel: 03 9344 5536
CARLTON VIC 3053 Fax: 03 9347 1761

IVF

Dr Geoffrey Driscoll
City West House
12 Caroline Street
WESTMEAD NSW 2145

Tel: 02 9689 1966
Fax: 02 9633 3730

GENERAL SURGERY

Dr Peter Burke
Surgeon
Consulting Rooms
31 Campsie Street Tel: 02 9789 6960
CAMPSIE NSW 2194 Fax: 02 9787 4783

Mr John Cocks
Surgeon
Suite 17-18
Box Hill Gardens Medical Centre
33 Nelson Road Tel: 03 9895 7566
BOX HILL VIC 3128 Fax: 03 9895 7607

Breast

Dr Michael Henderson
Department of Surgery
St Vincent's Hospital
Victoria Parade Tel: 03 9288 2545
FITZROY VIC 3065 Fax: 03 9288 2571

Colorectal

Mr Ian Jones
Suite 5
Private Medical Centre
Royal Melbourne Hospital Tel: 03 9347 4077
PARKVILLE VIC 3050 Fax: 03 9348 2075

Upper GI Surgery

Dr Christopher Worthley
Senior Visiting Surgeon
Gastrointestinal Services
Royal Adelaide Hospital
Level 2 North Wing
North Terrace Tel: 08 8222 5648
ADELAIDE SA 5000 Fax: 08 8222 5614

ORTHOPAEDIC SURGERY

Dr Philip McGrath
Department of Surgery
Westmead Hospital
Cnr Hawkesbury and Darcy Roads Tel: 02 9845 6886
WESTMEAD NSW 2145 Fax: 02 9893 7440

NEUROSURGERY

Mr Peter Bentivoglio
St Vincent's Clinic
Suite 704
438 Victoria Street Tel: 02 9332 6751
DARLINGHURST NSW 2010 Fax: 02 9332 6761

Mr Graeme Brazenor
Consulting Rooms
19 Erin Street Tel: 03 9429 6262
RICHMOND VIC 3121 Fax: 03 9429 6360

Mr Richard Vaughan
Chairman, Spine Society of Australia
c/- Stokes House
28 McCourt Street Tel: 08 9382 1933
LEEDERVILLE WA 6007 Fax: 08 9388 1253

PLASTIC SURGERY

Mr Frank Ham
Plastic and Reconstructive Surgeon
7th Floor
766 Elizabeth Street Tel: 03 9347 8499
MELBOURNE VIC 3000 Fax: 03 9349 1326

Mr Bruce Johnstone
Plastic and Reconstructive Surgeon
7th Floor
766 Elizabeth Street Tel: 03 9347 8499
MELBOURNE VIC 3000 Fax: 03 9349 1326

Burns

Dr Peter Kennedy
Director, Burns Unit
Concord Hospital
Hospital Road Tel: 02 9767 7775
CONCORD NSW 2139 Fax: 02 9767 7435

UROLOGY

Mr Laurie Cleeve
Urologist
Suite 2
Ground Floor
141 Grey Street Tel: 03 9419 1668
EAST MELBOURNE VIC 3002 Fax: 03 9416 3034

Mr D G Travis
Urologist
Suite 2
Ground Floor
141 Grey Street Tel: 03 9416-3772
EAST MELBOURNE VIC 3002 Fax: 03 9416 3034

OPHTHALMOLOGY

Dr Michael Hennessy
Staff Specialist Ophthalmologist
Prince of Wales Hospital
High Street Tel: 02 9382 2492
RANDWICK NSW 2031 Fax: 02 9398 6998

Dr Justin Playfair
Suite 508
5th Floor
Harley Place
251 Oxford Street Tel: 02 9389 4840
BONDI JUNCTION NSW 2022 Fax: 02 9387 8541

ENT

Mr John Kennedy
East Melbourne Head and Neck Clinic
St Elizabeth's Home
19 Simpson Street Tel: 03 9416 1222
EAST MELBOURNE VIC 3002 Fax: 03 9417 5216

Paediatrics

Dr Robert Berkowitz
Department of Otolaryngology
Royal Children's Hospital
Flemington Road Tel: 03 9345 6476
PARKVILLE VIC 3052 Fax: 03 9345 5595

ANAESTHESIA

Dr Gregory J Deacon
Chairman, Economics Advisory Committee
Australian Society of Anaesthetists
PO Box 600 Tel: 02 9327 4022
EDGECLIFF NSW 2027 Fax: 02 9327 7666

Prof. Bill Runciman
Head
Department Anaesthetics and Intensive Care
Royal Adelaide Hospital
North Terrace Tel: 08 8222 5422
ADELAIDE SA 5000 Fax: 08 8222 5887

Hyperbaric

Dr Michael Bennett
Medical Director
Dept Diving and Hyperbaric Medicine
Prince of Wales Hospital
High Street Tel: 02 9382 2222
RANDWICK NSW 2031 Fax: 02 9661 4878

GENERAL MEDICINE

Dr Peter Greenberg
Director, General Medical Services
Western Health Care Network
c/- The Royal Melbourne Hospital
Room 605, 6th Floor, Outpatients Building
Grattan Street Tel: 03 9342 7459
PARKVILLE VIC 3050 Fax: 03 9342 8082

Endocrinology

Associate Professor Duncan Topliss
Department of Endocrinology and Diabetes
Alfred Hospital
Commercial Road Tel: 03 9276 2460
PRAHRAN VIC 3181 Fax: 03 9276 3782

