Physician reimbursement under Medicare

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Payment for physician services in the United States is directly tied to the payment system implemented in the Medicare system. The use of a code to categorize medical and surgical services, as well as a relative value system to assess physician services and reimburse them accordingly, is now well established. In light of this, it is important for physicians to possess knowledge of how this coding and reimbursement system was established, how it is updated, what means are available to modify it, and how it is used in practice. The author addresses these issues, offering a primer for the neurosurgeon on the Medicare system as it relates to physician payment.

KEY WORDS • Medicare • reimbursement • resource-based relative value system • current procedural terminology

Medicare is the federal health insurance program for persons age 65 years and older, as well as certain disabled persons. It was enacted in 1965 and implemented in 1966 under former President Lyndon Johnson. Establishing the federal government as a payer for health care services was a major shift in fiscal responsibility. Prior to Medicare, liability for health care services was the sole responsibility of the patient, and philanthropic, religious, and community-based nonprofit organizations provided the majority of charitable support.

Making the federal government the primary payer for health care services was also a major shift in terms of the autonomy that physicians enjoyed over the practice of their trade. Although the bill’s authors specifically disavowed the right to regulate physician services, prior legal precedent established that the federal government had a right to regulate rationally that which it subsidized, thus opening the door for federal regulation of physician services.6

Since its enactment, Medicare has been both a reliable source of income for physicians as well as an administrative burden that has subjected them to increasing government control. Despite its effects on the practice of medicine, few would argue that Medicare has become an important, fiercely advocated, and politically charged federal benefit for many Americans. Its role in purchasing health care for millions of elderly and disabled people in an aging population ensures that the program will continue to be an integral part of a physician’s practice and thus an important program for physicians to understand.

PHYSICIAN REIMBURSEMENT UNDER MEDICARE

The Patient’s Perspective

Providing health care insurance for 39 million aged and disabled persons, Medicare cost an estimated $222 billion in 2000, a 3% decline over 1999.3 Of this $222 billion, $33.1 billion (15%) was spent on physician services.3 Medicare has two parts: Parts A (hospital insurance) and B (medical insurance). Part A is financed primarily by payroll taxes (1.45% of a wage paid by employer combined with 1.45% paid by employee) and is premium free for nearly all beneficiaries. Approximately 25% of Part B is financed by monthly premiums ($50 per month) paid by beneficiaries and the remainder from general federal revenues.

A person is eligible for Medicare Part A if he/she is 65 years or older and eligible for any type of monthly Social Security benefit. When a person enrolls in Part A of Medicare, he/she is automatically enrolled in Part B unless that person declines. If the individual enrolls in Part B, the premium is $50 per month and is deducted automatically from monthly Social Security benefits.

When Medicare beneficiaries are first admitted to the hospital, they pay an initial deductible of $792. Beginning on the 61st through the 90th day, they pay $198 per day in coinsurance. After the 90th day, they pay $396 per day for as many as 60 additional “lifetime reserve” days or can

Abbreviations used in this paper: AMA = American Medical Association; CMS = Centers for Medicare and Medicaid Services; CPT = Current Procedural Terminology; GPCI = geographic adjustment; PEAC = Practice Expense Advisory Committee; RUC = Relative Value Update Committee; RVU = relative value unit.
opt to pay the entire charge and continue to bank the 60 lifetime days. If there are more than 60 days between the discharge and a subsequent readmission, a new benefit period starts with the same $792 deductible and coinsurance provisions.

Medicare beneficiaries may be eligible for skilled nursing facility benefits if hospitalized for more than 3 days and if the skilled nursing facility admission begins within 30 days of the hospital discharge. In that case, the beneficiary owes nothing for the first 20 days and $99 per day for the next 80 days. There are no benefits after 100 days. Home health services are also covered if a beneficiary is confined at home with a 20% coinsurance payment for those services.

For Medicare Part B, the beneficiary is responsible for the first $100 of allowable charges per year. After that, Medicare pays for 80% of all physician-related charges and the beneficiary is responsible for the remaining 20%.

