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Medicare physician pay schedule faces a possible cut in 2002

Some experts predicting possible negative payment 'update' next year

Medicare payments for physician services could dramatically decline next year, predicts the Medicare Payment Advisory Commission (MedPAC).

Preliminary estimates released in March by Medicare put the 2002 physician payment update at -0.1%, which means 2002 fees will be lower than those in this year's fee schedule. However, in late June, MedPAC calculated that the actual 2002 payment update, which will be released next fall, could result in an even greater drop.

"The update for 2002 may ultimately be lower — perhaps significantly lower than [the original] estimate of -0.1 percent," MedPAC concluded.

The physician payment update is based on an inflation measure combined with the difference between the target spending level, called the sustainable growth rate (SGR), and actual spending on physician services in the previous year.

Due to expectations of slower enrollment growth in traditional Medicare, the 2002 estimated SGR is placed at 6%, compared to 7% estimated for 2001. The way the system works, if actual spending on physician services exceeds the SGR, the government lowers the following year's physician payment update.

According to MedPAC, updates over the past two years — 5.4% in 2000 and 4.5% in 2001 — "were somewhat generous . . . in that they were higher than the estimated change in input prices" in physician services. However, the estimate for next year's payment update is lower than the estimated change in input prices.

There is some good news: This drop in the update reinforces complaints that the current SGR formula needs to be revised to better reflect the cost of providing medical services.

Indeed, the word is that various medical lobbies are hoping for a negative update to help make their point when pressing for reimbursement reforms during the fall. ■

Ortho, radiology top pay scale for physicians

Family practice ranks lowest

Orthopedic surgery, radiology, and urology were among the most highly paid physician specialties during 2000, according to a new survey. Meanwhile, family practice, psychiatry, and pediatrics are at the low end of the pay scale.

According to a study by consulting firm Martin, Fletcher in Irving, TX, average annual salaries for orthopedic surgeons during 2000 were $350,000, and physicians specializing in radiology and urology made $300,000. At the other end of the scale, family practitioners and psychiatrists made $150,000, and pediatricians made $160,000.

Other salary ranges identified in the survey:

	Low	Average	High
Anesthesiology	$160,000	$265,000	$350,000
Cardiology	170,000	275,000	500,000
Emergency Medicine	120,000	180,000	220,000
Family Practice	100,000	150,000	180,000
Family Practice (incl. obstetrics)	130,000	160,000	210,000
General Surgery	150,000	250,000	350,000
Hospitalist	140,000	160,000	200,000
Internal Medicine	140,000	170,000	200,000
Neurology	180,000	200,000	250,000
OB/GYN	170,000	250,000	400,000
Orthopedic Surgery	220,000	350,000	687,000
Pediatrics	120,000	160,000	185,000

Percent Change in Total Payments by Specialty from the 5-year Review of Work

Specialty	Allowed charges (billions)	Percent change in total payments from increase in work	Percent change in total payments from change in PE	Total percent change in payments from 5 year review
Anesthesiology	1.5	1	0	1
Cardiac Surgery	0.3	5	1	6
Cardiology	4.2	0	−1	−1
Chiropractor	0.4	0	0	0
Clinics	1.6	0	0	0
Dermatology	1.4	0	0	0
Emergency Medicine	1.0	0	0	0
Family Practice	3.3	0	0	0
Gastroenterology	1.2	0	0	0
General Practice	1.0	0	0	0
General Surgery	2.0	3	1	4
Hematology Oncology	0.6	0	−1	−1
Internal Medicine	7.1	0	0	0
Nephrology	1.0	0	0	0
Neurology	0.9	0	0	0
Neurosurgery	0.4	0	0	0
Nonphysician Practitioner	1.2	0	0	0
Obstetrics/Gynecology	0.4	0	0	0
Ophthalmology	3.9	0	0	0
Optometrist	0.5	0	0	0
Orthopedic Surgery	2.3	0	0	0
Other Physician	1.6	0	0	0
Otolaryngology	0.6	0	0	0
Pathology	0.6	0	0	0
Plastic Surgery	0.2	0	0	0
Podiatry	1.1	0	0	0
Psychiatry	1.1	0	0	0
Pulmonary	1.1	0	0	0
Radiation Oncology	0.7	0	−1	−1
Radiology	3.3	0	−1	−1
Rheumatology	0.3	0	0	0
Suppliers	0.5	0	0	−1
Thoracic Surgery	0.5	4	1	5
Urology	1.3	0	0	0
Vascular Surgery	0.3	2	0	2

Note: This table incorporates two separate budget neutrality adjustments. The increase in practice expense relative value units is incorporated through a rescaling of all practice expense RVUs. In addition, all physician fee schedule payments (not the work RVUs) are reduced to make the increase in physician work RVUs budget neutral.

Source: 66 *Fed Reg* 31,070 (June 9, 2001).

New RVUs boost surgery, cut cardiology, radiology

Final values coming Nov. 1

Medicare has released its proposed changes in the relative value units (RVUs) that will be used to set next year's revised physician fee schedule for various services. If you're a surgeon, there is good news: Surgery specialties tend to get the biggest boost in total payments from the reconfigured RVUs this time around.

But, there is a "but." The word from government number-crunchers is that newly revised physician work time data will reduce the final practice expense RVUs for many of the services performed by cardiac and thoracic surgeons. This means while they are still likely to see a rise in their RVU base for 2002, it probably won't be as generous as initially proposed.

For cardiologists and radiologists, the bad news is they will probably see a cut in their Medicare fees as a result of the RVU review.

By law, Medicare must perform a review of the work RVUs used to set payments for physicians' services at least every five years. This is the second review of work RVUs since the fee schedule was implemented in 1992.

The final work RVUs are expected to be published Nov. 1, effective for physician services furnished starting Jan. 1, 2001.

Work on this second five-year review went into full swing with publication of a proposed rule in the *Federal Register* on July 17, 2000. Since then, Medicare has received comments from over 30 specialty groups and organizations involving more than 900 CPT and HCPCS codes.

