

# What surgeons should know about...

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## The 2001 Medicare fee schedule

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**T**he Health Care Financing Administration (HCFA) issued a final regulation on November 1, 2000, outlining changes in Medicare physician payment policies for 2001. In contrast to recent years, the combined impact of all the policy modifications that took effect this year produced at least modest average gains in Medicare income for the majority of medical and surgical specialties. These gains are projected to occur despite the fact that resource-based practice expense relative value units (RVUs) continue to decrease for many procedures as they are phased in to the fee schedule (see Table 1, p. 9). Following is a more detailed discussion of the new policies and fee schedule changes set forth in the regulation, and of the impact these revisions are expected to have on surgical specialties.

**Q. What is the fee schedule conversion factor for 2001, and how does it compare with last year's?**

**A.** The Medicare physician fee schedule conversion factor was increased 4.5 percent in 2001 to \$38.2581, up from \$36.6137 in 2000.

**Q. Where are we in the process of transitioning to resource-based practice expense RVUs?**

**A.** We are now in the third year of a four-year transition to new practice expense RVUs, with 75 percent of practice expense payments based on resource-based values and 25 percent on RVUs that were effective in 1998.

In 2002, Medicare physician payments will be entirely "resource-based." At least for the present, however, the new practice expense RVUs are considered "interim," meaning that they are subject to changes resulting from data refinements, adjustments to the methodology, the availability of new information, and so forth. In fact, Medicare law specifies that the resource-based values are supposed to be refined on a continuing basis throughout the transition period.

**Q. What will the ultimate impact on my Medicare payments be when the final practice expense values take effect in 2002?**

**A.** Table 2 on page 9 provides estimates of the full impact that the move to resource-based practice expense RVUs will have on average Medicare income for the surgical specialties. These figures are based on estimates provided by HCFA in various Medicare fee schedule regulations issued for 1999, 2000, and 2001, which were later combined. As a result, they should be viewed with some caution; figures were displayed to varying levels of precision in the different years, making accurate projections of the cumulative effect problematic. Further, as is always the case, the actual impact on an individual surgeon's income can vary significantly from the average calculated for the relevant specialty, depending on the mix of services he or she provides. (Orthopaedic surgeons who practice primarily in facility settings and perform a high volume of major joint procedures, for example, are likely to experience steeper cuts than shown on this table.)

<b>Table 1</b>	
<b>Estimated net change in Medicare payments between 2000-2001 for selected specialties</b>	
<b>Surgical specialties</b>	
Cardiac surgery	-1%
General surgery	2
Neurosurgery	1
Obstetrics/gynecology	6
Ophthalmology	6
Orthopaedic surgery	4
Otolaryngology	7
Plastic surgery	6
Thoracic surgery	-1
Urology	6
Vascular surgery	1
<b>Other specialties</b>	
Anesthesiology	2%
Cardiology	1
Emergency medicine	2
Family practice	6
Gastroenterology	0
Internal medicine	5
Pathology	2
Radiology	2

<b>Table 2</b>	
<b>Impact of practice expense RVU changes for surgical specialties</b>	
<b>Specialty</b>	<b>Cumulative 1999-2002 impact</b>
Cardiac surgery	-21%
General surgery	-7
Neurosurgery	-12
Obstetrics/gynecology	5
Ophthalmology	6
Orthopaedic surgery	-2
Otolaryngology	9
Plastic surgery	5
Thoracic surgery	-18
Urology	7
Vascular surgery	-14

**Q.** The College and other medical and surgical specialty societies have expressed serious concern in recent years over the poor progress HCFA seems to have made in refining the data used to calculate resource-based practice expense RVUs, even though the agency is required by law to make such refinements during each year of the four-year transition period. Were any sig-

**nificant improvements made to the data for 2001?**

**A.** Yes. The 2001 fee schedule reflects what is perhaps the most significant refinement yet made to the data HCFA used to develop resource-based practice expense RVUs. As first proposed by the College during the practice expense review process conducted by the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), estimates of the clinical staff costs associated with 15 major evaluation and management services were reduced. Together, these services account for approximately one-quarter of Medicare physician billings. As a result of this data edit, hundreds of millions of dollars were

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redistributed to other services, mitigating somewhat the practice expense payment reductions that continue to be phased in for many procedural services.

In addition, the RUC made recommendations for clinical staff, supply, and equipment inputs for dozens of CPT codes that were adopted by HCFA.

