

# What surgeons should know about...

---

## Responding to reductions in Medicare payment—What’s legal, what’s not

by Barbara Peck, JD, Senior Regulatory Associate, Division of Advocacy and Health Policy

As surgeons begin receiving their first Medicare reimbursement checks for 2007, many are starting to learn first-hand the impact of a variety of policy changes implemented January 1. Since the inception of the Medicare fee schedule, surgeons have often found themselves on the losing end of policy changes and 2007 should be no exception. The results of the third five-year review of work shifted more than \$4 billion to evaluation and management codes and reduced all work relative value units (RVUs) by 10 percent in the process, the Deficit Reduction Act of 2006 drastically reduced reimbursement for many codes that have a technical component, and the Medicare conversion factor remained frozen for the second year in a row while expenses and professional liability costs continued to creep higher and higher. In March, the Medicare Payment Advisory Commission (MedPAC) will release a report on possible alternatives to the sustainable growth rate (SGR) formula that will likely call for strict monitoring of physician costs; expansion of pay for performance; coordination of care between primary care physicians, specialists, and hospitals; geographic spending targets; and greater bundling of payments, including bundling hospital and surgeon payments. Lastly, on July 1, Medicare will begin implementing a voluntary pay-for-reporting program that has not been popular with many surgeons. As frustration and anger in the surgical community continue to rise, physicians frequently ask themselves—and the College—what actions can be taken in response to these pressures.

---

### Can physicians go on strike to protest Medicare physician payment rates?

A strike to protest Medicare payment rates is not an option. The Sherman Antitrust Act prohibits concerted activities that restrain trade;

the organization of a strike is undoubtedly a “concerted activity” and demanding higher reimbursement, or price fixing, is a per se violation. In the mid-1970s, the Supreme Court rejected the argument that professionals such as physicians were not subject to antitrust laws because they did not engage in what is typically thought of as trade. Since that landmark decision, numerous cases have been brought against physicians for violating antitrust laws.

---

### If physicians unionized, could they strike?

Generally speaking, physicians could not unionize and then go on strike. There is an organized labor exception to the antitrust laws and this exception allows unionized employees to strike against their employers. If a group of unionized physicians wanted to strike against their employer, such as a hospital or health maintenance organization, this exception could apply. However, when dealing with third-party payors, including Medicare, courts have ruled repeatedly that physicians are independent contractors, not employees, and that negotiations concerning reimbursement terms are not the equivalent of labor negotiations over terms of employment.

---

### What happens if physicians strike anyway?

The Federal Trade Commission (FTC) would likely seek injunctive relief (that is, a court order) directing physicians to immediately cease and desist. A court would grant the injunctive relief and anyone who did not follow it would be in contempt of court and could go to jail. In addition, the court would also issue substantial fines. In 1996, physicians in Puerto Rico, which is governed by U.S. antitrust laws, organized a strike of the Puerto Rican version of Medicaid

---

in an effort to demand higher prices. The strike lasted eight days and was focused exclusively on nonemergency care. The FTC was not only granted injunctive relief to stop the strike, but the College of Physicians–Surgeons of Puerto Rico and the island’s three largest physician practices were fined \$300,000.

---

### **Didn’t some physicians go on strike because of medical malpractice?**

In the past several years, physicians have taken strike-like actions in Nevada, New Jersey, and West Virginia over the professional liability crisis. There are several distinguishing factors, however. First, these actions did not involve reimbursement levels and, although they still may have restrained trade, it is not a clear-cut per se violation. Second, there is an exception to antitrust law called the Noerr-Pennington doctrine, which states actors do not violate antitrust laws when they act solely to elicit legislative, judicial, or administrative agency action. In the professional liability events, the aim was legislative action—passage of a tort reform bill—and not an increase in payment rates. Finally, several scholars did view these types of activities as a violation of antitrust law and the FTC and states’ attorney generals involved chose to look the other way. Please note, however, that just because no one prosecuted physicians taking strike-like actions to protest the professional liability crisis, this does not mean what they were doing was legal. A strike against the Medicare program would not likely receive the same response from the FTC.