Specialty societies give input

A key player in this review process is the American Medical Association's Specialty Society Relative Value Update Committee (RUC). The RUC is supported by the RUC Advisory Committee, which is made up of representatives of 100 specialty societies in the AMA's House of Delegates.

The RUC recommends RVU levels for new and revised CPT codes to Medicare, which can accept, reject, or revise these recommendations. For this review, Medicare received RVU recommendations from the RUC for all codes being analyzed, except anesthesia and conscious sedation-related codes.

For codes used only by nonphysician practitioners, the Health Care Professionals Advisory Committee, a companion to the RUC, has made recommendations to Medicare. **(For a review of code recommendations by specialty area, see the *Physician's Coding Strategist* section of this month's issue of *Physician's Payment Update,* pp. 119-122.)** ■

You can still get paid while on vacation

Medicare allows substitute billing

Here's a new twist on the idea of a paid vacation: Get Medicare to reimburse you for having a colleague see your patients while you are away from the office on vacation.

Sound too good to be true? According to **Kent Moore**, a reimbursement expert with the American Academy of Family Physicians in Leawood, KS, here's how it works.

"You may submit claims and receive payments from Medicare for covered visit services, including emergency visits and related services, that you arrange to be provided by a substitute physician on an occasional, reciprocal basis," says Moore.

For this to happen, however, you must meet the following four requirements:

1. You must be unavailable to provide the visit services.

2. Medicare patients must have arranged to receive or seek to receive the visit services from you.

3. Substitute physicians must not provide the visit services to Medicare patients over a continuous period of more than 60 days.

4. You must submit the claim using your unique physician identification number (UPIN) and attach a -Q5 modifier to the procedure code. Also be sure to cross-reference the entry to the appropriate service line item.

"Naturally, if you are in a group practice where claims are submitted in the name of the group, then reciprocal billing does not apply to you," he notes.

However, if you are a member of a group whose physicians bill in their own names, then

Medicare treats you as an independent physician, and the rules regarding reciprocal billing arrangements apply.

Like with any claim, proper and complete documentation is key to getting paid. In the case of a substitute physician:

• Maintain a record of each service provided by the substitute physician, including a reference to the substitute physician's UPIN. This file should be made available to your Medicare carrier upon request.

• Remember that reciprocal arrangements don't have to be in writing, and you may have arrangements with more than one physician. All reciprocal arrangement requirements are the same for assigned and unassigned claims.

• If the only substitute services a physician performs in connection with an operation are postoperative services furnished during the period covered by the global fee, you generally don't have to identify them on the claim as substitution services.

When it comes to locum tenens, "the requirements for claiming payment for locum tenens services are almost the same as those for reciprocal billing arrangements," observes Moore.

The only differences are that you have to use a -Q6 modifier, and you must pay the locum tenens physician on a per diem or fee-for-time basis. Remember: Locum tenens physicians cannot be your employees, and their patient services cannot be restricted to your office. ■

Rules on extender billing procedures can vary widely

Large growth expected in physician assistants

As more practices increase their use of nurse practitioners and physician assistants to increase productivity, it becomes even more important that they correctly code and bill Medicare and private payers for their services.

Some 66,000 physician assistants currently work in various health care settings nationwide, according to an estimate by the Bureau of Labor Statistics. The American Academy of Nurse Practitioners places the present number of nurse practitioners at about 70,000. By 2008, the government predicts the ranks of physician assistants will jump by nearly half again, with similar growth among nurse practitioners.

When it comes to commercial billing, each insurer has its own particular way of treating physician extenders.

"Every insurer has a different application form; the policy by which you code is different, and there's no set standard," notes family physician **Baretta Casey**, MD, of Pikeville, KY.

However, there are some basic billing principles that tend to be common to all kind of payers.

Billing methods

The first thing you want to determine is whether the extender's services are being billed to the physician services or billed independently.

• **Direct billing.** If they are to be billed independently, this is known as direct billing. Here the physician extender bills for his or her services using his or her own provider number.

Physician extenders can obtain a provider identification number by filling out the Centers for Medicare and Medicaid Services form 855 for general enrollment, which is available on-line at www.hcfa.gov/medicare/enrollment/forms/.

Services billed for independently by a physician extender are reimbursed at 85% of the physician's fee.

• **Incident to.** Physician extender services can also be billed "incident to" physician services under Medicare. These services are submitted to Medicare under the physician's provider number and are reimbursed at 100% of the Medicare fee schedule for physicians.

Note: To qualify for "incident to" billing, the services performed by the physician extender must first meet several requirements, says **Todd Welter**, a consultant with Medical Group Management Association in Englewood, CO.

To bill a physician extender's services as "incident to":

— the physician extender must be employed by the physician;

— the physician must perform the initial examination of the patient;

— the physician must directly supervise the physician extender who treats the patient.

When it comes to commercial insurers, some require physician extender services to be billed using the physician extender's provider number, and others require physician extenders to be billed under the physician's provider number.

Even others, including Medicare, allow both direct and "incident to" billing, depending on the circumstances.

If you are not sure how a particular payer wants to be billed, call its director of provider relations for details. Also be aware that state law can influence extender billing procedures. When in doubt about what to do, most experts advise you to follow Medicare's regulations for billing physician extenders. ■

States move to strengthen prompt-payment laws

Newer laws give providers more clout

Responding to physician complaints, a growing number of states have enacted new laws requiring health plans to pay providers promptly for their services.

If West Virginia, Alaska, Rhode Island, and Oregon pass their first prompt-payment laws this year as expected, it will bring to 45 the number of states with prompt-pay statutes.

"You learn from what's happened elsewhere," says **Michael E. Migliori**, MD, past president of the Rhode Island Medical Society. Rhode Island's proposed legislation, for example, would require that health plans report the status of any claim, an innovation not included in the first round of prompt-pay laws.

What makes a claim 'clean'?

One of the biggest hurdles facing lawmakers is devising an effective definition of clean claims that will stop health plans from holding up payments unnecessarily or from asking for several resubmissions of the same bill.

