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# Practice Management Symposium: How to Earn Money in the Post-Consult World

Presentation by  
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to the  
North American Neuro-Ophthalmology Society

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**ECG**

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# I. Introduction

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## 2010 Medicare Physician Fee Schedule (MPFS) Final Rule

- **Payment for consultation codes has been eliminated**, with the savings generated to be distributed to new and established patient visits.
- A new method for determining practice expense (PE) RVUs utilizing the *Physician Practice Information Survey* (PPIS) has been adopted.
- Malpractice RVUs have been updated according to specialty-specific malpractice premium data.
- Under the final rule, and consistent with current law, CMS included a -21.2% payment update beginning January 1, 2010.
  - » However, the U.S. Senate<sup>1</sup> is currently considering the Medicare Physician Payment Reform Act (H.R. 3961), which would replace the -21.2% update with 1.2% increase.<sup>2</sup>
  - » *Update: On March 2, President Obama signed H.R. 4961, the Temporary Extension Act of 2010, into law. This legislation delays implementing the 21.2 percent payment cut until April 1, 2010.*

<sup>1</sup> The House of Representative passed H.R. 3961 on November 19, 2009.

<sup>2</sup> The 1.2% increase is based on the Medicare Economic Index (MEI), which is a measure of inflation faced by physicians with respect to their practice costs and general wage levels.

# I. Introduction *(continued)*

## *Learning Objectives for Today's Practice Management Symposium*

- During this session, we will examine Medicare's decision to eliminate consultation codes effective January 2010 and the implications for the economics of neuro-ophthalmology practices.
- Using the new Medicare regulations, proprietary data from ECG Management Consultant, Inc.'s files, and actual data provided by a select group of neuro-ophthalmology practices, we will review the impact of Medicare's policy change.
- At the conclusion of this session, attendees will be able to:
  - » Understand the details of the policy change and the rationale and background for Medicare's decision.
  - » Model the financial impact on their Medicare business.
  - » Understand the initial response of other payors, including commercial health plans, Medicare Advantage and Medicaid FFS plans, and managed care plans.
  - » Consider alternatives to preserve income in response to the Medicare changes.

# I. Introduction *(continued)*

## *Practice Management Symposium Agenda*

- Overview of Physician Reimbursement
- The Elimination of Consultation Payments
- Implications for Neuro-Ophthalmology
- Potential Responses
  - » Payor-Related Tactics
  - » Practice Management Tactics
  - » Practice Profile Tactics
- Conclusion

## **II. Overview of Physician Reimbursement**

## II. Overview of Physician Reimbursement

### *“Physician Reimbursement” Definition*

Everything that may be billed to/reimbursed by a payor to a physician/group as a professional service on a CMS form 1500.

<b>Scope of Services</b>
Professional Services
Time-Based Anesthesia Services
Lab Codes
Office-Administered Drugs
Durable Medical Equipment (DME)/Supplies
<b>Major Settings of Care</b>
Physician Office Setting
Facility (Hospital-Based) Setting
Ambulatory Surgery Center

## II. Overview of Physician Reimbursement *(continued)*

### *Code Systems*

- The Healthcare Common Procedure Coding System (HCPCS) defines the standard codes used for billing healthcare services.
- HCPCS is divided into two principal subsystems.
  - » ***Level I of HCPCS*** comprises CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).
  - » ***Level II of HCPCS*** is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes.



## II. Overview of Physician Reimbursement *(continued)*

### *Level I of HCPCS, Also Known as CPT Codes*

- Codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals.
- These include time-based anesthesia codes that are developed by the American Society of Anesthesiologists and maintained by the AMA.
- Decisions regarding the addition, deletion, or revision of CPT codes are made by or under the authority of the AMA.
- The CPT codes are republished and updated annually by the AMA.

## II. Overview of Physician Reimbursement *(continued)*

### *Level II of HCPCS, Also Known as Alpha-Numeric Codes*

- These codes include:
  - » Other non-CPT services (e.g. – inpatient telehealth consultations).
  - » DME.
  - » Prosthetics, orthotics, and supplies.
  - » Ambulance services.
- The codes consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.
- In October 2003, the Secretary of HHS delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II codes.

## II. Overview of Physician Reimbursement *(continued)*

### *Reimbursement Methodologies*

- Payment for majority of services defined by RBRVS.
- Medicare and commercial payors apply RBRVS differently.
- It is important to understand:
  - » The service mix and settings of care of the practice.
  - » How commercial plan fee schedules/payment policies vary from Medicare.

