

# What surgeons should know about...

---

## Trends in Medicare reimbursement

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

**A**s most Fellows know from first-hand experience, recent changes and trends in Medicare physician payment policies have been unkind to surgeons. Although many of the problems currently plaguing the Medicare program affect all physicians, surgeons have borne the brunt of many policy changes. In addition, whereas many other specialties have responded to declining reimbursement by increasing the volume or the intensity of the services they provide, surgeons have very limited capacity to make these adjustments. After all, a patient's gallbladder can be removed only once.

Because surgeons must understand current trends in Medicare reimbursement in order to better organize their practice business plans and personal finances, this article explains the current Medicare reimbursement situation and how it is designed. It also looks ahead at potential modifications and how future deleterious effects may be avoided.

First, though, a quick review of the Medicare fee schedule's design is in order. The Medicare physician reimbursement formula is composed of five key components. First, each code in the Medicare fee schedule is assigned a work relative value unit (RVU), which estimates the time and intensity involved in performing the service. Each code is also assigned a practice expense RVU to account for direct expenses, such as equipment and supplies, and a portion of indirect expenses, such as rent. Each code is also assigned a professional liability insurance RVU. A geographic practice cost index (GPCI) adjustment is made to the work, practice expense, and liability RVUs to account for the geographic differences in providing services. After the GPCI adjustments are made, the work, practice expense, and liability RVUs are added together to arrive at the total RVUs for a specific code. Finally, this 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.

---

**It seems that every year there is talk about Medicare physician payment cuts. Why is this the pattern?**

Each year, the Centers for Medicare & Medicaid Services (CMS) updates the rates it pays Medicare providers. For most providers, this yearly update is like a cost-of-living raise and helps to offset the increased cost of providing services to beneficiaries. In order to adjust the Medicare physician fee schedule, CMS updates the conversion factor. This update is determined in part by the sustainable growth rate (SGR) formula. Since 2002, the SGR has yielded a negative update to the conversion factor, which means the conversion factor will be decreased instead of increased. In 2002, the conversion factor was cut by 5.2 percent. Congress took action in 2003, 2004, and 2005 to avert additional cuts to the conversion factor. A cut initially went into effect this year but was repealed in February when Congress passed the Deficit Reduction Act of 2006 (DRA). The DRA froze the Medicare conversion factor at the 2005 level.

---

**What will be the 2007 update to the fee schedule?**

In August, CMS announced the 2007 update for physicians will be cut by 5.1 percent. This reduction affects every code in the Medicare physician fee schedule.

---

**Why is the update to the Medicare conversion factor negative?**

Two factors are the primary causes of the conversion factor cuts: increased volume and unfunded pay fixes. Under the SGR formula, an expenditure target is set for physician spending. If spending for a single year exceeds the expenditure target, physician spending is cut the following year, so the government may recoup

the excess costs. For example, if the expenditure target for year one is \$60 billion and actual spending \$70 billion, the conversion factor will be cut the next year to make up the \$10 billion difference. The goal is to cut the conversion factor enough to bring year two expenditures in at \$50 billion, so spending for both years is at the \$120 billion cumulative target. Since 2002, spending on physician services has exceeded the expenditure targets. These overages have been fueled by an increase in the volume and intensity of services provided to Medicare beneficiaries.

In addition, the laws that Congress has passed in recent years to prevent the SGR cuts were unfunded. Congress increased spending by raising or freezing reimbursement per procedure but did not raise the expenditure target or put more money into the system. In essence, Congress continued to charge on a maxed-out credit card without increasing the monthly payment and, not surprisingly, the debt has risen. Currently, the SGR debt is approximately \$47 billion. Approximately \$23 billion of that balance results from increases in utilization, while the remainder is attributed to the unfunded pay fixes. In comparison, total SGR spending for 2006 is \$82 billion. There is a cap on how much the conversion factor can be cut in a single year, which means physicians will be “paying back” the overages until 2015 through a series of yearly cuts to the conversion factor. If not for the cap, the conversion factor would be cut 28 percent in 2007.