Most clean claim definitions "tend to leave far too much latitude for health plans," complains **Steve Keene**, director of governmental affairs at the North Carolina Medical Society in Raleigh. Instead, he favors the approach taken by the North Carolina legislature, which tries to reduce resubmissions by giving plans only one chance to identify all their problems with a claim.

New Mexico and Alabama, on the other hand, require a plan accept a claim as clean if it is "substantially" free of errors and can be processed without the missing data.

This means "if the middle initial is missing but the Social Security number is there and you can identify who it is, it is a clean claim," says **Richard Whitaker**, director of government affairs for the Medical Association of Alabama in Montgomery.

Despite these efforts, surveys show that 38% of doctors still report that it takes more than 45 days on average to receive payment on a clean claim, according to the American Medical Association (AMA) in Chicago.

"It's like sending [claims] into a black hole," said **Angelo Agro**, MD, president of the Medical Society of New Jersey in Lawrenceville.

A new wave of corrective actions are coming from state lawmakers to toughen up their existing laws. For instance, many recent proposals require plans to acknowledge that they have received a claim, explain all their concerns with a contested bill, and immediately pay uncontested parts of the bill.

Timeliness defined by postmark

In addition, the new laws tighten definitions of a "clean" or error-free claim, bar plans from overriding prompt-pay time limits in their contracts, and try to define exactly when a claim is deemed paid. For example, Hawaii specifically states it is the postmarked date on the payment.

Almost every rewrite stiffens enforcement, such as interest rates, fines, or more state monitoring. Interest rates can be as high as 18% per year in Georgia, but most are the 10% range, says the National Conference of State Legislatures in Washington, DC.

Here is a list of states that have recently revamped their provider prompt-pay laws:

- **New Jersey. Before:** Pay clean claims within 60 days. **Now:** Pay clean electronic claims within 30 days, clean paper claims within 40 days. **Before:** Plan does not have to acknowledge receipt of the claim. **Now:** Plan must acknowledge receipt of the claim and cannot add new stipulations when it is resubmitted.
- **Alabama. Before:** No definition of clean claim. **Now:** A claim is clean if it is "substantially" error-free and can be processed without more information. **Before:** No penalty for late payments. **Now:** Plan must pay 1.5% interest per month; state fines against plans with a pattern of late payments.
- **Utah. Before:** Only addressed patients'

complaints. **Now:** The law includes complaints from doctors, and the state will conduct random compliance audits. **Before:** Focused on plans' duties. **Now:** Doctors have up to 60 days to respond to plan's request for more information or pay late fees of 0.1% a day. ■

Necessity vs. benefits: Know the difference

Be aware of when to fight insurers

Disagreements over whether a specific service is medically necessary and whether it's a medical benefit under the terms of a particular health plan are often at the root of many of the conflicts over coverage and claim denials between payers and providers.

But keep in mind that medical necessity and medical benefits are two entirely different things — something health plans often fail to adequately educate either providers or patients about.

Each payer you deal with probably has its own definition of medical necessity. However, the following characteristics are common to all definitions, according to the American Academy of Family Physicians in Leawood, KS:

- Care should be appropriate.
- Care should resolve a problem or improve the patient's health, functioning, or well-being.
- Care should be provided in accordance with standards of good medical practice or generally accepted medical practice.
- Care should not be experimental, educational, or investigational.

Clinical necessity vs. medical necessity

While physicians define their patients' needs based on what they perceive as clinical necessity, "from the perspective of the health plan, a patient's needs are based on medical necessity, which takes into account perceived clinical necessity plus corporate protocols and standards that reflect economic criteria such as relative cost-effectiveness, the availability of less costly alternatives, and the benefit structure of the patient's health plan," says **James Bare**, a policy analyst at the AAFP. "Unless the case is submitted to outside review or arbitration, the health plan has the final word on medical necessity."

This means some services may be covered under the terms of the patient's contract but might not be considered medically necessary, or they may be medically necessary but not covered.

Where payers and providers often tend to come into conflict over reimbursement is when a patient's plan clearly covers a certain kind of service, but the plan determines it was not needed.

The likelihood that a plan will deny a claim is often a function of how the spheres of medical necessity and benefits interact, maintains Bare.

The following matrix, developed by Bare, will help you determine how likely you are to have a claim denied based on the interplay between medical necessity and medical benefits in each situation.

- **Need equals coverage.** The health plan determines there is both clinical need and contractual coverage. Most care falls into this category. The bill is paid.
- **Need/No coverage.** The plan determines there is clinical need for a treatment but no coverage. For example, a patient is a candidate for Viagra, but his employer excludes the drug as a treatment for impotence. The bill isn't paid.
- **No need/No coverage.** The health plan determines there is neither clinical need nor coverage for a particular treatment. For example, if there is a request for surgery or a corrective device for a child born with a cranial deformity, the plan might argue that the surgery is cosmetic rather than medically necessary because there is "no observable adverse impact" from the deformity. Thus, the service would not be covered, because cosmetic surgery is not a covered benefit under the terms of the family's contract with the health plan. "Conflict is likely, since the parents will probably perceive the existence of a very real need, even if the treatment is considered by the physician not to be medically necessary," notes Bare.
- **No need/Coverage.** A patient is clearly covered for a proposed service, but the health plan determines there is no need. "Here is where you have the greatest potential for conflict between the plan, physician, and patient," he says. Often, the health plan may simply disagree with the physician's recommendation or may argue that it conflicts with the health plan's protocol for the disease or condition in question. This is where

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Physician's Coding Strategist™

Winners and losers in the RVU update

Final values coming Nov. 1

The American Medical Association's Specialty Society Relative Value Update Committee (RUC) has recommended a wide variety of procedural coding changes that have been implemented by Medicare.

Following is a summary of the actions, categorized by specialty. The full list as it appears in the *Federal Register* can be found at www.hcfa.gov/regs/pfs/fr08jn01.pdf. The final RVUs are expected to be published Nov. 1.