**Q. What other significant changes were made to the practice expense data?**

**A.** Aggregate specialty-specific practice cost data from the AMA's Socioeconomic Monitoring System (SMS) are used to determine each specialty's practice expense "pool" before procedure-specific and general overhead costs are allocated down to the procedure code level. For 2000, data from the 1997 SMS data were used to establish these specialty pools. This year, HCFA changed its methodology and used a four-year average of the SMS data collected in 1995-1998.

While this change may enhance the stability of the data, it has raised problems for some specialties. Cardiothoracic surgeons, for example, conducted additional surveys in 1999 using the SMS methodology in order to increase the sample size for their specialty. As a result of these improved data, the practice expense pools HCFA assigned to cardiac and thoracic surgery were increased for 2000. However, under the four-year averaging method used this year, the positive effects of these data improvements were diluted substantially. Cardiac and thoracic surgeons are the specialties hit hardest by this change in methodology.

As a result of using the four-year averaging method, HCFA estimates that nine specialties will experience a positive or negative impact of approximately 1 percent; four specialties show a payment impact of about 2 percent.

**Q. Vascular surgeons comprise a relatively small specialty that is acknowledged to be underrepresented in the aggregate practice cost data collected through the SMS. What considerations has HCFA made for this specialty?**

**A.** HCFA used data collected through a joint survey conducted by the American Association of Vascular Surgery and the Society for Vascular Surgery to supplement the information already in-hand. As a result, HCFA's estimate of the practice expense per hour figure for vascular surgery increased 18 percent, from \$63.80 to \$75.10.

**Q. Some specialties have argued pointedly during the practice expense refinement process that HCFA made a serious error in 2000 when it eliminated from its data base the costs incurred by physicians when clinical staff employed by them provide services in facility settings. How was this issue addressed in the final rule?**

**A.** Several specialty societies, including the College, opposed these data edits, arguing that, at the very least, they should be postponed until additional facts can be collected. However, HCFA maintains that where the use of such staff is not separately billable, they are covered by Medicare's diagnosis-related group (DRG) payments. Consequently, the agency still has not restored these cost estimates to the practice expense data base.

HCFA agreed, however, that it would be helpful to determine whether hospitals are, in fact, still providing the staffing that is assumed in their DRG payments. To that end, the agency has asked the Office of the Inspector General to conduct a specific, independent assessment of staffing arrange-

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ments between hospitals and thoracic surgeons. (Thoracic surgeons have submitted data estimating that 74 percent of them employ clinical staff who assist in the hospital.)

**Q.** **It is disturbing that many refinement issues remain at this point in the transition process, when three-quarters of physician practice expense payments are based on these new “resource-based” values. What does the future hold for meaningful refinement?**

**A.** HCFA stated in the rule that, so long as there remains a “good faith effort” among all parties, it will not close the door on further code-level practice expense RVU refinements when the transition period ends in 2002. Also, the agency is required by law to review and make adjustments to the practice expense values five years after they take full effect—that is, no later than 2007.

**Q.** **Medicare payments are adjusted to reflect area cost differences through geographic practice cost indices (GPCIs) that have been established for each of the three fee schedule components (physician work, practice expenses, and malpractice expenses). In addition, HCFA is required by law to review and make changes to these indices at least once every three years. The GPCIs were last changed in 1998; what changes were made this year and what is the estimated impact?**

**A.** This year, the GPCIs were changed to reflect more current data on rents and malpractice expenses. Because more than a year has elapsed since the last GPCI revision, these changes will be phased in over a two-year period. Accord-

ing to HCFA, only 14 of the 89 fee schedule areas will change by two percent or more; 16 others will change by 1 to 1.9 percent. The remaining 59 areas are estimated to experience payment changes of less than 1 percent under the revised GPCIs.

**Q.** **In 2000, resource-based malpractice RVUs were incorporated into the Medicare fee schedule. Have any changes been made to those values?**

**A.** The malpractice RVUs were revised slightly this year to reflect more current data on premium costs. In addition, HCFA accepted a recommendation made by the College and the Society for Surgical Oncology and has now “crosswalked” surgical oncology to general surgery for the purpose of estimating the specialty’s malpractice risk factor, rather than to a lower “all physician” average as it did originally.

HCFA estimates that the malpractice RVU changes will have little impact on specialty level payments. Across the 62 specialties shown by HCFA in the regulation, the overall impact is projected to be 0.0 percent.

