

What surgeons should know about . . .

The 2002 Medicare fee schedule

by Cynthia A. Brown, Director, Division of Advocacy and Health Policy

As required by law, the Centers for Medicare & Medicaid Services (CMS) published final regulations concerning the 2002 Medicare Fee Schedule on November 1, 2001. Because the new rule followed two proposals that were issued over the summer, much of its content was anticipated. Nevertheless, the regulation contains both good and bad news relevant to surgeons. For example, the regulation finalizes changes in relative value units (RVUs) assigned to the physician work component of many services listed in the fee schedule following the completion of the five-year review. These new work values were developed after a lengthy process and, for many surgical services, are considerably higher than those that were effective in 2001. On the other hand, suspicions raised more recently were confirmed when the regulation announced a significant reduction in the fee schedule conversion factor.

Following are answers to questions surgeons may have about the new regulation and its impact on Medicare payments and policies in 2002.

Q. What is the fee schedule conversion factor for 2002?

A. The conversion factor that is used to translate fee schedule RVUs into payments was reduced by 5.4 percent for 2002, to \$36.20 (down from \$38.26 last year).

Q. Because practice costs keep increasing, it is clear that this change in the conversion factor is not intended to keep Medicare payments in line with inflation. How was the new figure calculated?

A. The fee schedule conversion factor is revised annually according to a complex formula established by law. The conversion factor is affected by the annual update as well as further adjustments to reflect other changes in law or policy. For the 2002 update of -5.4 percent, the following percentages were applied:

Medicare Economic Index (MEI)	2.6%
SGR adjustment	-7.0
BBRA adjustment	-0.2
Practice expense transition adjustment	-0.18
Five-year review adjustment	-0.46

The percentages listed do not total -5.4 precisely because the update formula is multiplicative rather than additive. In other words, the 2.6 percent MEI is recorded in the formula as 1.026, and it is multiplied by an SGR adjustment of 0.930 (corresponding to the -7.0 percentage figure).

Q. The sustainable growth rate (SGR) adjustment obviously had the greatest impact on the fee schedule update. What is it, why is it there, and how is it calculated?

A. The SGR is a prospectively determined expenditure target that is intended to restrain the growth in Medicare spending for physician services. It encompasses a variety of factors, but most importantly, it ties physician payments directly to the health of the nation's economy. In prosperous times, when the gross domestic product (GDP) growth rate is high, the expenditure target also is set high. Then, if aggregate spending remains below the target, a corresponding SGR "bonus" adjustment is made to the MEI

(Medicare's inflation rate) the following year. This past year, however, a sluggish economy was accompanied by relatively high rates of spending growth for physician and other Medicare Part B health care services. Consequently, a negative SGR adjustment was applied. (Indeed, the -7.0% adjustment is the maximum reduction allowed by law.)

Of course, relying on overall economic factors to determine the appropriate amount to spend on health care for the elderly makes little sense. Unfortunately, reliance on such an artificial "affordability factor" is only one of several serious problems with the SGR.

For example, the prospective nature of the spending target requires CMS to make predictions about factors such as economic growth and Medicare fee-for-service enrollment. Yet, when actual growth numbers become available, the agency is not allowed to recalculate the SGR standard to reflect those data prior to making the comparison with actual physician spending growth—a comparison that ultimately determines the SGR adjustment factor.

This problem was illustrated in 1998 and 1999, when agency underestimates of GDP growth, compounded by overestimates of shifting Medicare enrollment from traditional fee-for-service to managed care plans, resulted in inappropriately low SGR estimates for both years. The subsequent fee schedule updates were above the MEI but would have been even higher if CMS could have gone back and used real data before comparing actual spending growth to the target. Furthermore, the SGR system is cumulative—meaning that both targets and spending growth are calculated by taking into account spending during the preceding year, the current year, and the coming year. So, excessive spending in a preceding year and a current year have an influence on updates granted in future years. Of particular interest, if the SGRs in 1998 and 1999 could have been modified to reflect actual rates of economic and fee-for-service

enrollment growth, this difference would have more than compensated for this year's imbalance and the 2002 conversion factor update would likely have been a positive number close to the MEI.

Finally, the SGR system does not account for the introduction of costly new technologies or drug therapies that can drive Medicare spending increases.

Q. Why were the other adjustments made to the conversion factor?

A. In addition to the SGR adjustment (reduction) applied to the MEI, the conversion factor update reflects the following:

- A -0.2 percent adjustment that, according to the 1999 Balanced Budget Refinement Act (BBRA), must be applied every year from 2001 through 2004 in order to finance technical changes in the SGR law that was intended to reduce the potential for wide annual fluctuations in the conversion factor.
- A -0.18 percent adjustment to account for increased volume and intensity of services that CMS actuaries expect to occur because of changes in practice expense RVUs in 2002.
- A -0.46 percent budget neutrality adjustment to ensure that changes in work RVUs resulting from the five-year review do not cause a net increase in Medicare physician spending.

Q. What is happening to the practice expense RVUs in 2002?

A. This will be the last year of the four-year transition to resource-based practice expense RVUs. From this point on, further changes made to the practice expense component should arise primarily as the result of refinement efforts conducted by the Practice Expense Advisory Committee (PEAC) of the American Medical Association/Specialty Society Relative Value Scale

Update Committee (RUC). For 2002, CMS received recommendations from the PEAC on refinements for cost data for over 1,100 physician services, most of which were accepted. These services fall principally within the scope of orthopaedic surgery, dermatology, pathology, physical medicine, and ophthalmology.

