

What surgeons should know about...

The 2007 Medicare physician fee schedule

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The 2007 Medicare physician fee schedule brings with it massive changes that will have a significant effect on all aspects of surgical reimbursement. Unfortunately, its impact is negative in almost all instances. The fee schedule, which was released in November 2006 and went into effect on January 1, includes major adjustments to almost every component of the Medicare physician reimbursement formula.

To review, the Medicare physician reimbursement formula comprises five key elements. First, each code on the Medicare fee schedule is assigned a work relative value unit (RVU) based on the time and intensity of the physician's work in providing the service. Each code is also assigned a practice expense RVU, which accounts for the direct expenses (such as equipment and supplies) associated with providing the service and a portion of the indirect expenses (such as rent). Each code is also assigned a professional liability insurance (PLI) RVU. Geographic practice cost index (GPCI) adjustments are made to the work, practice expense, and PLI RVUs to account for the geographic differences in providing services. After the GPCI adjustments are made, the work and practice expense and PLI RVUs are added together to create the total RVUs for a specific code. Finally, the sum is multiplied by the Medicare conversion factor to determine final payment. If any portion of the formula is reduced, total payment for the code is reduced. All of this information is listed on the Medicare physician fee schedule.

What will be the Medicare physician update for 2007?

The 2007 update to the Medicare physician fee schedule conversion factor will be a freeze for the second year in a row and the conversion factor will remain at \$37.8975. Initially, a 5 percent cut was predicted, but Congress took action on the last day

of the lame duck session in December to avert the cut. In January 2006, a similar cut initially went into effect, but it was repealed in February when Congress passed the Deficit Reduction Act of 2006 (DRA), which froze the Medicare conversion factor at the 2005 level.

Between July 1 and December 31, 2007, physicians who report on at least three quality measures through the Physician Voluntary Reporting Program (PVRP) will receive a 1.5 percent increase in their payments. This one-time bonus payment will apply to all Medicare claims submitted by the physician. Fellows should watch for more information in the future on the PVRP and the potential bonus payments.

The 2007 conversion factor freeze marks the fifth year in a row that Congress has had to take action to prevent a cut to the conversion factor. The conversion factor was reduced by 5.2 percent in 2002, but Congress took action in 2003, 2004, 2005, and 2006 to avert additional cuts.

Why does Congress have to take action every year to prevent a cut to the Medicare conversion factor?

The conversion factor is calculated based on the sustainable growth rate (SGR), which sets an annual expenditure target for Medicare physician services. Since 2002, aggregate spending on physician services has exceeded the targets; by law, these overages must be repaid through cuts to the conversion factor. These overages have been fueled by an increase in the volume and intensity of services provided to Medicare beneficiaries. In particular, there has been yearly double-digit growth in evaluation and management (E/M) services, imaging, and laboratory tests. Surgery and major procedures have the lowest growth rates, and general surgery has the lowest overall growth rate of any specialty, coming in at an average of 0.6 percent per year.

Although a 5 percent cut to the conversion factor in 2007—had Congress not taken action—would have hit surgeons hard, under the SGR, it could be worse. There is a cap on how much the conversion factor may be cut in a single year, and if not for the cap, the conversion factor would be reduced 28 percent in 2007 to make up for the increase in expenditures since 2002.

Unfortunately, because the cuts are being spread out over multiple years, the conversion factor is currently slated to be decreased approximately 5 percent every year until 2015. Under current law, it is estimated that by 2015, the conversion factor will have been whittled down to \$23.87.

What is the five-year review of work?

Every five years CMS must comprehensively review all work relative values and make any needed adjustments. To carry out this exercise, physician organizations, including the College, and the Centers for Medicare & Medicaid Services (CMS) may request that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) review the value of a specific code. If compelling evidence is presented to prove that the level of work or intensity of the code has changed, the value of the code will be raised or lowered accordingly. The changes must be budget neutral, meaning they cannot cost the Medicare program more money. Hence, if some values increase, others in the system decrease proportionately. On January 1, the changes for the third five-year review were implemented.

How will the five-year review affect payment rates?

The results of the five-year review will shift more than \$4 billion in the Medicare fee schedule to E/M codes. A coalition of medical specialties, led by the American College of Physicians, brought forward many E/M codes for reevaluation. The RUC recommended that CMS drastically increase the value of several E/M codes, including 99213 (intermediate office visit), the most used code in the fee schedule. The amount of money needed to cover these increases is more than Medicare physician spending on general,

cardiac, colorectal, and vascular surgery and neurosurgery combined. To pay for the increases to the E/M codes, all of the work RVUs on the fee schedule will be reduced by approximately 10 percent.