Vascular Surgery

The Society for Vascular Surgery and the North American Chapter of the International Society for Cardiovascular Surgery requested increases in work RVUs for 95 codes.

RUC recommendation: Of these, the RUC recommended increases for 91 codes, a decrease for one code, and no changes for three codes.

General Surgery/Colon and Rectal Surgery

The American Society of General Surgeons submitted 55 codes it believed to be undervalued. The society recommended increased work RVUs for each service.

RUC recommendation: RUC recommended that the work RVUs for the following codes be increased: code 36489, placement of central venous catheter (subclavian, jugular, or other vein (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy)), percutaneous, age 2 years or under (2.50) to correct a rank-order anomaly; 60100, biopsy thyroid, percutaneous core needle (1.56), to appropriately reflect the work involved and fit in the range of biopsy codes; and 31600, tracheostomy, planned (separate procedure) (7.18), based on the building-block approach and the comparison to similar procedures.

Medicare's response: Accepted all the RUC's recommendations.

Thoracic Surgery

The RUC reviewed 89 thoracic surgery codes. Of these, it recommended increases for 44 codes, no changes for 43 codes, and decreases for 2 codes. The recommendations, categorized by family, are as follows:

Family 1: The RUC recommended no increase in work RVUs for codes 32000, 32005, 32020, 32035, 32225, 32602, 32651, and 32652. The RUC recommended increases in work RVUs for codes 32220 (24.00) and 32320 (24.00).

Family 2: The RUC recommended increases for codes 32440 (25.00) and 32480 (23.75). The RUC also recommended increases in work RVUs for codes 32100 (15.24) and 32110 (23.00).

Family 3: The RUC recommended increases in codes 32482 (25.00) and 32500 (22.00), based on the median work RVUs for each code.

Family 4: The RUC recommended no increase for code 32655 but proposed increases for codes 31600 (7.18) and 32500 (22.00).

Family 5: The RUC recommended increases for code 38746 (4.89) based on the work RVU for

38747, but recommended no increases for codes 39010, 39220, or 39400.

Family 6: The RUC agreed with the Society of Thoracic Surgeons analysis of work for codes 43107 (40.00) and 43112 (43.50).

Family 7: The RUC recommended an increase for codes 43117 (40.00) and 43122 (40.00).

Family 8: The RUC recommended no increase for codes 31625 or 31645.

Family 9: The RUC recommended increases for codes 33400 (28.50), 33405 (35.00), 33406 (37.50), 33411 (36.25), 33412 (42.00), and 33413 (43.50), based on a building-block approach that used code 33405 as the anchor code for this family.

Family 10: The RUC recommended increases for codes 33426 (33.00), 33427 (40.00), 33430 (33.50), and 33475 (33.00), based on a building-block approach that used code 33427 as the anchor code for this family.

Family 11: The RUC recommended increases for codes 33510 (29.00), 33511 (30.00), 33512 (31.80), and 33513 (32.00), based on a building-block approach that used code 33512 as the anchor code for the family. The RUC also recommended decreases for codes 33514 (32.75) and 33516 (35.00).

Family 12: The RUC recommended no increases for add-on codes 33517, 33518, 33519, 33521, 33522, 33523, and 33530, because it believes they were inappropriately surveyed as 90-day global procedure codes and the results were not reliable.

Family 13: The RUC recommended increases in work RVUs for codes 33533 (30.00), 33534 (32.20), 33535 (34.50), and 33536 (37.50), based on a building-block approach that used code 33533 as the anchor code for the family of codes.

Family 14: The RUC recommended increases in work RVUs for codes 33860 (38.00), 33861 (42.00), 33863 (45.00), and 33870 (44.00) based on a building-block approach that used code 33860 as the anchor code for the family.

Family 15: The RUC recommended no increases in work RVUs for codes 33750, 33820, and 33840 due to a lack of compelling evidence to support an increase.

Family 16: The RUC recommended an increase in code 33660 (30.00) based on intraservice work RVUs for 33401 and pre- and postservice work RVUs for 33641.

Family 17: The RUC recommended no increase in work RVUs for code 33415 because it did not believe that the typical patient for this procedure had changed.

However, the RUC recommended an increase in work RVUs in code 33681 (30.61) because the intraservice intensity of 33681 is more complex than it was five years ago.

Family 18: The RUC recommended increases in codes 33615 (34.00), 33670 (35.00), and 33730 (34.25) based on a comparison to code 33412.

Family 19: The RUC recommended increases in work RVUs for codes 33611 (34.00), 33612 (35.00), 33694 (34.00), and 33697 (36.00).

Family 20: The RUC recommended an increase in code 33617 (37.00) after comparing it to code 33412 and noting that 33617 has greater intraservice time and higher intensity ranking than code 33412.

Family 21: The RUC recommended an increase in code 33619 (45.00) after comparing it to codes 48150 and 62530.

Family 22: The RUC recommended an increase in code 33506 (35.50) to preserve proper rank order within this family. The RUC recommended an increase in code 33770 (37.00) after finding that the work of this code is more than that of the comparison code 33697. The RUC recommended an increase in code 33778 (40.00) after comparing it to 33870 and 33412, which are less intense procedures. The RUC recommended an increase in code 33780 (41.75) based on a comparison to 33778. 33780 involves more work and warrants an additional 1.75 RVUs due to the additional 35 minutes of intraservice time.

Family 23: The RUC recommended an increase in code 33786 (39.00) after comparing it to 33412, which has less time and intensity. Given the limited specialty survey data, the RUC believed that the recommended increase in code 33919 to 40.00 work RVUs was warranted but that the survey did not support a value higher than the median survey value. ■

RUV review also looks at families of services

Medicare acts on Committee's recommendations

Medicare has proposed adopting the relative value units (RVUs) recommended by the American Medical Association's Specialty Society Relative Value Update Committee (RUC) to maintain code relativity for families of services.