Recently, those eligible for Medicare have been given the option of enrolling in two other forms of Medicare. A person may opt for a Medicare managed care plan in which health care networks provide care for Medicare patients in return for a set monthly payment from Medicare. The main difference in this plan from the original is that the risk of caring for the patient, regardless of the number or complexity of illnesses, is shifted from the government to the health care network. In addition, a Medicare recipient may opt into a private fee-for-service plan offered by a private insurance company. Medicare pays the insurance company a set amount for each beneficiary per month, and the insurance company in turn charges the beneficiary an additional amount based on the amount of services the beneficiary consumes.

Finally, Medicare beneficiaries may choose from one of 10 standard Medigap plans that, for a monthly premium, will cover the “gaps” in Medicare coverage or provide additional benefits such as limited coverage of prescription drugs, at-home recovery, foreign travel, or preventive care.

Physician Payment

Since January 1, 1992, payment for physician services has been based on a fee schedule. The fee schedule also applies to chiropractors, podiatrists, optometrists, nurse practitioners, and physician assistants. The use of a fee schedule replaced the prior method of paying for “reasonable charges” because of wide geographic region-related variations in fees, a rapid rise in program payments, and the fact that payments frequently did not reflect the resources used and that physicians in different specialties could receive different payments for the same service. The new fee schedule is based on the “relative value” of the service and was recommended to the Congress by the Physician Payment Review Commission, a congressionally established advisory body. In September 1997, this committee was replaced by the Medicare Payment Advisory Commission, which is an independent federal body that advises Congress on Medicare including issues of physician payment. It is composed of physicians, nurses, osteopaths, clinical researchers, attorneys, and insurance company executives.

The fee that a physician is paid has three components: the relative value for the service, a GPCI, and a national dollar conversion factor. The relative value portion of this equation is composed of the following: 1) a physician work component that measures the time, skill, and intensity associated with the service provided—this component accounts for 54.5% of a service’s relative value; 2) a practice-related expense component that measures average practice expenses such as office rents and employee wages and that varies on a code-by-code basis depending on whether the service is performed in a facility or nonfacility setting—this accounts for 42.3% of a service’s relative value; and 3) malpractice expense component that reflects average insurance cost—this accounts for 3.2% of a service’s relative value.2 The GPCI is designed to account for variations in the costs of practicing medicine. A separate GPCI is determined for each of the three component of the RVU and takes into consideration median hourly earnings of workers in the area, office rents, medical equipment and supplies, and other miscellaneous expenses. There are 90 GPCI areas nationwide. The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. The conversion factor is updated yearly. The conversion factor for 2001 was $38.2581. The law specifies that physicians who provide covered services in any rural or urban Health Professional Shortage Area (there are 2,901 such areas in the United States) are entitled to an incentive payment of 10% more than what they would otherwise be paid under the fee schedule.4

The general formula for determining total RVUs is: [work RVU × work GPCI] + [practice expense RVU × practice expense GPCI] + [malpractice RVU × malpractice GPCI] = total RVU; payment = total RVU × conversion factor ($38.2581 for 2001). See Table 1 for several examples of payments in Pittsburgh.

Current Procedure Terminology coding and RVUs are important not only with regard to reimbursement from Medicare but also for private insurers. Although no data have been published, there is a general notion that CPT coding and RVUs are used by most private insurers as a basis for reimbursement of physician-related services.

Changes and Updates in Physician Reimbursement

As noted in Table 1, each physician service corresponds to a CPT code. There are approximately 9000 numbers, each of which corresponds to a specific physician service. The AMA developed the CPT code and secured a copyright for its protection. (Recently the contract under which the AMA licenses use of the CPT to the government has been placed under scrutiny.) Both the development and subsequent updating of the CPT codes and the RVUs assigned to that code are conducted by the AMA partnered with the CMS.