Geriatrics

Dr Terence Finnigan
Neuroscience, Aged Care and
Musculoskeletal Services Unit
Royal North Shore Hospital
Pacific Highway Tel: 02 9926 7111
ST LEONARDS NSW 2065 Fax: 02 9926 7779

Infectious Diseases

Dr Philip Jones
Department of Infectious Diseases
Prince Henry Hospital
Anzac Parade Tel: 02 9694 5895
LITTLE BAY NSW 2036 Fax: 02 9382 5401

RENAL MEDICINE

Dr Lindsay Barratt
Director of Nephrology
Flinders Medical Centre
Cornish Road Tel: 08 8204 4965
BEDFORD PARK SA 5042 Fax: 08 8374 0848

Dr Timothy Mathew
Director, Renal Unit
Queen Elizabeth Hospital
28 Woodville Road Tel: 08 8222 6665
WOODVILLE SA 5011 Fax: 08 8222 6664

GENERAL PRACTICE

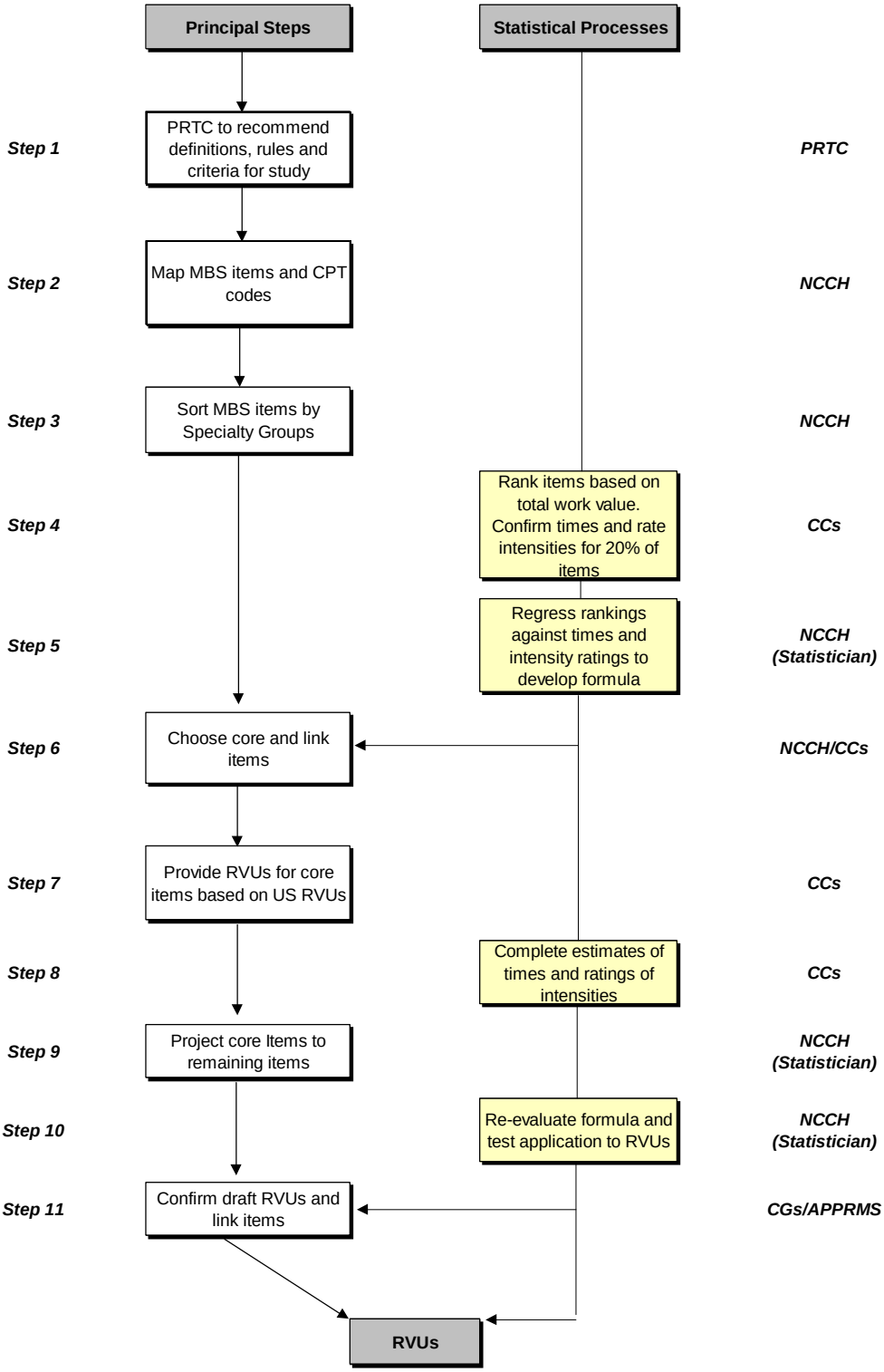
Dr Brian Bowring
P O Box 163 Tel: 03 6382 1333
GEORGETOWN TAS 7253 Fax: 03 6382 3535

Dr Paul Dugdale
Doctors Reform Society
5 Hale Crescent Tel: 02 6249 3051
TURNER ACT 2601 Fax: 02 6257 1594