Here are Medicare's answers to RUC recommendations related to specific families of services:

• **Lymphadenectomy.** The RUC recommended an increase in work RVUs for the fully surveyed code 38745 (Axillary lymphadenectomy; complete) from 8.84 to 11.0 RVUs based on comparisons with codes 60210 (Partial thyroid lobectomy, unilateral, with or without isthmusectomy) and 32100 (Thoracotomy, major with exploration and biopsy).

Medicare's response: Assigned the median survey RVUs of 13.00 to code 38745. To maintain relativity within this family, it extrapolated the 47% increase in work RVUs of code 38745 to codes 38740 (Axillary lymphadenectomy; superficial) and 38760 (Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)) for proposed work RVUs of 10.02 and 12.94, respectively.

• **Colectomy.** The RUC recommended no change in the work RVUs for this family of codes.

Medicare's response: "If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes and vascular surgery codes." Medicare, in turn, proposed the following work RVUs for the codes in this family:

Proposed Colectomy-related RVUs

Code	Work RVUs
44140	21.00
44143	22.99
44144	21.53
44145	26.42
44146	27.54
44150	23.95
44151	26.88
44152	27.83
44153	30.59
44155	27.86
44156	30.79

• **Intestine Repair.** The RUC recommended an increase of 14% for all work RVUs in this family based on a recommended increase in fully surveyed code 44604 (Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy) from 14.28 work RVUs to 16.03 work RVUs.

Medicare's response: Agreed with the increase in work RVUs for code 44604, while noting that there are several rank-order anomalies currently in this family of codes that would be exacerbated by an across-the-board increase in work RVUs.

Therefore, it is also proposing to correct the rank-order anomalies as follows:

— Valuing code 44602 (Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation) at 16.03 work RVUs. The work RVUs for code 44602 are identical to the work RVUs for code 44604 because they describe the same procedure, except code 44604 is for the large intestine.

— Valuing code 44605 (Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy) at 19.53 work RVUs. The work RVUs for code 44605 are identical to the work RVUs for code 44604, except that code 44605 includes creating a colostomy, with the attendant increase in postoperative wound care. The intraservice work of creating a colostomy is captured by subtracting the work RVUs for code 44140 from code 44143, which leaves 1.99 RVUs. In addition, there is one extra postoperative visit required for code 44605. Medicare believes 44605 is equivalent to 99233, which has 1.51 work RVUs. Therefore, the agency added 1.99 and 1.51 work RVUs to the work RVUs for code 44604 to arrive at 19.53 work RVUs for code 44605.

— Valuing code 44603 (Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations) at 18.66 work RVUs. The additional work required for code 44603 as compared to code 44602 is similar to the additional work required for code 44605 as compared to code 44604, except, because there is no actual colostomy, the additional postoperative visit is comparable to code 99231, with 0.64 work RVUs. Therefore, the agency added work RVUs of 1.99 and 0.64 to the work RVUs of code 44602 to arrive at 18.66 work RVUs for code 44603.

Medicare also said the current work RVUs for codes 44640 (Closure of intestinal cutaneous fistula), 44650 (Closure of enteroenteric or enterocolic fistula), 44660 (Closure of enterovesical fistula; without intestinal or bladder resection), and 44661 (Closure of enterovesical fistula; with bowel and/or bladder resection) are rank-order anomalies, as they are undervalued compared to code 44604.

As a result, it proposed assigning 22.27 work RVUs to code 44650. To keep the current relativity with the other codes, Medicare also proposed 21.65 work RVUs for code 44640, 21.36 work RVUs for code 44660, and 24.81 work RVUs for code 44661. Medicare also wants to accept the

RUC recommendations for the remaining codes (44615, 44620, 44625, 44626, 44680, 44700, and 44850).

• **Anus/rectum — Hemorrhoids/fistula.** The RUC extrapolated a 14% decrease in work RVUs to all codes in this family based upon a decrease in work RVUs for the fully surveyed code 46262 (Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy).

Medicare's response: It agreed with the RUC recommendation for the surveyed code, but disagreed with the extrapolation to the anal fistula repair codes and the anal abscess treatment codes. Instead, it proposed maintaining the current RVUs for codes 46270, 46275, 46280, 46288, 45000, 45020, 45100, 45108, 46040, 46045, and 46060. It also agreed with the RUC's recommendations to decrease the work RVUs for other codes in this family of codes (46250, 46255, 46257, 46258, 46260, 46261, 46262, 46934, 46936, 46945, and 46946).

• **Abdomen, peritoneum, omentum.** The RUC recommended an increase for the fully surveyed code 49020 (Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open) from 16.79 work RVUs to 20.73 work RVUs.

Medicare's response: It disagreed, proposing a work RVU valuation of 22.84.

Obstetrics/Gynecology

The American College of Obstetrics and Gynecology referenced 35 codes for review by the RUC.

RUC recommendation: Increases in the RVUs for the following codes: 56515 (2.76), 56740 (4.57), 57100 (1.20), 58152 (20.60), 58260 (12.98), 58262 (14.77), 58263 (16.06), 58275 (15.76), 58280 (17.01), 58267 (17.04), 58285 (22.26), 58600 (5.60), 58605 (5.00), 58700 (12.05), 58740 (14.00), 58825 (10.98), 58920 (11.36), 58951 (22.38), 59812 (4.01), and 59870 (6.01).

Medicare's response: It accepted the RUC's recommendations.

Cardiology

The American College of Cardiology recommended review of three procedure codes: 93350, 33234, and 33235.

RUC recommendation: It supported an increase in the work RVUs for code 93350 to account for the increased work and more complex conditions of the patient population and proposed increasing the work RVUs to 1.48.

Medicare's response: It accepted the RUC's recommendations.

Radiology

The American College of Radiology identified three codes they believe are undervalued: 76065, Radiologic examination of an infant, and two mammography procedure codes (76090 and 76091).

RUC recommendation: It recommended work RVUs of 0.70 for code 76065. For the mammography procedure codes, the RUC recommended work RVUs of 0.70 for code 76090 and 0.87 for code 76091.