**Q.** **How will all these changes in data and methodology, combined with the conversion factor increase, actually affect Medicare payments for important surgical services?**

**A.** Table 3 on page 12 shows national average payment amounts in 2001 for selected high-volume surgical services provided by a number of specialties.

**Q.** **For 2000, HCFA reduced work RVUs for certain critical care codes because**

**Table 3****Medicare payments for selected high volume surgical services 2000-2001:  
National averages**

CPT	Procedure	2000 payment	2001 payment	% change
19240	Removal of breast	\$ 995	\$1,030	3.5%
27130	Total hip replacement	1,542	1,574	2.1
27244	Repair of thigh fracture	1,187	1,172	-1.3
27447	Total knee replacement	1,631	1,655	1.5
33512	CABG, three-vein	2,273	2,217	-2.5
35301	Rechanneling of artery	1,236	1,228	-0.1
44140	Partial removal of colon	1,124	1,143	1.7
49505	Repair inguinal hernia	418	427	2.2
52601	Prostatectomy (TURP)	850	844	-0.1
63047	Removal of spinal lamina	1,136	1,143	0.1
66821	After cataract laser surgery	182	212	16.5
66984	Remove cataract, insert lens	748	745	-0.0

**of changes that were made in their CPT definitions. The College and others argued against that change. Did HCFA reconsider its decision?**

**A.** Yes. The CPT language describing critical care was again revised, so HCFA reversed its decision and reinstated the work RVUs for these two codes. Beginning in 2001, physician work RVUs will again be 4.0 for CPT 99291, and 2.0 for CPT 99292. (For 2000, the work values for these codes were 3.6 and 1.8, respectively.)

**Q.** **In a proposed rule issued last July, HCFA announced its plans to create new HCFA Common Procedure System (HCPCS) codes to describe care plan oversight and physician certification or recertification of home health services, because of its concern that anticipated CPT coding changes would be inconsistent with Medi-**

**care coverage criteria for these services. Did the agency go ahead with this plan?**

**A.** Yes. HCFA finalized its proposal for four new “G” codes:

- G0181—physician supervision of a patient receiving Medicare-covered services from a participating home health agency.
- G0182—physician supervision of a patient receiving Medicare-covered services from a Medicare participating hospice.
- G0180—physician services for initial certification of Medicare-covered home health services.
- G0179—physician services for recertification of Medicare-covered home health services.

Responding to comments made by the College, the final rule clarifies that surgeons who provide certification or recertification services for home health care will, in fact, be allowed to report the applicable codes even if the care is related to an operation and even if this is done during a global service period.

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**Q.** In the July proposed rule, HCFA announced plans to correct an inconsistency between the RVUs assigned to observation care codes and Medicare policies pertaining to reimbursement for hospital admissions and discharges occurring on the same day. What policies were set forth in the final rule?

**A.** Based on comments, HCFA refined its proposal as follows:

- HCFA will pay for both inpatient hospital admission services (CPT codes 99221-99223) and hospital discharge services (CPT codes 99238 and 99239) for patients in the hospital for 24 hours or more.

- To appropriately report CPT codes 99234-99236 to Medicare, the patient must be an inpatient or be under observation care for a minimum of eight hours on a single calendar date.

- No discharge service payment will be allowed for patients under observation in the hospital less than eight hours. For these patients, physicians should report CPT codes 99218-99220.

- For patients admitted for observation care and then discharged on a different calendar date, codes 99218 through 99220 should be used for the first day, with observation discharge code 99217 for the second day.

- For those admitted to inpatient hospital care and then discharged on a different calendar date, codes 99221 through 99223 should be used with discharge day management codes 99238 or 99239.

- For inpatient admission and discharge less than eight hours later on the same calendar date, codes 99221 through 99223 should be used. Hospital discharge day management service codes should not be used.

Physicians must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for

observation care or treatment status must also be documented.

HCFA anticipates little financial impact from these coding rules, except for those few physicians who actually have been billing 99234-99236 for stays less than eight hours.

**Q.** Last July, HCFA proposed to change the global period for certain CPT codes that involve the insertion, removal, and replacement of pacemakers and cardioverter defibrillators from 90 days to zero days, with a concurrent reduction in work and practice expense RVUs to reflect the lack of postoperative care associated with the service. Did the agency make this change?

**A.** As a result of comments received on the proposed rule, this change was not made. The global period for these services remains at 90 days, and no reductions were made in the RVUs. □