## II. Overview of Physician Reimbursement *(continued)*

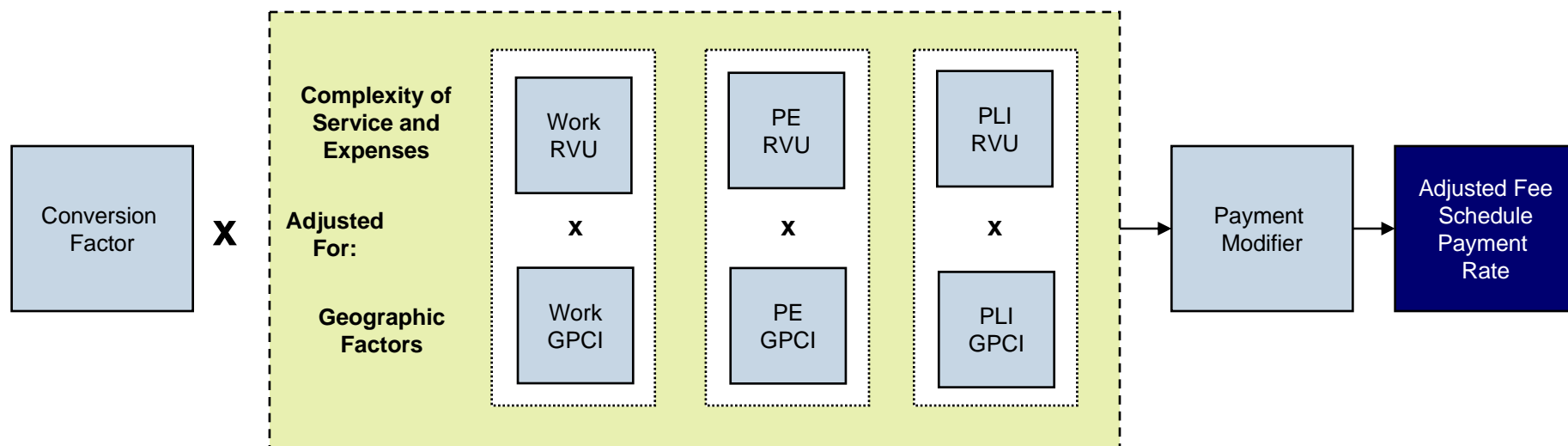
### RBRVS

- Three inputs go into the total RVU.
  - » **Work** = Face-to-face physician time, plus intensity of work.
  - » **Practice Expense (PE)** = Practice expense relative to other procedures (with no intensity of expense).
  - » **Professional Liability Insurance (PLI)** = Malpractice risk.
- Also, geographic adjustments are applied to the RVU calculation and can be material.
  - » 99213 – National payment (no GPCI) is \$65.76.
  - » 99213 – San Mateo, California, with GPCI is \$79.60 or 121% of national.
  - » 99213 – North Dakota with GPCI is \$58.21 or 89% of national.