---

### **Can physicians collectively boycott Medicare?**

Physicians cannot boycott Medicare. Under antitrust law, a boycott is considered a “restraint of trade.” State and federal governments have prosecuted a number of provider boycotts of Medicare, Medicaid, and other government payment programs. These cases involved concerted activity by physicians, pharmacists, nursing homes, dentists, and optometrists, aimed at exerting collective pressure to achieve higher reimbursement. For example, in an action against the

Michigan State Medical Society, the FTC prosecuted physicians over their agreement to coerce payors into increasing fee-for-service payment levels through threats of nonparticipation.

---

### **Why can’t a physician strike or boycott of Medicare fall under the Noerr-Pennington doctrine?**

Several provider groups have attempted to use this doctrine to argue their boycott-related actions should be labeled as lobbying, because the ultimate goal was the passage of legislation. But this argument has been rejected by the courts. The Noerr-Pennington doctrine does not protect defendants from liability for concerted price fixing or boycott activities aimed at governmental payors. This doctrine shields collective action by provider associations to secure anticompetitive legislation, such as a price increase, or other governmental actions favorable to their members, but it does not afford protection in boycott cases involving coercive refusals to deal with Medicare, Medicaid, or other government entities. The Supreme Court has made this point clear, holding that the doctrine has no applicability where conduct crosses the line from advocating for government action and becomes a collective boycott designed to evoke change in governmental policy.

---

### **Can the American College of Surgeons or another group tell its physicians not to participate in Medicare or other payment system?**

Neither the College nor any other organization can take any action that would have the effect of restraining trade. Under antitrust law, there is a concept called “signaling” that prohibits organizations from taking an action or not taking an action that signals its members to individually engage in anticompetitive behavior.

---

### **What recourse do physicians have?**

There are three general options available to physicians fed up with the system: (1) Become politically involved through lobbying and political donations; (2) participate in the regulatory

---

framework for payment by responding to information and survey requests, working with local Medicare carriers, and participating in committees; and (3) evaluate the individual practice business plan and make payor and case mix changes that will enhance revenue.

As explained previously, the Noerr-Pennington doctrine creates an antitrust exception for lobbying activities. Each year for the past five years, Congress has had to take action to prevent a cut to the Medicare conversion factor. And, each year, the College and other organizations have asked members to call, write, or e-mail their elected officials and tell them how the payment cuts are affecting practices and ask them to support specific legislation. And, each year, the response falls far short of its potential for a membership as large and well informed as the College's. In the coming year, Congress will once again be faced with tough decisions on how to respond to the impending Medicare physician payment cuts and they must hear from their constituents—including members of the College—on this issue. Physicians can also ask their patients to get involved by signing petitions, sending letters, and calling their elected officials.

Congress is not the only player in the physician payment arena, however. The College is constantly working with the Centers for Medicare & Medicaid Services (CMS) to ensure services are adequately covered and valued. Much of this work involves requesting data from members. For example, over the next year, a new multi-specialty practice expense survey will be sent for data collection from members that will be used to adjust the practice expense RVUs. However, the response rate for these types of activities is typically low and jeopardizes the College's ability to provide credible evidence to CMS on the value of services.

---

### **If I am a Medicare-participating physician, do I have to treat Medicare beneficiaries?**

Being a “participating physician” under the Medicare program does not mean that you have to treat Medicare patients when they are

referred to you or call for an appointment. The “participating provider” status means that if a physician chooses to see a Medicare patient, he or she agrees to accept the Medicare fee schedule rate as the full reimbursement and will not bill beneficiaries for any additional charges beyond allowable copayments (this process is referred to as “accepting assignment”). Practices are free to close their practices to new Medicare patients or to limit the number of Medicare appointments. However, if a practice is going to stop scheduling appointments for those patients with whom it already has a preexisting physician-patient relationship, it must follow proper bioethical procedures related to notice, request for charts, and so on.