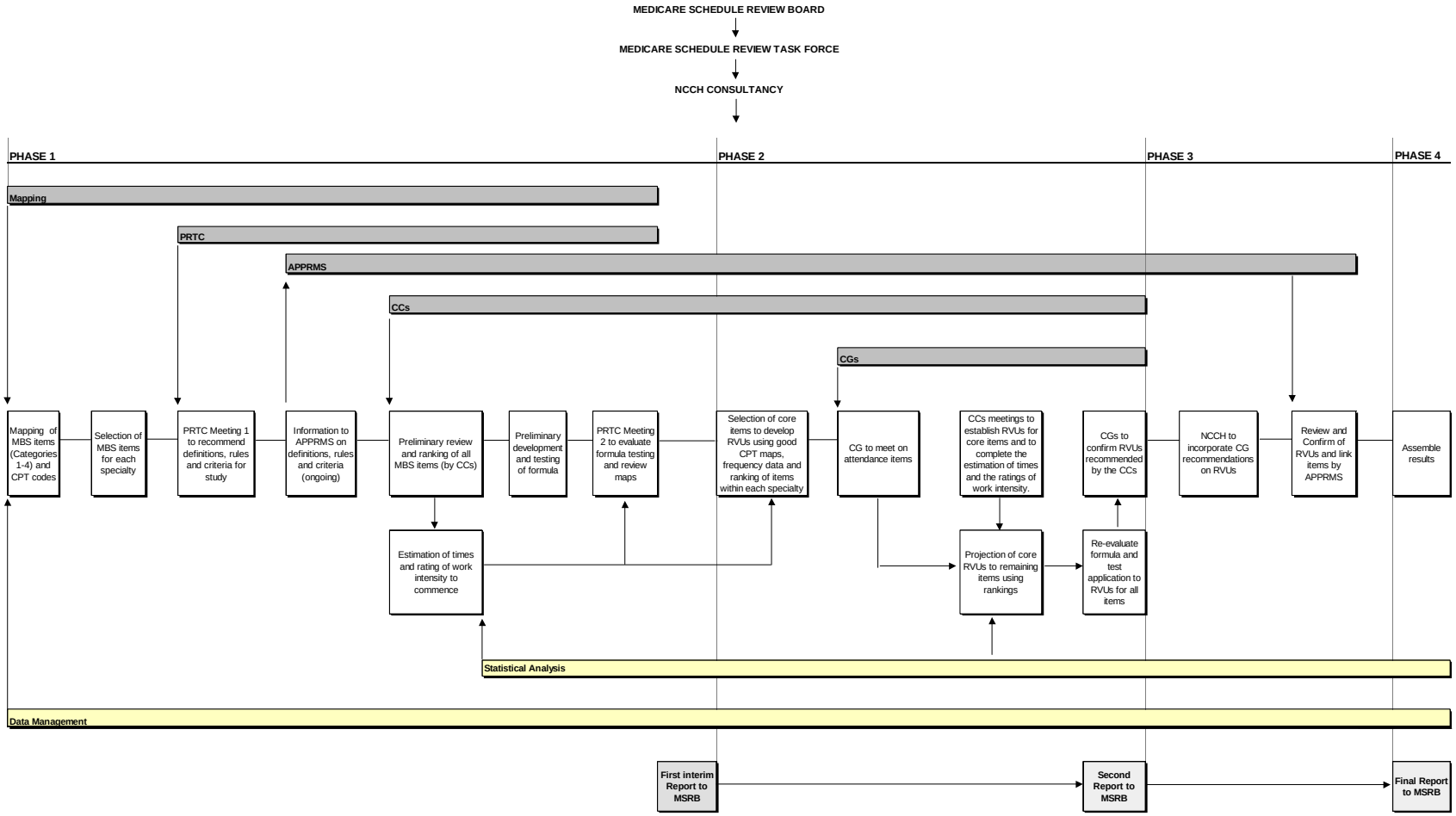
EMERGENCY MEDICINE

Dr Michael Cleary
Medical Administrator
Division of Medicine
Princess Alexandra Hospital
Ipswich Road Tel: 07 3240 7349
WOOLLONGABBA QLD 4102 Fax: 07 3240 7104