Medicare's response: It accepted the RUC's recommendations.

Ophthalmology

The American Academy of Ophthalmology requested review of nine codes, including one code for evaluation of the global period.

RUC recommendation: The RUC agreed to change the global period from 90 days to 10 days for code 65855 (Laser surgery of eye) and also reduced the work RVUs to 3.85 to account for this reduction in the global period. For code 67218, the RUC recommended work RVUs of 18.53. For code 92018, the RUC recommended that the work RVUs be increased to 2.50, with the understanding that the code would be sent to the CPT Editorial Panel for clarification.

Medicare's response: It accepted all of the RUC recommendations.

Orthopedic surgery

The American Academy of Orthopaedic forwarded 42 codes for review it felt were undervalued.

RUC recommendation: The RUC recommended increasing the work RVUs for the following codes: 29883 (11.05), 29450 (2.08), 28299 (9.18), 28705 (18.80), 23472 (21.10), 26562 (15.00), 20245 (8.50), 27075 (35.00), 27077 (40.00), 27284 (23.45), 27286 (23.45), 27822 (11.00), 27823 (13.00), 28445 (15.62) and 27724 (18.20).

Medicare's response: It accepted all of the RUC's recommended hikes except for orthopedic surgery code 20245 (Biopsy, bone, excisional; deep (eg, humerus, ischium, femur). ■

(Continued from page 118)

clear documentation and a willingness to fight the initial coverage decision can pay off.

• **Treatment is experimental.** Generally, a procedure or technology is no longer considered experimental when it has Food & Drug Administration (FDA) approval or, in the case of a drug, when major drug company has listed it as safe and efficacious for a particular use. However, "these criteria may not be sufficient from the perspective of some health plans," says Bare.

The FDA tests primarily for safety, not effectiveness, he points out. Most FDA reviews are 510(k) reviews, which are meant to assess claims of substantial equivalency with a device marketed before 1976. It is also possible that a manufacturer produces a product that is equivalent to a procedure or technology of no value. In fact, "only 20% of medical interventions in current use have substantial research support," estimates Bare.

Fighting back

More and more states are adding formal procedures to appeal denied coverage and claims. Also, the U.S. Department of Labor has proposed a new set of national standards for governing the time it should take to make and appeal a coverage decision.

When a patient wishes to fight a plan's decision to deny a claim for a service, the patient's options include:

• **Litigation.** While the Supreme Court has affirmed that health plans cannot be sued for giving doctors financial bonuses to hold down treatment costs (*Pegram et al v. Herdrich*), health plans can be sued for denials of care.

"In general, the courts appear inclined to treat these cases as quality-of-care issues rather than denial-of-benefits issues, thereby permitting many cases that might have otherwise been dismissed to go forward," says Bare.

One increasingly popular legal strategy is to file these cases in state courts under the Racketeer Influenced and Corrupt Organizations Act, which allows for larger damage awards than cases filed under the Employee Retirement Income Security Act of 1974 in federal courts.

A New York appellate court recently ruled that Prudential members can sue the plan in a class-action suit for fraud, breach of contract, and deceptive trade. "The basis of this class-action suit was that, through its marketing tools, Prudential said its doctors would make medical determinations, when, in fact, the determinations were made by nurses using the much-debated clinical guidelines produced by the actuarial firm of Milliman & Robertson," says Bare.

• **Department of Labor regulations.** Just because scientific evidence clearly demonstrates the value of an intervention (i.e., it prevents or lessens the impact of disease more effectively than does the current established standard of care), that does not mean the health plan will agree to pay for the intervention. In such instances, the new regulations from the Department of Labor will require health plans to provide "the specific reason or reasons for rejected claims and reduced benefits," he says. In the case of denials due to the experimental nature of the requested service, the health plan will also be required to "explain the scientific or clinical judgment of the plan" on request.

• **State mandates.** Health plans must comply with legislative mandates to cover certain services. It is estimated that 22% of total benefit dollars are associated with legislative mandates. Federal and state legislative mandates supersede contractual obligations and require the health plan to cover mandated services, even when the issue of whether the services are experimental or mainstream is unresolved. ■

Facts and Figures About Insurance Claims

• A 1999 study by PricewaterhouseCoopers found that insurance and managed care industries could generate up to $280 million in annual interest income simply by denying 1% of the claims they receive, then reversing the denials following an independent review process.

• Only 6% of claims denied by Medicare are protested, according to the General Accounting Office. However, 60% of the denials that are challenged by practitioners result in the physician being paid more.

One reason for the high provider win rate when protesting Medicare claim denials is that up to 90% of the decisions made by Medicare contractors about whether services are medically necessary or not are made by workers with only a high school education and no medical training.

A Medicare exodus? Depends on who's talking

Different figures show different trends

Increasingly frustrated with red tape and reimbursement hassles, more physicians — especially those in urban areas — are deciding to opt out of the Medicare program, recent studies show.

The Association of American Physicians and Surgeons, for instance, estimates 23% of physicians nationwide do not accept new Medicare patients. A survey in Colorado showed that as many as 40% of family physicians are refusing new Medicare patients.

"Many doctors have closed their practices to new Medicare patients," says **Marilyn Rissmiller**, program manager of the health care financing department at the Colorado Medical Society in Denver. In fact, in Denver, only about 15% of doctors take new Medicare patients.

'Arcane, absurd, and inconsistent' rules

When Medicare was first introduced, "everybody was willing to accept the concept of providing for the health care needs of the elderly," says **Richard Corlin**, MD, a gastroenterologist in Santa Monica, CA. "But we didn't realize that the rules would be so arcane, absurd, and inconsistent that any technical violation is considered fraud."

In fact, fear of being hit with warrantless fraud-and-abuse audits and corresponding legal costs is a primary reason why many of Colorado's family physicians are limiting their Medicare practices, says Rissmiller.

Medicare officials, however, dispute the idea that fewer physicians are participating in the program. In fact, physician participation in Medicare is actually increasing, according to the agency.