---

### **What is Medicare nonparticipation status?**

If a physician elects to be a nonparticipating provider, he or she chooses on a claim-by-claim basis whether to accept Medicare assignment. If a nonparticipating provider decides to accept assignment for a particular service, he or she will submit the claim to Medicare and will receive 95 percent of the Medicare fee schedule amount for the service. If the decision is made not to accept assignment, the physician will be permitted to bill the beneficiary up to the limiting charge, which is 115 percent of the 95 percent of the fee schedule amount. Under this arrangement, Medicare will send the beneficiary reimbursement for its portion (80% of the 95% of the fee schedule amount) and the beneficiary will be responsible for the remaining amount.

For example, if the Medicare fee schedule amount for a service is \$100, Medicare charges are based on 95 percent of that figure (\$95). The limiting charge—the total amount the physician may bill the beneficiary—is \$109.25 (115% of \$95). Medicare pays 80 percent of the \$95 and the beneficiary pays 20 percent as a copay. In this example, Medicare would pay \$76, the beneficiary would pay \$33.25 (\$19 of which is the copay and \$14.25 of which is related to the limiting charge), and the physician would receive \$109.25 for this service. It is important to note that the physician would have to collect the full \$109.25 from the beneficiary because Medicare

---

would reimburse the beneficiary, not the physician, for its \$76 share. If the physician chose to accept assignment on this particular case, he or she would receive the \$76 directly from Medicare and \$19 from the beneficiary.

### **How does the Medicare opt-out option work?**

A third participation option for physicians is to opt out of Medicare altogether. Contrary to popular myth, opting out is not the same as being excluded from the program. Under the opt-out plan, the physician and Medicare beneficiary agree to a private contract amount for the physician's services. There is no limit on the amount the physician can charge the beneficiary, and the beneficiary is financially responsible for the full amount. It is important to note that the physician and beneficiary are only contracting for the cost of the physician's services, and Medicare will continue to pay for any inpatient charges, laboratory or imaging work, and services billed by other physicians such as anesthesiologists. In addition, physicians may not privately contract with beneficiaries in need of emergency medical services. For example, if a physician who has opted out is on-call and a Medicare beneficiary comes to the emergency room in need of an emergency appendectomy, the physician cannot privately contract with the beneficiary for a fee amount. In this instance, the physician would instead bill Medicare as a nonparticipating provider and would receive 95 percent of the Medicare fee schedule amount for his or her services. It is also possible for a practice to employ some physicians who have opted out and others who are still participating providers. Finally, if a physician chooses to opt out, he or she must do so for a period of two years. After the two-year period, the physician can elect to rejoin the Medicare program as a participating or nonparticipating physician.

### **When can I change my participation status?**

Physicians can change their participation status during open enrollment, which typically runs from mid-November to the end of Decem-

ber. Although this date may seem like a long way off, it is strongly suggested that physicians seek both legal and financial advice well in advance of changing their participation status in order to ensure they are making the best decision for their practice.

### **What else can I do to respond to changes in Medicare reimbursement levels?**

Many practices are taking two approaches to respond to Medicare reimbursement changes: (1) Maximizing physician time for providing services, and (2) generating other sources of revenue. In order to maximize physician time, practices need to evaluate how physicians are currently spending their time and where changes can be made by either increasing use of physician extenders or nonsurgeon physicians or dropping some services altogether and marketing other services. For example, some practices have found it beneficial to increase the number of physician assistants or to add additional partners who are not surgeons, including radiologists, neurologists, cardiologists, and gastroenterologists. Multispecialty practices tend to better cope with marketplace changes. In addition, other practices have stopped performing certain poorly reimbursed services in order to concentrate on other services.

At the same time, many surgeons have explored other sources of revenue completely, including on-call stipends, medical directorships, consulting arrangements, medical chart review, and boutique services. As always, physicians should carefully evaluate such arrangements to ensure they are not running askew of the anti-kickback or Stark laws. The College offers practice management teleconferences twice monthly that may be beneficial to maximizing practice efficiency and output. Information on these teleconferences can be found at: <http://www.facs.org/ahp/workshops/teleconferences.html>. Q