PROFESSIONAL RELATIVITIES STUDY - METHODOLOGY



PROFESSIONAL RELATIVITIES STUDY - OUTLINE OF PROCESSES



Professional Relativities Study

Allocation of MBS Items for Review by Specialty Groups

	Specialty groups	Items selected - 1	Items selected - 2	Items manually allocated	Items allocated from exception report		Items allocated manually for small group review	Total items per group	% Dist
					>50%	<50%			
	Not allocated Criteria 1 or 2	*487*							
1	GENERAL PRACTICE	99	34	8	46	4	0	191	5.8
2	FACIO-MAXILLARY SURGERY	7	0	154	0	0	0	161	4.9
3	OBSTETRICS & GYNAECOLOGY	108	12	12	15	3	0	150	4.5
4	GENERAL SURGERY	262	34	38	29	10	0	373	11.3
5	CARDIO THORACIC SURGERY	117	2	10	0	0	0	129	3.9
6	NEUROSURGERY	124	0	17	0	0	0	141	4.3
7	ORTHOPAEDIC SURGERY	442	17	28	13	8	0	508	15.3
8	PAEDIATRIC SURGERY	92	0	30	0	0	0	122	3.7
9	PLASTIC SURGERY	218	7	41	5	2	0	273	8.2
10	UROLOGY	126	4	13	5	4	0	152	4.6
11	VASCULAR SURGERY	137	1	47	0	1	0	186	5.6
12	OPHTHALMOLOGY	151	5	10	5	0	0	171	5.2
13	ENT	144	6	8	6	5	0	169	5.1
14	ANAESTHESIOLOGY	158	5	34	13	3	0	213	6.4
15	DERMATOLOGY	27	4	8	2	3	0	44	1.3
16	IVF	27	0	2	0	0	0	29	0.9
17	GENERAL MEDICINE	3	8	0	1	0	2	14	0.4
18	CARDIOLOGY	27	2	4	4	2	0	39	1.2
19	RENAL MEDICINE	3	0	1	0	0	4	8	0.2
20	GASTROENTEROLOGY	33	2	4	0	0	0	39	1.2
21	NEUROLOGY	19	3	0	0	0	0	22	0.7
22	PAEDIATRIC MEDICINE	10	2	0	0	1	5	18	0.5
23	REHABILITATION MEDICINE	2	0	0	0	0	4	6	0.2
24	RHEUMATOLOGY	3	0	1	0	0	3	7	0.2
25	THORACIC MEDICINE	12	3	2	0	1	0	18	0.5
27	RADIATION ONCOLOGY	42	1	9	0	0	0	52	1.6
28	CLINICAL HAEMATOLOGY	12	3	0	0	0	1	16	0.5
29	MEDICAL ONCOLOGY	9	1	0	0	0	1	11	0.3
30	INTENSIVE CARE	14	0	0	0	0	4	18	0.5
31	NUCLEAR MEDCINE	21	0	4	0	0	0	25	0.8
32	IMMUNOLOGY	3	1	0	0	0	2	6	0.2
		2452	**157**	**485**	**144**	**47**	**26**	**3311**	**100.0**
	% of total items allocated per criteria	*74%*	*5%*	*15%*	*4%*	*1%*	*1%*	*100%*	

Summary

Total items (MBS Category 2-4) = 2941
Total link items (Approx.) = 376

2. Professional Relativities Technical Committee (PRTC)

Outcomes Report (*without attachments*)

Professional Relativities Study

Professional Relativities Technical Committee

Outcomes Report - Meeting No.1

Date: **Saturday 23 August 1997**

Venue: **Kingsford Room, Sydney Sheraton Airport Hotel**
Cnr O'Riordan and Robey Street, Mascot

Facilitator: **A/Prof Rosemary Roberts**

Report Date: 14 October 1997

National Centre For Classification In Health

Professional Relativities Technical Committee
Outcomes Report

The meeting was opened at 9.30 am by A/Prof Rosemary Roberts.

Present: As per list of Attendees
Apologies: Mrs Sue Walker, National Centre for Classification in Health (NCCH) Queensland.

1. INTRODUCTION

1.1 Aims of the Day

A/Prof. Rosemary Roberts outlined the aims of the day. These included:

i an overview of the study methodology
ii an overview of the workplan and timeline
iii recommendations by the PRTC on:
- definitions
- criteria
- methods
- other study guidelines

iv review of division of specialty groups for the study
v calculation of weighted Relative Value Units (RVUs)

1.2 Guidelines for CGAI

John Popplewell spoke on the guidelines provided to the Professional Relativities Technical Committee (PRTC) in establishing ground rules for setting professional relativities.

It was explained that the Medicare Benefits Schedule would be the basis for the study. Only the professional work component of services would be addressed in this part of the study, with financial aspects of the study being undertaken by a separate consultancy examining remuneration issues. All services will have identifiable pre, intra and post service components, with expected variability in intensity within the "intra" components of many services, and that work is to be measured as a combination of time and intensity.

It was pointed out that the specialty Clinical Haematology should be included in the proposed specialty groups approved by the Medicare Schedule Review Board (MSRB). The NCCH will be recommending to the MSRB this and other groups be included in the study.

It was further recommended that "Sub-Specialties" within General Surgery, such as Colo-rectal and Upper Gastrointestinal need to be included in the study.

2. BACKGROUND TO THE PRS

2.1 Study Methodology and Workplan/Timeline

The NCCH clarified the stages of the Professional Relativities Study (PRS) methodology. This included mapping Medicare Benefits Schedule and the U.S. Current Procedural Terminology (MBS/CPT) items, ranking of items, estimates of time and intensity, formula development, choosing core and link items, development of Relative Value Units (RVUs) for core items (using CPT RVUs), projection of core RVUs, review and confirmation of RVUs.

The NCCH was asked by members of the PRTC to clarify its selection process for inviting Clinician Consultants (CCs) to be involved in the study. It was explained that many of the CCs were known to the NCCH from previous working arrangements. The PRTC requested that these names be circulated to the committee.

It was pointed out that during the study *consultations* should be considered in the same context as *procedures*.

Clarification was sought as to why the Australian study was being modelled on the Harvard US study. It was stated that the US study is the most developed of any comparable international attempt at a similar study.

The issue of specialty group representatives for the Consensus Groups (CGs) was discussed. The Medicare Schedule Review Task Force (MSRTF) have written to specialty Societies and groups requesting 4 representatives each for the study. The PRTC is to be informed of all specialty group representatives for the study.

2.2 Project Management and Committee Roles

The roles of the of the PRS committees were outlined.

The role of the PRTC is listed hereunder:

i Recommend definition of time - total service time intra, pre and post.
ii Discuss direct/indirect time and effect on MBS relativities.
iii Recommend effect of using existing MBS item relativities for RVUs.
iv Recommend formula for calculating time and intensity to establish RVUs.
v Recommend methods for RVUs for consultations, therapeutic and anaesthesia items.
vi Recommend criteria for choosing core and link items.

vii Recommend method for translating RVUs from core to remaining items.
viii Recommend criteria for accepting a good map.