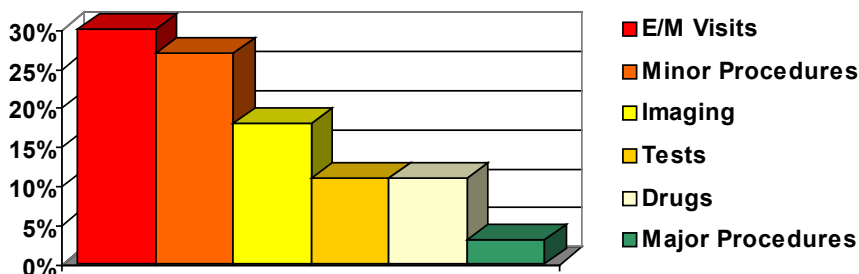
### How much has the volume of services grown?

The SGR formula allows physician spending to grow at the rate of real per capita gross domestic product, or approximately 2 percent per year. However, since 2000, physician spending has risen considerably higher than the SGR allows.

<b>Year</b>	<b>Growth rate</b>
2000	10.3%
2001	14.2
2002	7.0
2003	10.2
2004	11.4
2005	8.5

Although these numbers are certainly alarming, this is not the first time in the history of the Medicare program that physician services have seen significant growth rates. During the early 1980s, spending on Medicare physician services grew at a rate near 9 percent, leading to rate freezes in the mid-1980s. Continued growth in the late 1980s led to the creation of the Medicare fee schedule and the resource-based relative value scale (RBRVS) used today. In addition, Medicare physician spending has outpaced growth in hospital spending since the program’s inception. From 1967 to 2000, Part B spending grew an average of 4.5 percent a year whereas Part A spending grew an average of

Components of physician spending growth increase, 2003-2004



2.7 percent a year. Traditionally, spending hikes for physician services have been double that of hospital spending growth.

### What services have the largest volume increases?

While most surgical services have a volume growth of approximately 2 percent or less, many other physician services do not. In particular, imaging, office visits, physician-administered drugs, and minor in-office procedures have experienced growth rates of 7 percent to 25 percent a year. Unfortunately for surgeons, currently all growth is treated the same and all physicians are cut equally under the SGR. (See figure, page 9.)

### Why is volume increasing?

Volume is increasing for myriad reasons. First, Medicare beneficiaries are on average older and sicker than ever before and, therefore, require more services. Second, many services have moved from the inpatient setting to the outpatient setting, and no funding has been redistributed from Medicare Part A to Medicare Part B to account for these changes. Third, advances in technology and drugs have led to greater medical and surgical

interventions. Finally, many policymakers believe a significant portion of the growth is caused by unnecessary or duplicative services.

### Are there other reasons besides reductions to the conversion factor that surgical reimbursements been reduced?

Another key factor in Medicare payment policy is “budget neutrality.” Under this concept, increases in payment for some services cannot lead to an overall increase in Medicare spending. For example, if the work RVUs for a certain family of codes increases because of a change in the work or intensity involved in providing the service, other codes must decrease to offset these hikes. This practice can have particularly devastating effects if codes with high utilization are increased. For example, even minor increases to high-volume primary care codes can lead to significant decreases in other specialties, such as surgery.

Since the inception of the RBRVS system in 1992, a conscious effort to boost the reimbursement for primary care services has been made. This push has led to the increase of work RVUs for primary care services, which are paid for by decreases to other services. In addition, many

Reimbursement trends for common surgical procedures

Service	1989 average	2006 average	2007 estimated	% change
Cataract removal	\$1,573	\$684	\$ 608	-61
Total knee replacement	2,301	1,511	1,314	-43
TURP*-prostatectomy	1,139	695	738	-35
Colectomy	1,256	1,226	1,134	-10
Laminectomy	2,078	1,051	962	-54
CABG†	3,957	2,049	2,051	-48
Mastectomy	1,051	997	958	-9
Repair retinal detachment	2,833	1,375	1,274	-55
Craniotomy for hematoma	2,018	1,749	1,677	-17
Cesarean delivery	1,038	1,884	1,814	75
Office visit	31	53	60	94

\*Transurethral resection of the prostate

† Coronary artery bypass graft

---

medical specialties such as dermatology and cardiology have successfully lobbied for changes to the methodology and data used to determine the practice expense RVU. These increases, too, have to be funded by cuts to other services. In general, any time a policy is implemented to benefit a certain specialty or code, other services must suffer.