How is the five-year review budget neutrality adjustment being implemented?

CMS is implementing a new component of the fee schedule called the “work adjuster.” Under this plan, the actual work RVUs for each code will be published at their full value. Before reimbursement is made, however, the total work RVUs will be multiplied by 0.893. For example, if a code has a value of eight work RVUs, this figure will be multiplied by 0.893 for a value of 7.14, and the reduced value will be used to determine total RVUs and, therefore, payment. This calculation has a particularly negative effect on codes that are work-heavy, including most surgical codes.

Are all surgical codes being cut 10 percent as a result of the five-year review?

Not all surgical codes are being cut 10 percent. The E/M increases are also being applied to the E/M codes that are built into the global surgical payments. How much a code will increase depends on the number and type of E/M services in the global payment. On the Medicare physician fee schedule, the actual work RVUs for many surgical codes will show an increase that is related to the increased value of the E/M codes. However, these increases will be too small to cover the 0.893 work adjuster discussed previously. In total, most surgical codes will be cut 3 percent to 7 percent, depending on how many E/M visits are built into the codes.

Are the values of any surgical codes increasing as a result of the five-year review?

Yes, some surgical code values are increasing. During the five-year review, many surgical codes also were reviewed, and the American College of Surgeons, which represents general surgery on the RUC, requested that more than 30 codes be revalued during the five-year review. All of

the codes—including 19180 (removal of breast), 44120 (removal of small intestine), 44130 (colectomy) and the remainder of the colectomy family of codes, and 38100 (splenectomy)—received increases in their work RVUs between 5 percent and 30 percent. Many of the surgical specialty groups, including cardiothoracic, vascular, and orthopaedic surgery and neurosurgery, also submitted codes for reevaluation and generally fared well. Unfortunately, some of the increases will have a negligible effect after the work adjustment is applied and the conversion factor is cut. For example, CMS approved a 20 percent increase to the RVUs for a kidney transplant, but after the work adjuster is applied, the code will only be increased by 10 percent.

What changes are being made to the practice expense component, and how will they affect payment?

The 2007 fee schedule also includes significant changes to the practice expense component. Nine specialties, including dermatology and gastroenterology, will receive significant increases in their practice expenses. Of course, these changes will be budget neutral and will be funded through cuts to other specialties. Beginning January 1, the final methodology will be phased in over four years. General surgery will see a slight increase—1 percent—at the end of the phase-in, whereas neurosurgery, ophthalmology, and orthopaedic and cardiothoracic surgery will undergo cuts of 2 percent to 4 percent. Surgeons may be interested to know that budget-neutrality adjustments are already applied to both the direct practice expenses and indirect expenses for each code. These adjustments translate to Medicare paying for 61 percent of direct expenses and 35 percent of indirect expenses. These changes are not new in 2007, but they help explain why it often seems as though the Medicare reimbursement level is too low to even cover expenses.

What changes are being made to the GPCIs?

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 put a three-year limit on GPCI adjustments made to

the work RVUs. Essentially, under the provision, work RVUs cannot be decreased because of the GPCI adjustment. If a physician payment area has a work GPCI of less than 1.0, which would decrease the work RVUs under the payment formula, the GPCI adjustment is frozen at 1.0 and no adjustment is made. Nationwide, 58 of the 89 physician payment areas received a 1 percent to 2 percent benefit from this provision, which was slated to end December 31, 2006. The legislation passed by Congress in December to avert the 5 percent cut to the conversion factor also extended this provision for one more year until December 31, 2007.

Are there additional cuts to imaging services?

Yes, there are additional cuts. As a result of the DRA, on January 1, diagnostic imaging procedures reimbursed under the Medicare fee schedule—including imaging that takes place in a physician office or independent diagnostic testing facility—will be reimbursed at the lesser rate between the fee schedule and the Hospital Outpatient Prospective Payment System. For many magnetic resonance imaging procedures performed in physician offices, this will translate to a 30 percent to 49 percent cut in the technical component portion of the payment. Cuts for other types of imaging modalities, including ultrasound and X ray, vary by procedure. All surgeons who own in-office imaging equipment will see a significant drop in reimbursement for the technical component. In addition, some specialties that perform advanced imaging services, including vascular surgery, will also experience further payment cuts.

On a positive note, CMS decided to hold the multi-imaging procedure discount, which was implemented last year, at 25 percent instead of raising it to 50 percent as originally proposed. [\[Q\]](#)