3. RECOMMENDATIONS BY THE PRTC

Recommendations were sought from the PRTC for the items listed in the following technical papers :

3.1 Study Definitions
3.2 Formula for Use in Study
3.3 Criteria - good maps, core and link items
3.4 Methodology - for applying definitions, formula criteria
3.5 Rules - parameters for study application

3.1 Study Definitions

The PRTC comments and recommendations on the definitions are detailed in table format *(refer to Glossary of Terms).* Work is to be measured as a combination of time and intensity.

3.2 Formula for Use in Study

A formula for the PRS will be developed using regression analysis. The PRTC confirmed that the following components of relativities should be considered for inclusion in the formula:

i pre-service time
ii intra-service time
iii post-service time
iv cognitive skills, clini cal judgement and communication skills
v technical skill and physical effort
vi stress due to risk

3.3 Criteria

3.3.1 Criteria for accepting a good map

The NCCH explained that there were three criterion for accepting a "good map" ie correlation between Medicare Benefits Schedule (MBS) and the U.S. Current Procedural Terminology (CPT) items:

i Good terminology rating
ii Good code to code rating
iii Known relativity between pre, intra and post service times for CPT and MBS

PRTC Comments:

Members asked about the homogeneity of MBS items and CPT codes and the use of CPT frequencies for accepting a good map.

A draft spreadsheet for calculating weighted RVUs based on the CPT RVUs and frequencies was tabled. The members queried the use of all frequency data for mapped items. The statistician will provide advice on these calculations.

3.3.2 Criteria for choosing core items

The PRTC agreed that the criteria for choosing core items should be based on the following:

i high frequency
- ii good map - *see 3.3.1*
- iii good spread throughout MBS item rankings
- iv at least one multi-specialty item (ie item being ranked by more than one specialty)
- v clinical importance

PRTC Comments:

No objections were raised. However it was noted that criterion iv above would not always be possible.

3.3.3 Criteria for choosing link items

- i core items
- ii high frequency in both specialties

PRTC Comments:

A question was raised as to qualifying "high frequency". The statistician advised that in this context, high frequencies were relative to the distribution of MBS items within the speciality group.

It was agreed that the CPT RVU would be used as the benchmark for the link items between specialties.

The statistician explained that the RVUs would be used to test the formula, by analysing goodness-of-fit with time and intensity for each specialty.

3.4 Method

3.4.1 Methods for RVU development, therapeutic & anaesthesia items

i based on CPT results, time estimates and intensity ratings for core items

ii based on interpolation/extrapolation and formula for non core items

PRTC Comments:

There was some concern about using United States (US) procedural times which are thought to be significantly longer than Australian procedural times. It was recommended that Australian times be used in the first instance and US times would be used to inform about differences in the RVUs.

3.4.2 Translating RVUs from core to remaining items

To be done initially mostly by interpolation (with some extrapolation) based on the rankings provided by the clinician consultants. Later this will be revised using the final formula.

PRTC Comments:

This involves projection from core items using interpolation (extrapolation) and information from time estimates and intensity items.

3.4.3 Linking Specialties

It was agreed that the study should address the establishment of cross specialty procedures and pairs of procedures between specialties of similar relative value. There was no further methodology established under this item.

3.4.4 Scope of application of RVUs already developed by Clinical Societies, Associations and Colleges.

The MSRTF has written to Colleges and craft groups for advice and information on any work undertaken in respect of relativities in their specialty crafts.

PRTC Comments:

It was advised that Anaesthetists already use relativities, based on intensity and time.

Members also commented that the specialist clinicians have been waiting for a standard for development of specialist relativities and that the PRS would address this gap.
Discussion was held concerning the difficulties in developing RVUs within the specialty groups, such as: distinguishing between referred and non-referred cases, opportunity cost of training. However, it was agreed that where specialties had already established RVUs, these could be of assistance when ranking and rating intensities.

3.5 Other

3.5.1 Relativity of Attendance items to other items

Given the recent changes to the Attendance items in the MBS and the crossover of the old item numbers across specialties, the PRTC was asked to recommend a strategy for developing attendance RVUs.

PRTC Recommendations

The PRTC agreed that the new structure for attendance items should be used for the PRS.

It was further recommended that

i each specialty group look at attendance items in conjunction with the procedural items

ii a different method be used for allocation of Attendance items to specialties for the rating of intensity

iii the Consensus Group for Attendances should meet earlier than planned in order to make recommendations to the specialty groups for the comparison of procedure and attendance items.

3.5.2 Criteria for assigning MBS items to Specialty craft groups

Two sets of preliminary analyses of MBS data will be used to assign items to specialty groups. Firstly, items used by each specialty group will be analysed. Secondly, a review of all items by service providers will be undertaken to ensure that the specialty providing the majority of services per item is included wherever practicable. In some instances a specialty may be responsible for a small percentage of the total frequency for a particular item number yet the same item number may represent a significant number of that specialty's total work.

For example: MBS item 50124 (Joint or other Synovial Cavity aspiration injection of...) has the highest usage for Orthopaedic and General Practice Specialty groups. However, it represents 95% of the usage of procedural items by Rheumatologists.

The statistician recommended that any item be given a maximum of 2 specialties for ranking and rating. This would minimise:

i the analysis of rankings and ratings per specialty, and
ii the time needed for analysis of link items.

