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Reimbursement Issues

Reimbursement has always been a critical issue for physicians. Given the current focus on the health care industry's spiraling costs, the importance of developing a fair and defensible fee schedule cannot be stressed enough.

Reimbursement Trends

Significant changes in Medicare reimbursement for physicians were anticipated in 2007, including adjustments to the conversion factor (CF), physician work relative value units (RVUs) for 2007, and application of a budget neutrality adjustment to work RVUs. However, at print time it appears that Congress has intervened once again to prevent a reduction in the conversion factor, which will be maintained at the 2006 level. It does appear that the work RVU changes resulting from the third five-year review and the application of the budget neutrality adjustment to work RVUs will be implemented as planned.

By law, the Centers for Medicare and Medicaid Services must apply a number of adjustments to the CF and RVUs to meet statutory requirements related to the sustainable growth rate (SGR). As in previous years, a negative update will be required to meet SGR statutory requirements. In 2003, 2004, and 2005, when negative updates of between 4.0 percent and 5.0 percent were expected, Congress passed emergency legislation allowing minimal increases for these years of 1.6 percent, 1.5 percent, and 1.5 percent respectively. In 2006, when the SGR required a negative 4.4 percent update, Congress once again passed emergency legislation. This time Congress did not allow any increase, but did maintain reimbursement levels at the 2005 amounts. Once again, for 2007 Congress has intervened and the expected negative 5.0 percent update to the conversion factor to meet SGR statutory requirements will not be implemented. According to the bill passed December 9, 2006, the conversion factor will be maintained at the 2006 level of 37.8975.

Even though the negative update to the CF will not be implemented for 2007, two other significant changes will be made. One is the change to the physician work RVUs resulting from the third five-year review and the other is the change to the formula for calculating total RVUs. For 2007, it is necessary to apply a budget neutrality (BN) adjustor, also called a budget neutrality factor (BNF), of 0.8994 to the work RVUs. The product must then be rounded to two decimal places before the rest of the calculations are performed. This adjustment affects national and GPCI (geographic practice cost index) adjusted RVUs and calculated reimbursement rates.

The change to the formula for calculating these values was necessitated by changes to work RVUs, which in turn occurred as a result of the third five-year review of work RVUs. The five-year review began in 2005, and changes resulting from that review will be fully implemented for services provided on or after January 1, 2007. The revisions reflect changes in medical practice, coding changes, and new data on the physician work required to perform each service.

Due to the changes to work RVUs resulting from the third five-year review, budget neutrality could not be maintained by the usual method of manipulating the conversion factor. The budget neutrality provision requires that any changes to RVUs not result in a variance of expenditures of more than \$20 million, either higher or lower, than what would have resulted had the RVUs not changed. Because the changes resulting from the five-year review would have caused the variance to exceed the \$20 million variance, even with the adjustments to the conversion factor (CF), an additional adjustment to work RVUs was required.

Previously, the formula for calculating GPCI-adjusted RVUs was:

$$(\text{Work RVUs} \times \text{Work GPCI}) + (\text{PE}^* \text{ RVUs} \times \text{PE GPCI}) + (\text{Malpractice RVUs} \times \text{Malpractice GPCI}) = \text{Total RVUs}$$

The total RVUs were then multiplied by the conversion factor to obtain the locality-specific fee schedule amount:

$$\text{Total RVUs} \times \text{CF} = \text{Locality-specific fee schedule amount}$$

The new formula requires an additional step:

$$\text{Work RVUs} \times \text{BN adjustor} = \text{BN adjusted Work RVUs} \text{ (rounded to two decimal places)}$$

$$(\text{BN adjusted work RVUs rounded to two decimal places} \times \text{Work GPCI}) + (\text{PE}^* \text{ RVUs} \times \text{PE GPCI}) + (\text{Malpractice RVUs} \times \text{Malpractice GPCI}) = \text{Total BN adjusted RVUs}$$

The BN adjusted total RVUs must now be multiplied by the conversion factor to obtain the locality-specific BNF adjusted fee schedule amount:

$$\text{BN adjusted total RVUs} \times \text{CF} = \text{Locality-specific BNF adjusted fee schedule amount}$$

* PE is subdivided into nonfacility and facility. Select the PE value for the appropriate site of service when performing the calculation.

Evaluation and Management

Evaluation and Management (E/M) codes are structured according to a common formula: the extent or intensity of select components of a medical encounter, coupled with the risk and complexities associated with the diagnosis and medical decision making, determine the code selection.

E/M Guidelines

New and Established Patient Service

Several code subcategories in the E/M section are based on the patient's status as being either new or established. CPT guidelines clarify this distinction by providing the following time references:

- **New patient:** one who has not received any services from that physician, or other physician of the same specialty in the same practice, within three years
- **Established patient:** one who has received services from that physician, or other physician of the same specialty in the same practice, within three years

If one physician is on call or covering for another physician, classify the patient encounter new or established as you would for the physician who is unavailable.

E/M Service Key Components

The components of history, examination, and medical decision making are considered the keys to selecting the correct level of E/M codes. In most cases, all three components must be addressed in the documentation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.