The AMA contributes to the maintenance of the CPT coding system through the work of the AMA/Specialty RUC, which was created by the AMA in 1991. The RUC is composed of 29 members, 23 of whom are appointed by major national medical specialty societies and six of whom are representatives from the AMA CPT editorial panel, American Osteopathic Association, Health Care Professionals Advisory Committee, and Practice Expense Advisory Committee. Neurosurgery is among the 23 specialties represented on the RUC.
When a new or updated CPT code is accepted by the AMA CPT editorial panel, specialty societies are required to survey at least 30 physicians within their specialty about the physician-related work involved in the procedure. The procedure-related information gathered includes the respondent’s estimate of the appropriate work relative value, the intraservice or–operative time involved, the typical number of hospital and office visits provided, and ratings of the complexity of judgment and technical skill relative to similar services. Presentations by a specialty society are very carefully examined for accuracy, data-related quality, and relativity to other physician-provided services both within and among specialties. The RUC may either adopt the specialty’s recommendation or change the recommendation before it is submitted to the CMS. Final recommendations to the CMS must be adopted by a two-thirds majority of RUC members. The former’s acceptance rate for RUC’s recommendations has increased to more than 90% annually.

The AMA also gathers data that the CMS uses to reimburse for the practice expense portion of the RVUs. Each of the direct expense totals (clinical labor, medical equipment, and medical supplies) is allocated to individual procedures based on estimates from the RUC’s PEAC. Indirect costs (office expenses, administrative labor, and other expenses) are allocated to procedures based on a combination of the procedure’s work RVUs and the direct practice expense estimates. If the procedure is performed by more than one specialty, a weighted average is computed based on the frequency with which each specialty performs the procedure in Medicare patients.

An important caveat to the RUC and PEAC recommendation is that the CMS must maintain budget neutrality. Federal law mandates that upward revision of certain codes or each addition of new codes must be offset by reductions in other codes. This sets the groundwork for internal conflict among the RUC members because what is good for one specialty is inherently bad for another. Recently, neurosurgery lost approximately 11% of the practice expense RVUs based on the PEAC data.

An example of how the aforementioned process can work properly can be found in coding and reimbursement for skull base surgery. In 1994, the CPT editorial panel added a new section of codes for surgery of the skull base (codes 61580–61619). Prior to 1994, there were no codes that accurately and comprehensively described the specific procedures involved in skull base surgery. The RUC surveyed its members in response to the added CPT codes with the American Academy of Otolaryngology, American Society of Plastic and Reconstructive Surgeons, and the American Association of Neurological Surgeons participating in the surveying of their respective members. These RUC members agreed on clinical vignettes, work RVUs, and typical duration of surgery, postoperative hospital stay, and number of posthospitalization visits. The entire committee ultimately accepted the recommendation of the RUC members. The RUC recommendations were then accepted by the Health Care Finance Administration (now the CMS) where all but four of the 28 CPT and RVU recommendations were accepted. The four recommendations rejected by the administration were open to public comment and a “refinement panel” convened by the Health Care Finance Administration and moderated by their medical officers. The refinement panel considered the four codes and voted to increase their RVUs to the RUC-recommended levels. Thus all 28 recommendations were ultimately enacted, as initially recommended by the RUC, and became effective in 1995.

### Management Medicare Patients

Fiscal intermediaries and carriers (insurance companies or other business organizations under contract with the government) process Medicare claims. Physician-related charges are submitted directly to the Medicare carrier. Physicians who accept Medicare patients must two choices: to accept or reject an assignment from Medicare. If a physician accepts assignment, he/she bills Medicare for its responsible portion and bills the patient for the balance. If the physician accepts assignment, he/she cannot charge more than the total service-related amount allowed by Medicare.

Physicians who accept Medicare recipients have two choices: to accept or reject an assignment from Medicare. If a neurosurgeon accepts assignment, he/she bills Medicare for its responsible portion and bills the patient for the remainder. Neurosurgeons who accept assignment may not charge more than the total service-related amount allowed by Medicare.

If the neurosurgeon does not accept assignment, he/she must still send the claim to the Medicare carrier. Typically, the patient initially pays for services and Medicare then reimburses the patient for the portion of the bill that is allowable. The patient is liable to the neurosurgeon for any additional charge above what Medicare allows in addition to the $100 annual deductible, as well as the 20% coinsurance. Although charges may be higher than what the physician accepted assignment, he/she cannot charge more than 15% above the Medicare-allowable charge, and the allowable charge is 5% less than what those physicians accepting assignment may charge.