It was further recommended that the frequency distribution per specialty should be used to allocate MBS items to specialties as opposed to pure frequencies.

PRTC Recommendations:

It was recommended that:

i When selecting items for a group, MBS items will first be allocated to the specialty to which the item represents the highest proportion of items performed by that specialty.

ii Secondly, items will be allocated to a specialty if the specialty provides a high percentage of services for the MBS item.

iii Where a specialty has 100% of an item, (ie service provision) it should review the item regardless of the frequency distribution within that specialty.

iv If GPs provide greater than 50%, they should be included for reviewing item.

v If GPs are doing greater than 30%, they should be considered for reviewing item.

Subsequent to the draft PRTC Outcomes Report, MBS items have been assigned to specialty groups.

4. OTHER BUSINESS

The PRTC requested that the following information be provided to the committee:

1. Abbreviations relating to all components of the study
2. Names of the NCCH Clinician Consultants
3. Membership of all CGs - to be forwarded at a later date

3. Guidelines for Clinician Consultants (Phase 1)

3.1 Guidelines for ranking and rating MBS procedural items

3.2 List 1 - MBS items selected for Speciality Group (sorted by MBS item number) (*SAMPLE)*

3.3 List 2 - MBS items selected for Specialty Group (sorted by Anaesthetic time) (*SAMPLE)*

3.4 Disc containing a copy of List 1 and List 2 for optional use (excel sheet)

3.5 Worksheets for ranking and rating MBS items (*SAMPLE)*

3.1 GUIDELINES FOR RANKING AND RATING MBS PROCEDURAL ITEMS

These guidelines have been developed to assist with the ranking of MBS items, the estimation of time and rating of intensity. All MBS items in your specialty will require your attention for purposes of ranking and rating. Specifically, **all** items are to be **ranked**, and at least **20%** of items are to be rated at this stage. The remaining items will be rated at the Clinician Consultants meeting. If time permits all items should be rated now. It is **your choice** as to the items to be rated, however we recommend that a cross section be chosen.

Although the order set out in the guidelines is to rank and then estimate time and rate intensity, the NCCH has no objection (in fact it makes good sense) to the estimates of time and ratings of intensity being undertaken prior to the ranking. The only proviso is that all items must be ranked at this stage. The ranking and rating procedures are described on the following pages. *Note: ranking and rating of attendance items will be undertaken in Phase 2.*

The following tools have been provided for your use:

1. **List 1 - Summary Sheet -** list of MBS items allocated to your Specialty (sorted by MBS item number)

2. **List 2 - Information sheet -** list of all items (sorted by MBS Anaesthetic time) to assist with rankings

3. **Worksheets** for each item divided into four sections:

Section 1	MBS item number and description (as per MBS schedule)
Section 2	Time estimates for MBS item
Section 3	Ratings of intensity
Section 4	Comments

4. Floppy disk with both List 1 and List 2

In order to test the formula for RVU development and to select core items the following tasks need to be completed by the Clinician Consultants at this stage of the Professional Relativities Study:

Task 1 **Review** Specialty items provided for appropriateness;

Task 2 **Rank** all MBS items according to work value from 1-N;

Task 3 **Estimate times** for pre intra and post service work components for each MBS item (at least 20% of items);

Task 4 **Rate** the intraservice intensity (1-10) for at least 20% of MBS items;

Task 5 **Record** rankings and ratings on worksheets provided (1 per item)

Note: Feedback will be provided to Clinician Consultants on the implications of all rankings, time estimates and ratings of intensity.

TASK 1 Reviewing Specialty Items

Step 1

Please review your Specialty Items as provided to ensure that they are relevant to the work your specialty provides

Step 2

Please forward any comments you may have regarding omissions, relevance and/or accuracy of the items
(*comments section of worksheet may be used for this purpose*)

Step 3

Please still include all items in your rankings and ratings at this stage

TASK 2 Ranking MBS items

The ranking process involves placing each MBS item in order in terms of the total work value of that item. It requires your judgement of the total work value, ie time and intensity, for each item.

Step 1

Please rank **all items** from 1-N, where 1 is the highest ranked item in terms of total work value and N is the lowest.

- you may use the worksheets provided for this procedure (for sorting items into ranks)
- List 2 has also been provided to assist with rankings
- where specialties have more than 50 items to rank and rate, these worksheets have been sorted into piles of 50 sheets

Step 2

Please use the box on the top right hand corner of the Worksheet to write the rank order of each item

- if time permits, you may wish to summarise rankings on List 1 or List 2 as a check

TASK 3 Estimating Time

For the purpose of the PRS, time includes the following components:

i *pre service time*
ii *intra service time*
iii *post service time*

Please refer to Glossary of terms and PRS definitions in Section 4.

Step 1

Please estimate the time taken to undertake the procedure for each MBS item in your specialty

- time should be estimated for **pre, intra, and post service** components (refer to glossary for definitions of pre, intra and post service time)
- At this stage time estimates are required for at least 20% of the total MBS items for your group, however, if time permits all times should be estimated.

Step 2

Please document your estimated times in section 2 of the worksheet provided for each item.

- time should be recorded in minutes.

Step 3

Please summarise your ratings on List 1 or List 2 (*if time permits*)

TASK 4 Rating Work Intensity

Intensity includes the following elements:

i *Cognitive skill, clinical judgement and communication skills.*

ii *Technical skills and physical effort.*

iii *Stress due to risk to patient and/or difficulty of the procedure.*

Please refer to Glossary of terms and PRS definitions in Section 4.