## II. Overview of Physician Reimbursement *(continued)*

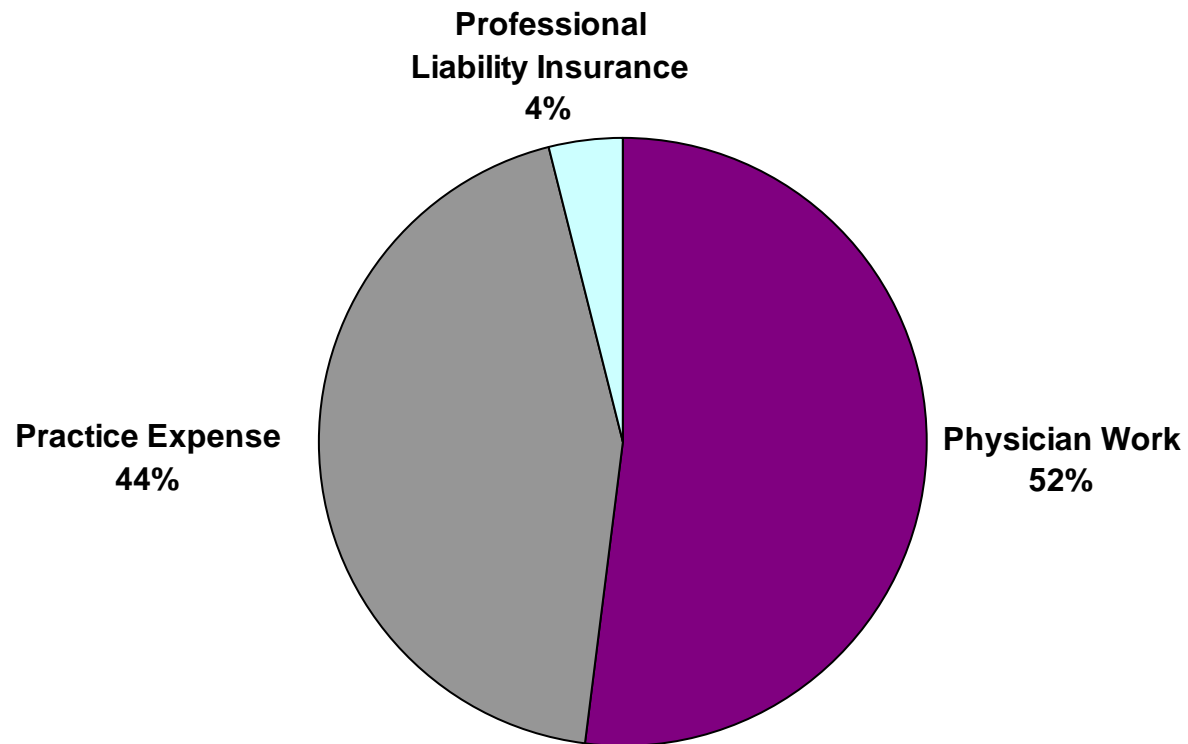
- Payment level is calculated by multiplying the total RVU by a conversion factor (\$36.0666 in 2009).
  - » Adjusted based on site of service (SOS).
  - » Apply Medicare payment rules.

### Total RVUs From MPFS



## II. Overview of Physician Reimbursement *(continued)*

*Percentage Distribution of RVU Components*



## II. Overview of Physician Reimbursement *(continued)*

### *SOS Adjustments to RBRVS*

- Separate PE RVU weights are for services provided in an office-based (“nonfacility”) or provider-based (“facility”) practice location.
- Distinction takes into account the higher expenses that the physician will incur in an office-based setting (e.g., rent, nursing staff, supplies).
- For 99213, the Medicare SOS adjustment is:
  - » 26% based on the national RVU.
  - » GPCI-adjusted SOS ranges from 23% to 31%.

# III. The Elimination of Consultation Payments



# III. The Elimination of Consultation Payments

## *Significant 2010 Medicare Payment Changes*

- Elimination of consultation code payments.
- Other important changes:
  - » Conversion factor update.
  - » Adoption of new PE RVUs methodology.
  - » Revision of PLI RVUs.

### III. The Elimination of Consultation Payments *(continued)*

#### *Medicare Payments for Consultations*

- Payments for the use of consultation codes have been eliminated:
  - » Includes outpatient consults (99241–99245).
  - » Includes inpatient consults (99251–99255).
  - » Excludes G-codes associated with telehealth consultations.
- Instead, physicians are expected to bill for consultation services under the outpatient visit and inpatient service evaluation and management (E&M) codes.
- In recognition of savings generated from the elimination of consultation payments, work RVUs (WRVUs) have been increased to raise payments for:
  - » New patient visits (99201–99205).
  - » Established patient visits (99211–99215).

### III. The Elimination of Consultation Payments *(continued)*

#### *Payments for New and Established Patient Visits*

<b>CPT Code</b>	<b>Description</b>	<b>2009 WRVU Value</b>	<b>2010 WRVU Value</b>	<b>Variance (2009–2010)</b>	<b>Percentage Increase (2009–2010)</b>
99201	Office/outpatient visit, new	0.45	0.48	0.03	6.67%
99202	Office/outpatient visit, new	0.88	0.93	0.05	5.68%
99203	Office/outpatient visit, new	1.34	1.42	0.08	5.97%
99204	Office/outpatient visit, new	2.30	2.43	0.13	5.65%
99205	Office/outpatient visit, new	3.00	3.17	0.17	5.67%
99211	Office/outpatient visit, est	0.17	0.18	0.01	5.88%
99212	Office/outpatient visit, est	0.45	0.48	0.03	6.67%
99213	Office/outpatient visit, est	0.92	0.97	0.05	5.43%
99214	Office/outpatient visit, est	1.42	1.50	0.08	5.63%
99215	Office/outpatient visit, est	2.00	2.11	0.11	5.50%