---

**How has reimbursement changed for common surgical procedures?**

Reimbursement is determined code by code. Although some codes have undergone an increase in payment in recent years, in general, reimbursement for many surgical codes has declined in the past 15 years. (See table, page 10.)

---

**If one of the components of physician payment is practice expense, why does it seem as though Medicare is not even covering costs for providing some services?**

Again, the culprit is budget neutrality. The practice expense RVUs comprise two components: direct expenses and indirect expenses. Direct expenses are costs that can be directly attributed to providing a specific service—equipment, supplies, and clinical staff time. To determine these expenses, the Practice Expense Review Committee, a subcommittee of the American Medical Association/Specialty Society Relative Value System Update Committee (RUC) counts each and every pair of gloves, suture kit, and cotton swab commonly used in performing a specific service. For many surgical services, specific packages of supplies have been designed and are often assigned to common services like postoperative office visits.

Indirect expenses are costs that cannot be allocated to a specific service. These include rent, administrative staff, and other administrative costs. To determine indirect practice expenses, CMS assigns each specialty a rate, which is used to determine the indirect practice expense inputs for codes commonly used by that specialty. Using these methodologies, Medicare should, in theory, be paying for the costs incurred for providing services to beneficiaries. However, at the

end of the process for formulating the direct and indirect practice expenses for a code, a budget neutrality adjustment is made. This adjustment reduces the direct practice expense inputs to 65 percent of their value and the indirect practice expense inputs to 35 percent of their value.

---

**It sounds like the Medicare physician payment system is broken. What is the government doing to fix it?**

Congress and CMS are moving ahead with plans to implement physician pay-for-performance, or value-based purchasing, in the Medicare program. Policymakers believe that increased transparency in health care pricing will increase quality and lower costs overall. Reducing overall costs will, in turn, allow the Medicare program to maintain a higher payment rate per procedure. In addition, policymakers believe these types of programs will help in the proliferation of health savings accounts and other health insurance alternatives that require more active financial participation from patients. The belief is that these types of programs will also reduce health care costs.

---

**Has CMS stepped up fraud and abuse investigations as a result of the increase in volume?**

Yes. The Office of the Inspector General has conducted several high-profile fraud and abuse investigations, including a recent settlement with Medtronic for alleged kickbacks involving spine surgeons. In addition, CMS has instituted a new program called the Medically Unlikely Edits, which automatically rejects claims that are not anatomically probable.

---


**Are surgeons the only physicians experiencing declining reimbursements?**

No. Several other specialties, including anesthesiology, have also seen significant reductions in reimbursement in the past 15 years. In addition, after years of stable or increasing reimbursements, radiology has found itself in the crosshairs of several cost-cutting policies. First, as a result of the Deficit Reduction Act,

---

on January 1, 2007, diagnostic imaging procedures reimbursed under the Medicare fee schedule, which include imaging that takes place in a physician office or independent diagnostic testing facility, will be reimbursed at the lesser of the fee schedule rate and the Hospital Outpatient Prospective Payment System rate. For many magnetic resonance imaging procedures performed in physician offices, this formula will translate into 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. In addition, a separate policy will reduce the payment rate for multiple imaging procedures performed on the same day. Both policy changes are predicted to save billions of dollars. Unfortunately, Congress opted to put the money back into the general treasury instead of keeping the savings in the Medicare system, rendering it unavailable to offset spending increases in other areas.

that they take steps to prevent the payment reductions.

For more information about the College's ongoing efforts in this area, visit [www.facs.org](http://www.facs.org). 

---

### **Are surgeon incomes declining?**

According to a recent Center for Health System Change study, inflation-adjusted incomes for surgeons dropped by 8.2 percent from 1995 to 2003. Average salaries for professional workers in the U.S. rose 7 percent during that time period. Besides reduced income, the average hours per week spent on direct patient care increased by 6.2 percent for surgeons. Whereas the total hours worked for other types of physicians shrunk by 4 percent to 5 percent, total hours worked by surgeons remained constant.

---

### **What is the College doing to address these negative trends?**

As of press time, the College has continued to work with policymakers to override the SGR once again and prevent the related pay cut in 2007. The College also is seeking to prevent future reductions by asking that Congress consider developing distinct expenditure targets for various specialties to better account for the unique nature of the services they provide. In addition, the College has asked that Fellows contact their members of Congress and ask