For 2003, there may be some adjustment to practice expense RVUs assigned to the postoperative period of global surgical services to reflect refinements made in 2001 to the price inputs used to calculate practice costs for evaluation and management services. Those changes, if they do occur, will be subject to public comment when a proposed rule on next year's fee schedule is issued in the summer.

Q. In the fall, predictions indicated that the five-year review would result in good news for many surgical specialties, including general surgery. Did the final rule make this prediction come true?

A. Yes. CMS did change the physician work RVUs for several hundred surgical services as a result of the five-year review. Absent the reduction made in the conversion factor, significant gains were made by general, vascular, and thoracic surgery, in particular.

For some services, the work RVU changes were large enough to offset the conversion factor reduction. For the rest, surgeons should realize some financial gain from other public and private payors who base their payments on Medicare fee schedule RVUs. The table on this page illustrates the combined impact of the five-year review and conversion factor fee schedule changes on the national average payment for a sample service, inguinal hernia repair.

Q. This past summer, there was some confusion about CMS's plans to

Medicare payment changes for CPT 49505, inguinal hernia repair

	2001	2002	Change
Work RVUs	6.49	7.60	17.1%
Practice expense RVUs (facility)	4.02	4.13	2.7
Malpractice RVUs	0.65	0.65	0
Total RVUs	11.16	12.38	10.9
Conversion factor	\$38.26	\$36.20	-5.4
National average payment	\$426.98	\$448.16	5.0

change Medicare's payment policies for critical care services. Were any such policy changes made for 2002?

A. No. Medicare's critical care payment policies remain unchanged. That is, Medicare will continue to pay separately for critical care services that are supported by the required documentation. Surgeons may bill separately for critical care services during a global service period only when those services are unrelated to the operation, or for patients who have suffered trauma or burns. CMS will review comments submitted and determine whether to propose changes in global surgical service payments or Medicare critical care payment policies for 2003.

Q. CMS also asked questions about Medicare payment policies involving the -62 modifier that is used to report co-surgery. Were any decisions on this subject announced in the final rule?

A. No. Most groups and individuals commenting on the co-surgery issues raised by CMS stated that current payment policy is reasonable and that the agency should focus on education efforts to ensure appropriate use of the modifier. CMS intends to review the comments carefully and propose any changes as part of a future rulemaking process.

Q. Were any new payment policies implemented for 2002 that affect screening mammography?

A. Medicare has paid for screening mammography since 1991. However, the law governing these services required use of a payment methodology other than the physician fee schedule. Under that law, mammography screening payment equaled the *lesser* of: (1) the actual charge for the service; (2) the physician fee schedule amount for a bilateral diagnostic mammogram; or (3) \$55.00 (a 1991 figure updated annually by the MEI). That law was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and, starting in 2002, Medicare will pay for these services under the physician fee schedule at a rate of about \$88.50 (before the application of any geographic adjustments).

In addition, CMS created a temporary “G-code” (G0236) and RVUs to reflect recent FDA approval of computer-aided detection used in conjunction with diagnostic mammography.

Q. What other changes did BIPA make to Medicare screening service payment policies?

A. BIPA provided for the following screening services of interest to surgeons, each of which was addressed in the final rule:

- Low-risk women who do not qualify for annual coverage of a screening pelvic examination

that includes a clinical breast examination are now covered for services received every two (as opposed to three) years.

- Glaucoma screening services are now covered for individuals with diabetes or family history of glaucoma and for others determined to be at “high risk” for the disease.

- BIPA amended the law governing *screening colonoscopy* to extend coverage of the procedures once every 10 years for individuals not at high risk for colorectal cancer. The final rule amends regulations to conform to policies that already have been implemented through carrier manual provisions.

Q. Many important issues were raised this year that involve Medicare payment for surgical services. What role did the College play in these developments?

A. For the past five years, the College’s General Surgery Coding and Reimbursement Committee has worked diligently on an exhaustive review of the RVUs assigned to general surgery services. Using a new methodology, these efforts resulted in the development of new work values that were ultimately accepted by CMS at the conclusion of the five-year review. The vast majority of these services received RVU increases.

The College also led coalition efforts to develop consensus among the specialty societies and provide coordinated input to CMS on the critical care and co-surgery issues.

Finally, College staff and Fellows who responded to legislative alerts have been actively engaged in an effort to persuade Congress to intervene and legislate an increase in the 2002 conversion factor. A bill to accomplish this, S. 1707, was introduced in November by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA), key members of the Senate Finance Committee. H.R.

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Completed application forms for the International Guest Scholarships for the year 2003 and all of the supporting documentation must be received at the office of the International Liaison Division prior to July 1, 2002, in order for an applicant to receive consideration by the selection

committee. All applicants will be notified of the selection committee's decision in November 2002. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

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3351 was introduced in the House as a companion bill by Reps. Michael Bilirakis (R-FL) and Sherrod Brown (D-OH). At press time, the future of this legislation was uncertain. But, in any event, it is clear that the College and all

medical and surgical specialty societies must devote considerable resources this year in a cooperative endeavor to implement substantial changes to a number of fatal flaws in the Medicare payment system. □

ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.