Step 1

Please rate the intra service intensity of each of your items according to the above elements and on a scale of 1-10, with 1 being the lowest order of scale and 10 being the highest order of scale. The median of the scale is 5.

- You may use half values to rate if you wish
- At least 20% of the total items is required. If time permits all items should be rated for intensity.

Important Note:
Only intra service time should be rated for procedural items

Step 2

Please record your ratings in section 3 of the worksheet

Step 3

Please summarise your ratings on List 1 or List 2 (*if time permits)*

TASK 5 Recording Procedure

Step 1

Please ensure that each worksheet has been given a ranking number and that time estimates and intensity ratings are recorded on the worksheet for the items rated.

Step 2

List 1 is provided to enable you to summarise your information, however, List 2 may be more useful for this purpose.

Step 3

Optional
A computer disk is also provided for the recording of this information if you wish to utilise it.

Step 4

Would you please return the worksheets, List 1/2 (if completed) and computer disc (if used) to the NCCH in the envelope provided

MBS Item	Truncated MBS Descriptor	Frequency	Anaest Time (mins)	Schedule Fee	Rank (1-N)	Time Estimates (mins.)			Ratings of Intensity (1-10)		
						Pre Service	Intra Service	Post Service	Cognitive skill/ Clinical judgement/ Communicatio	Technical skill/ Physical Effort	Stress due to risk
11900	Urine flow study including peak urine flow measurement, not being a service associated with a service to which item	23486		20.25							
11906	Urethral pressure profilometry, not being a service associated with a service to which item 11012-11027,	3145		81.55							
11909	Urethral pressure profilometry with simultaneous measurement of urethral sphincter electromyography, not	652		121.20							
11912	Cystometrography with simultaneous measurement of rectal pressure, not being a service associated with a	3673	15	121.20							
11918	Cystometrography in conjunction with imaging, with measurement of any 1 or more of urine flow rate, urethral	11085	15	314.50							
13203	Ovulation monitoring services, for superovulated treatment cycles of less than 9 days duration and artificial	13610		366.95							
13215	Transfer of embryos or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 appl	11311	45	83.90							
14203	Hormone or living tissue implantation, by direct implantation involving incision and suture	21062	30	37.55							
14206	Hormone or living tissue implantation - by cannula	16703		26.15							
16500	Antenatal attendance	1E+06		24.50							
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened	7052		24.50							
16504	Treatment of habitual miscarriage by injection of hormones - each injection up to a maximum of 12 injections, where the	601		24.50							
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital,	5469		24.50							
16508	Pregnancy complicated by acute intercurrent infection, intra-uterine growth retardation, threatened premature labour with	7161		24.50							
16509	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each attendance that is not a routine	11742		24.50							
16511	Cervix, purse string ligation of	419	30	161.45							
16512	Cervix, removal of purse string ligature of	200	30	46.60							
16514	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)	28755		26.95							
16515	Management of vaginal delivery as an independent procedure where the patient's care has been transferred by	236		254.45							
16519	Management of labour and delivery by any means (including Caesarean section) including post-partum care	79642		391.95							

MBS Item	Truncated MBS Descriptor	Frequency	Anaest Time (mins)	Schedule Fee	Rank (1-N)	Time Estimates (mins.)			Ratings of Intensity (1-10)		
						Pre Service	Intraservice	Post Service	Cognitive skill/ Clinical judgement/ Communicatio	Technical skill/ Physical Effort	Stress due to risk
35561	Vaginectomy, radical, for proven invasive malignancy - 1 surgeon (Assist.)	26	300	1012.95							
35562	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Assist.)	1	300	831.65							
35565	Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (Assist.)	34	210	502.15							
35548	Vulvectomy, radical, for malignancy (Assist.)	55	195	612.45							
35723	Retro-peritoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological	218	195	354.70							
35753	Laparoscopically assisted hysterectomy, with salpingectomy, oophorectomy or excision of ovarian cyst, one or both sides,	68	195	637.10							
35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involvin	247	180	1066.25							
35729	Ovarian transposition out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy	30	180	159.95							
35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy (Assist.)	92	180	576.15							
35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including	230	165	906.25							
35700	Fallopian tubes, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous	492	165	536.05							
35720	Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (Assist.)	321	165	495.30							
35567	Vaginal repair including 1 or more of anterior, posterior or enterocele repair, with sacrospinous colpopexy (Assist.)	950	150	515.45							
35623	Hysteroscopic resection of myoma or uterine septum followed by endometrial ablation by laser or diathermy	559	150	601.50							
35670	Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Assist.)	136	150	746.20							
35697	Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more	129	150	694.75							
35726	Infra-colic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Assist.)	334	150	354.70							
35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated	6	150	576.15							
30587	Pancreatic cyst, anastomosis to Roux loop of jejunum (Assist.)	6	135	533.15							
35560	Vagina, partial or complete removal of (Assist.)	109	120	502.15							

Ranking Order (1-N)
(1 is the item of most value)

1. MBS ITEM INFORMATION

MBS Item Number **11900**

MBS Description

Urine flow study including peak urine flow measurement, not being a service associated with a service to which item 11918 applies

Total frequency (1996/97)	Anaesthetic time (MBS)	Schedule Fee (derived)
23486		$20.25

2. TIME ESTIMATES FOR MBS ITEM

Pre Service Time (mins)	Intraservice time (mins)	Post service time (mins)