Based on Medicare's figures, 86.3% of doctors accepted Medicare patients in 2000, up from 74.8% in 1996.

"Naturally, we have heard anecdotal reports about doctors leaving the program, but we have no analytic reason to think there's a problem," says **Murray Ross**, executive director of the Medicare Payment Advisory Commission (MedPAC).

According to a 1999 physician survey by MedPAC, while doctors had serious concerns about the program, most still took new Medicare patients. The survey found:

- 95.7% of physicians surveyed accept some or all new Medicare patients.
- 64.7% were very concerned about reimbursement levels.
- 45.4% were very concerned about external review and oversight of clinical decisions.
- 69.7% were very concerned about time spent on billing-related paperwork.
- 47.8% were very concerned about malpractice issues and liability insurance. ■

HCFA gets a new name and an ambitious agenda

Agency splits into three business centers

In June, the Bush Administration renamed the Health Care Financing Administration. The agency's new name will be the Centers for Medicare and Medicaid Services (CMS).

Tommy Thompson, Secretary of the Department of Health and Human Services, says the change symbolizes his commitment to improving the agency's services to beneficiaries, doctors, hospitals, and other health care providers.

Along with the name change, CMS will be reorganized into three divisions:

- The Center for Beneficiary Choices, which will provide information to Medicare patients in private health plans;
- The Center for Medicare Management, which will run the traditional fee-for-service version of the insurance program;
- The Center for Medicaid and State Operations, which will handle Medicaid and the State Children's Health Insurance Program.

To help develop brand recognition for its new name, CMS plans to conduct a $35 million national media campaign this fall to highlight the types of Medicare insurance available to the elderly, including HMOs, fee-for-service Medicare, private insurance to fill gaps in Medicare, and medical savings accounts.

Meanwhile, CMS and HHS want to double the number of beneficiaries enrolled in Medicare HMOs within four years, which would place 30% of seniors in managed care by 2005. ■

AMA releases principles to guide its own Web sites

Visitors must volunteer to provide personal data

Practices that want to create principles governing the privacy of their web sites and those used by their staffs now have another reference source. The American Medical Association (AMA) in Chicago has issued a set of guidelines governing editorial content, advertising, sponsorship, privacy and confidentiality, and secure electronic commerce for its web sites.

The guidelines' writers note that access to the Internet has the potential to speed the transformation of the patient-physician relationship from that of a physician authority administering advice and treatment to that of shared decision-making between patient and physician.

"[The AMA guidelines are not designed to be] global, in the sense of being international, and encompassing, [as are the] International e-Health Code of Ethics [offered by the Internet Healthcare Coalition in Washington, DC]," says **John Mack**, coalition president.

"For the most part, the AMA guidelines are very specific for AMA publications and web sites, and while there are many common points, these guidelines could not be expected to be followed by all health Web sites," says Mack.

Be aware of third parties

Like the Internet Healthcare Coalition, the AMA is concerned about the privacy rights of the people who visit the assocation's web site. The AMA plans to protect web site visitors' rights in these ways:

1. A link to the privacy policy of the Publications web site should be provided on the home page or the site navigational bar and should be easily accessible to the user. The Publications web site should adhere to the privacy principles posted.

2. Individuals responsible for web sites that post advertising should be aware of current technology and access possessed by third parties that post or link to advertisements. Web sites should ensure that the technology and access used by third parties adhere to the web site's privacy policies.

3. The site should not collect name, e-mail address, or any other personal information unless voluntarily provided by the visitor after the visitor is informed about the potential use of such information.

4. The process of opting in to any functionality that includes collection of personal information should include an explicit notice that personal information will be saved, with an explanation of how the information will be used and by whom. The opt-in statement should not be embedded in a lengthy document and should be explicit and clear to the viewer.

5. Collection, retention, and use of nonmedical personal information about site visitors may be offered to viewers when the AMA believes that such information would be useful in providing site visitors with products, services, and other opportunities, provided such use adheres to these principles and is within bounds of current regulations and law. (For more information, go to www.ftc.gov/privacy/index.html.)

Opting out

Individuals may agree to have such nonmedical personal information collected or may choose not to, with the understanding that opting out of having such information collected prevents the site from being tailored to their particular needs and interests. Such information will not include personal health information, such as any information about medical conditions or medications purchased.

6. Names and e-mail addresses of site visitors should not be provided or released to a third party without the site visitor's express permission.

7. E-mail information, personal information about specific visitor's access and navigation, and information volunteered by site visitors (such as survey information and site registration information) may be used by the site owner to improve the site but should not be shared with or sold to other organizations for commercial purposes without express permission.

8. The AMA will use e-mail addresses voluntarily provided by site visitors to notify them about updates, products, services, activities, or upcoming events. Site visitors who do not wish to receive such notifications via e-mail should be able to opt out of receiving such information at any time.

9. The AMA has licensed its physician and medical student list to third parties for more than 50 years. This information is licensed to database

licensees under strict guidelines. The names and addresses of physicians in the AMA Physician Masterfile are made available only for communications that are germane to the practice of medicine or of interest to physicians or medical students as consumers. E-mail addresses are excluded from such licensing agreements.

10. Nonidentifiable Publications web site visitor data may be collected and used in aggregate to help shape and direct the creation and maintenance of content and to determine the type of advertisement to be seen by site visitors while on the AMA site.

Personal medical information protected

11. The AMA will not collect and will not allow third parties to collect personal medical information (medical conditions, health-seeking behaviors and questions, and use of or requests for information about drugs, therapies, or medical devices) without the express consent of the site visitor after explanation of the potential uses of such information.

12. At this time, the AMA Publications web sites do not use "persistent cookies," a means of tracking traits of web site visitors. Users will be notified if and when AMA Publications web sites begin using persistent cookies, as specified in these guidelines.

13. E-mail messages sent to a web site might not be secure. Site visitors should be discouraged from sending confidential information by e-mail. Site visitors sending e-mail accept the risk that a third party may intercept e-mail messages.