History

The history component is categorized by four levels:

- **Problem Focused**—chief complaint; brief history of present illness or problem
- **Expanded Problem Focused**—chief complaint; brief history of present illness; problem-pertinent system review
- **Detailed**—chief complaint; extended history of present illness; problem-pertinent system review (with limited related systems); pertinent past, family, and/or social history directly related to the patient's problems

• **Comprehensive**—chief complaint; extended history of present illness; system review related to present illness (with review of all additional systems); complete past, family, and social history

Physical Examination

The physical examination component is similarly divided into four levels of complexity:

- **Problem Focused**—an exam limited to the affected body area or organ system
- **Expanded Problem Focused**—a limited examination of the affected body area or organ system and of other symptomatic or related organ systems
- **Detailed**—an extended examination of the affected body area(s) and other symptomatic or related organ system(s)
- **Comprehensive**—a complete single system specialty examination or a general multi-system examination of systems (the extent of which is based on age and identified risk factors)

Medical Decision Making

Medical decision making is the final piece of the current E/M coding puzzle, and is a bit more complicated to determine than are the history and examination components. Three subcomponents must be evaluated to determine the overall complexity level of the medical decision.

Contributory Components

Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, but they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates (more than 50 percent of the encounter). In these cases, time determines the proper code. Documentation of the exact amount of time spent will verify and substantiate your selected code. Along with the time, spell out what was discussed during the encounter. If a physician coordinates care with an interdisciplinary team of physicians or health professionals/agencies without a patient encounter, report it as a case management service.

Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:

guidelines that identify not only the number of preoperative days included, but also the number of hours. Other payers are more liberal and allow a separate payment for care prior to surgery or even same-day care.

Because of the different interpretations of preoperative care by payers, it is necessary to understand and negotiate the best possible contract with the payer. In other words, take advantage of any extra benefits that you may be able to negotiate. For other noncontracted payers it is a good idea to develop a written policy regarding these types of issues. A written policy will help your office staff to have specific billing rules they can reference, and lets insurance auditors know your billing protocol is consistent. A written policy also makes it easier for your staff to appeal denials.

Existing contracts should specify a payer's rules regarding separate reimbursement for preoperative care. Make note of these rules for contracted payers and especially for those most frequently billed.

Preoperative Care and Medicare

Medicare does not consider the surgeon's initial evaluation or consultation to determine the necessity for surgery part of the global payment; a separate allowance is made. Reporting of this E/M service is dependent on the complexity of the surgical procedure. Procedures that are defined as major surgery, generally those with a 90-day follow-up period, should be reported with modifier 57. Modifier 57 has been created to identify an E/M visit that resulted in the initial decision for major surgery. Procedures that have been defined as minor surgery, generally those with follow-up days of 0 or 10, should be reported with modifier 25.

Once the decision for surgery has been made, preoperative visits for care of the surgical problem, other than the initial evaluation, are usually included in the surgical package. Preoperative visits for care of the surgical problem other than the initial evaluation beginning one day prior to surgery, regardless of location, are included in the surgical fee. Only those same-day services that are unrelated to or can be identified separately from the procedure are reimbursed separately by Medicare.

Postoperative Care

Typical postoperative follow-up care is included in the surgical package. When a patient is seen for a routine follow-up postoperative visit within the usual follow-up period, use CPT code 99024 for reporting and documentation purposes. No fee should be charged as 99024 is used for record-keeping purposes only.

The usual postoperative follow-up period is defined by the payer. Most commercial payers use the follow-up periods (0, 10, or 90 days) designated by Medicare. This should be verified with the payer.

Postoperative Care and Medicare

Medicare's policy defines the postoperative period for nearly all major surgical services as 90 days following the date of surgery. Minor surgeries have either a 0- or a 10-day postoperative period. The following are included in postoperative care:

- Dressing change and local incisional care
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints
- Insertion, irrigation, and removal of urinary catheters
- Insertion and removal of routine peripheral IV line, nasogastric, and rectal tubes
- Change and removal of tracheostomy tubes

Minor surgeries have either a 0- or a 10-day postoperative period. Those with 10-day periods include all postoperative services related to the recovery from surgery. Other services during that period, whether for the underlying condition or for an unrelated condition, are paid separately.

Endoscopic procedures performed through an existing body orifice have no postoperative days and all postoperative E/M care is reported separately. Incisional procedures, such as laparoscopy, include 10 or 90 days of postoperative care, depending upon the complexity of the procedure.

Postoperative Complication

Postoperative care incorporated in the surgical package only includes normal, uncomplicated follow-up care. Treatment of complications, such as wound dehiscence, infection, and bleeding, can be reported separately. Report inpatient and outpatient services for these postoperative complications along with the surgical service. The diagnostic code and all medical records documentation should reflect the exacerbation or acute nature of the problem being treated. Use modifier 78 to identify a return to the operating room to manage postoperative complications.

Complications and Medicare

Medicare does not allow separate reimbursement for any additional medical or surgical services required of the surgeon during the postoperative period of the surgery when treatment of the complication does not require a return trip to the operating room. However, Medicare does allow reimbursement for postoperative complications requiring a return trip to the operating room. These services are denoted with modifier 78 Return to the operating room for a related procedure during the postoperative period. The payment level for these "re-operations" for complication is set at the value of the intra-operative portion of the procedure described by the CPT code. If there is no code that describes the service and an unlisted procedure code must be used payment cannot exceed 50 percent of the intra-operative portion of the service originally performed. See modifier 78 in the Modifier section of the Introduction for additional