3. RATINGS OF INTENSITY (1-10) - *Half values (ie 5.5) may be used if necessary*

(10 is highest order of scale)

	Cognitive skill Clinical judgement Communication skills	Technical skill Physical effort	Stress due to risk
Intraservice			

4. COMMENTS

_____

_____

_____

4. Abbreviations and Glossary

4.1 Abbreviations

4.2 Glossary of terms and PRS definitions

4.1 ABBREVIATIONS

APPRMS	Advisory Panel on Professional Relativities in Medical Services
CCs	Clinician Consultants
CGs	Consensus Groups
CPT	Current Procedural Terminology (American Medical Association)
DHFS	Department of Health and Family Services
MBS	Medicare Benefits Schedule
MSRB	Medicare Schedule Review Board
MSRTF	Medicare Schedule Review Task Force
NCCH	National Centre for Classification in Health
PRS	Professional Relativities Study
PRTC	Professional Relativities Technical Committee
RBRV	Resource Based Relative Value
RBRVS	Resource Based Relative Value Scale
RVU	Relative Value Unit

4.2 GLOSSARY OF TERMS AND PRS DEFINITIONS

Anaesthetic Time	Anaesthetic time begins when the anaesthetist begins to prepare the patient for anaesthesia care in the operating room or in an equivalent area and ends when the anaesthetist is no longer in personal attendance, that is, when the patient may be safely placed under the supervision of other personnel.
Cognitive Skill Clinical Judgement Communication Skills	First component of intensity (PRS) ?)*For procedures - rated only for "intra service" time, with an average taken for pre and post service times.*
Core Item	Items to be selected for development of RVU estimates
Current Procedural Terminology	System for coding physician services developed by the American Medical Association to file claims with Medicare and other third-party payers; level 3 of the HCFA Common Procedure Coding System (HCPCS)[1] The CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians [2]
Direct Time	Face-to-face time with patient.
Extrapolation	Projection from known results to unknown cases where the unknown cases lie outside the range of the known cases
Indirect Time	Non face-to-face patient related time
Interpolation	Projection of known results to unknown cases where the unknown cases lie within the range of the known cases

Intensity	The three components of intensity for the purpose of the PRS are: i cognitive skill, clinical judgement and communication skills ii technical skill and physical effort iii stress due to risk - risk to patient and/or difficulty of procedure
Intra Service Time	**For procedures:** time in which the service provider is in direct contact with the patient in the procedure room. ? *For most procedures this would be 'skin to skin' time ie. opening to closing. For others it would include positioning of the patient.* **For consultations:** Face-to-face time with the patient (excluding pre-service time)
Linking Specialties	Where the same procedure is carried out by different specialties or the items are of equal professional work. Two approaches for data linking are possible: i MBS items carried out by different specialties ii linking different item numbers
Mapping	The term 'mapping' refers to the process of finding an 'equivalent' code between two classifications enabling interpretation of one classification to the other [3]
Post Service Time	**For procedures:** Closure or end of service to completion o of normal "after care". ? *Includes Recovery, ICU, CCU.* **For consultations:** Time spent on specific service after cessation of face-to-face contact.
Pre-Service Time	Time taken to prepare for a specific service. ? *For procedures includes dress, scrub and wait.*
Ranking	Placing items in order eg 1-N

Rating	Giving a score on a predetermined scale e.g. 1-10 or 1-100
Regression Analysis	Determination of the relationship between a dependent variable and a number of other variables (independent variables) by statistical means
Relative Value Scale (U.S. Definition)	An index of physicians' services ranked according to "value", with value defined according to the basis for the scale. In a charge-based relative value scale, services are ranked according to the average fee for the service or some other charge basis. A resource-based relative value scale ranks services according to the relative costs of the resources required to provide them.[2]
Remaining item	Non-core item
Resource Based Relative Value Scale (U.S. Definition)	A relative value scale based on the resource costs of providing physician services; adopted in OBRA 89 as the basis for physician payment for Medicare Part B services effective January 1, 1992. The relative value of each service is the sum of relative value units (RVUs) representing physician work, practice expense, and professional liability insurance (PLI) adjusted for each locality by a geographic adjustment factor and converted into dollar payment amounts by a conversion factor[2]
Technical Skill Physical Effort	Second component of intensity (PRS) ? *For procedures - rated only for "intra service" time, with an average taken for pre and post service times.*
Relative Value Unit	The unit of measure for the professional work component in the Relative Value Study.
Stress Due To Risk	Third component of intensity (PRS) Includes stress due to risk to patient and/or difficulty of procedure ? *For procedures - rated only for "intra service" time,*

	with an average taken for pre and post service times.
Time	Total service time incorporates both patient related (face-to-face) and (non face-to-face) direct and indirect time.
Total work	Time + Intensity

[1] American Medical Association - Medicare RBRVS: The Physicians Guide - 1997
[2] American Medical Association - Physicians Current Procedural Terminology - 1997
[3] National Coding Centre - Coding Matters Vol. 2, No.4 April 1996

5. Literature

5.1 Measurement and analysis of intraservice work
(Hsiao, W.C. et al, 28 October 1988)

5.2 An overview of the development and refinement of the Resource-Based Relative Value Scale
(Hsiao, W.C. et al, November 1992)

5.3 Assessing the implementation of physician-payment reform
(Hsiao, W.C. et al, 1 April 1995)

5.4 Valuing medical work
(Deeble, J.S, 1 July 1996)