14. Market research conducted by the site or its agent to enhance the site should be clearly identified as such.

15. E-mail alerts and newsletters should contain an "unsubscribe" option.

(Editor's note: To view the principles in their entirety, visit AMA's web site at www.ama-assn.org/ama/pub/category/2703.html.) ■

Bush administration to push Medicare competition

Cut proposed in number of contractors

Thomas Scully, new head of the recently renamed Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), says one of his top policy priorities will be to inject more competition into the Medicare contractor bidding process.

Scully plans to accomplish this by cutting the number of Medicare fiscal intermediaries and making the bidding process more competitive — moves that are likely to be opposed by those intermediaries.

Testifying recently before the Senate, Scully said he feels the process for selecting unnecessarily limits the number of contractors that can bid. He said he and Health and Human Services Secretary Tommy Thompson want to see the law changed to allow prospective contractors to bid.

CMS also hopes reducing the number of Medicare contractors will eliminate some of the confusion currently caused by the disparity in reimbursement policies among different contractors across the country, as well as gaps in quality of service.

Other goals

Other changes the Bush administration plans to implement when it comes to Medicare payment practices include the following, according to CMS officials' Senate testimony:

• move from paper transactions and communications to a paperless, automated system;

• eliminate regulatory red tape for providers, reduce unnecessary burdens, and establish key contacts for each state in CMS regional offices who will answer providers' questions and address their concerns;

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- Medicare's 2002 physician fee schedule
- Employment contracts that really work
- Keeping more of what you bill
- Product line billing

• update information technology with a common, departmentwide computer system and a single, up-to-date financial management system for CMS;

• ensure materials, including regulations, are written in "plain, understandable English" instead of the dry and confusing language of bureaucrats;

• expand provider and beneficiary education campaigns, making the toll-free information line for consumers operative 24 hours a day by October and posting more information on CMS on the agency's Web site.

In a June 14 letter, Scully told Rep. Nancy L. Johnston (R-CT), House Ways and Means Subcommittee on Health chairwoman, and ranking minority member Fortney H. Stark (D-CA) that one of the managed care innovations he wants to implement is allowing beneficiaries to enroll on-line.

"We are in the process of reviewing waiver requests, some of which include on-line enrollment," he said. "Once approved, we will monitor and consider new procedures for further pilot testing and/or national implementation of on-line enrollment."

Scully's letter also mentioned the administration's commitment to finding a way to accomplish more accurate risk-adjusted payments.

"The improved approach will incorporate ambulatory diagnoses beyond those collected in an inpatient setting," he said. In addition to more accurate payments, the collection methods will be less burdensome to the industry.

Other steps the agency has already taken to reduce the review process for beneficiary documents include:

— establishing a 10-day review period for Medicare+Choice organizations that use model materials without modification that describe their 2002 benefits, including the Annual Notice of Change and the Summary of Benefits;

— allowing Medicare+Choice organizations to release their notices of change and summaries prior to approval of their adjusted community rate proposals, provided these materials include the disclaimer "pending federal approval";

— suspending the final verification requirement for notices of change and summaries. Rather than being required to send a copy to CMS for approval prior to printing and dissemination, the Medicare+Choice organization will only have to send a copy after the materials have been sent to beneficiaries. ■

Reimbursement ROUNDUP

Supervisory rule added to bad-rule hit list

The list of troublesome regulations physician leaders would like to scuttle has grown to include rules that physicians must follow in supervising medical residents.

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Editor: **Larry Reynolds**, (202) 347-2147.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).
Production Editor: **Brent Winter**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

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The Physicians' Regulatory Issues Team at the Centers for Medicare and Medicaid Services (CMS) has added that requirement to its list of rules that cause doctors the greatest hassles.

"Physicians tell us these requirements are confusing and may lead to debatable errors," says **Barbara Paul**, MD, CMS medical advisor and director of the team of outside physicians appointed to work with agency staff on streamlining its regulatory methods.

This item is now added to the team's list of top problems faced by doctors who participate in Medicare. The team plans to address the problems on its list. Already on the list: coverage of preoperative evaluations, advance beneficiary notices, coverage of follow-up visits, certificates of medical necessity, and laboratory services. ▼

HHS task force will target patient safety

Department of Health and Human Services (HHS) Secretary **Tommy Thompson** has announced that a new Patient Safety Task Force has been established to coordinate a joint effort among several agencies to improve existing systems to collect data on patient safety.

These agencies include The Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare and Medicaid Services. HHS' fiscal 2002 budget proposal includes $72 million for efforts to improve patient safety and reduce the number of adverse events, an increase of $15 million over fiscal year 2001.

In addition, Thompson has charged the task force with studying how to implement a user-friendly Internet-based patient safety reporting format. The group will develop computer networks, user-friendly reporting systems, and standards for coding the content of the reports, reports *AHA News*. The system will feature a uniform data collection method. The Centers for Disease Control and Prevention and the Food and Drug Administration will provide data on medical errors, while the Agency for Healthcare Research and Quality will analyze the causes of medical errors. ▼

Hospital profit margins show negligible increase

Operating profit margins at U.S. hospitals flattened at an annualized average of 3.69% in 2000, indicating only a slim degree of financial health, according to a report by Evanston, IL-based Solucient, a provider of benchmark information on health care.

Hospital operating margins increased 0.41% over 1999 and remained relatively low, a full 36.6% lower than in 1997. Solucient president **Gregg Bennett** says margins of 3%-4% are not sustainable in the long run, especially given the pressure from drug costs and labor shortages. He also says hospitals are still feeling the sting of the 1997 Balanced Budget Act and its clamp on Medicare payments.

According to the study, "The Health of Our Nation's Hospitals," smaller hospitals finished the year at 4.84%, their highest operating margin since 1997. Larger hospitals produced the slimmest operating margins at 2.83%. Regionally, western hospitals posted the weakest operating margins at 3.9%, while northeastern hospitals fared the best, going from breaking even in 1999 to almost 5% in 2000. For more information, visit www.solucient.com. ■