Hypothetically, Patient A makes three office visits this year at $50 per visit. Medicare will only pay for $40 per office visit. If Dr. B accepts the assignment, he/she will bill Patient A $80 for the first two office visits. On the third office visit, Dr. B will bill the Medicare carrier for $40. The Medicare carrier will then send Dr. B a check for $16 ($80 - $64) $20 being the amount over the $100 annual deductible.

<table>
<thead>
<tr>
<th>Procedure (CPT code)</th>
<th>Practice Work RVU</th>
<th>Practice Expense RVU</th>
<th>Malpractice RVU</th>
<th>Total RVU</th>
<th>Conversion Factor</th>
<th>Total Pay</th>
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<tbody>
<tr>
<td>lumbar disc op (63030)</td>
<td>12</td>
<td>0.989</td>
<td>9.62</td>
<td>0.93</td>
<td>2.21</td>
<td>0.705</td>
</tr>
<tr>
<td>cervical disc op (63075)</td>
<td>19.41</td>
<td>0.989</td>
<td>13.5</td>
<td>0.93</td>
<td>3.73</td>
<td>0.705</td>
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<tr>
<td>brain aneurysm (61700)</td>
<td>50.52</td>
<td>0.989</td>
<td>27.76</td>
<td>0.93</td>
<td>10.18</td>
<td>0.705</td>
</tr>
<tr>
<td>focus radiotherapy (61793)</td>
<td>17.24</td>
<td>0.989</td>
<td>10.87</td>
<td>0.93</td>
<td>3.51</td>
<td>0.705</td>
</tr>
</tbody>
</table>
deductible) and Patient A will be liable for the remainder. If Dr. B does not accept the assignment, Medicare’s allowable charges will be 5% less than for participating physicians. In this case, Medicare would only allow for $38 (95% of $40) per office visit. Moreover, Dr. B cannot bill Patient A more than $43.70 (115% of $38) for the office visit even though his/her usual charge is $50. Thus, for the first two office visits, Patient A would pay Dr. B directly. On the third office visit, after recognized annual charges now at $114 ($38 × 3), Patient A would receive a check for $11.20 (80% of $14) from Medicare and would be personally liable for the remainder (total bill up to $131.10 [$43.70 × 3]). Any subsequent physician services used by Patient A during that year would be charged at a rate of 115% above the allowable Medicare service-related charge, with Medicare paying 80% of the charge.

A final option for neurosurgeons dealing with Medicare-eligible patients is simply to enter into private written contracts with a patient agreeing not to submit a claim for a service covered by Medicare. The terms of such a contract must indicate that, by signing the contract, the beneficiary: 1) agrees not to submit a Medicare claim; 2) acknowledges that Medigap plans do not, and that other supplemental insurance plans may choose not to, make payment for services furnished under the contract; 3) agrees to be responsible for payments for services; 4) acknowledges that no Medicare reimbursement will be provided; and 5) acknowledges that the physician is not limited in the amount he/she can bill for services. A contract cannot be signed when the beneficiary faces an emergency or urgent health care situation.5

The physician must sign an affidavit and file with the Medicare carrier within days after entering into the first contract stating that he/she will not submit any claim to Medicare for 2 years and that he/she will not receive any Medicare payment for any services provided to Medicare beneficiaries either directly or on a capitated basis.5

CONCLUSIONS

Medicare’s reimbursement for physician services involves a complicated partnership between physicians and the government. By paying for physician services, the government has the legal right to regulate reimbursement in ways that are rationally related to achieve the ends of caring for Medicare-eligible Americans. To date, the government has been rather loose in allowing physicians to set appropriate reimbursement levels. Physicians, through the AMA, have a prominent voice in determining what services will be covered and how much they will be reimbursed. This information is used not only by Medicare but also by private insurance companies in determining the relative value of physician-provided services.

Physicians have several choices when dealing with Medicare patients. They may choose to accept Medicare payment, care for Medicare patients but not accept payment in full from Medicare, or enter into private contracts with patients in which they do not bill Medicare at all and hold each patient individually liable for payment of services.

References

6. Wickard v. Filburn 317 U.S. 11 at 131

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