### III. The Elimination of Consultation Payments *(continued)*

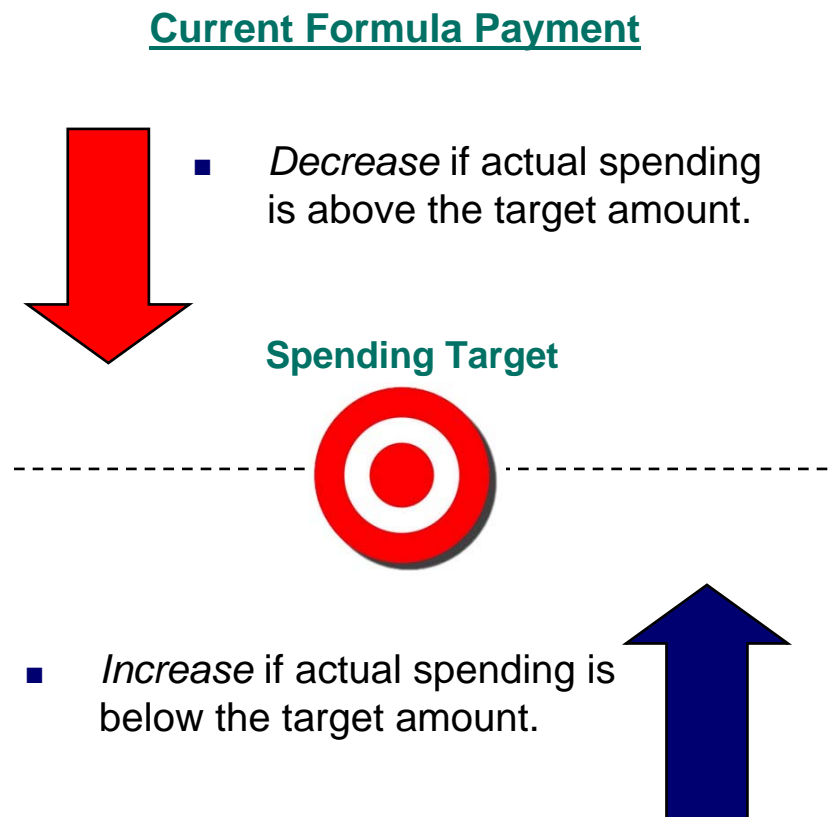
#### *Payments for Office Consultations as New Patient Visits*

<b>CPT Code</b>	<b>Description</b>	<b>2009 WRVU Value</b>	<b>2010 WRVU Value</b>	<b>Variance (2009 Consult to 2010 New Patient Visit)</b>	<b>Percentage Increase (2009–2010)</b>
99241	Office consultation	0.64	0.48	(0.16)	-25.00%
99242	Office consultation	1.34	0.93	(0.41)	-30.60%
99243	Office consultation	1.88	1.42	(0.46)	-24.47%
99244	Office consultation	3.02	2.43	(0.59)	-19.54%
99245	Office consultation	3.77	3.17	(0.60)	-15.92%

### III. The Elimination of Consultation Payments *(continued)*

#### *Other Medicare Payment Changes – Conversion Factor Update*

- Since the enactment of the Balanced Budget Act of 1997, MPFS rates have been updated annually based on a formula that includes the sustainable growth rate (SGR) mechanism.
- The SGR was developed as method for controlling spending for physician services provided under Medicare Part B by adjusting payments rates annually to reflect the differences between actual and the projected spending target.
- This means that payment rates to physicians increase if spending is below the target and decrease if spending is above the target.



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### III. The Elimination of Consultation Payments *(continued)*

#### MPFS Payment Update (2002–2010)<sup>1</sup>

Year	Current Formula Update	Actual Update
2002	-4.8%	-4.8%
2003	-4.4%	1.4%
2004	-4.5%	1.5%
2005	-3.3%	1.5%
2006	-4.4%	0.2%
2007	-5.0%	0.0%
Jan. – Jun. 2008	-10.1%	0.5%
Jul. – Dec. 2008	-10.6%	0.0%
2009	-15.1%	1.1%
2010	-21.2%	-

NOTE: The -10.6% SGR formula update for July through December 2008 is a reduction from June 2008 level. The 0% actual update is maintaining the 0.5% update from January through June 2008.

- Actual spending since 2002 has been above projected targets, resulting in negative payment updates under the current formula.<sup>2</sup>
- However, these projected negative updates have been averted each year through action taken by CMS or legislation enacted by Congress.
- Unfortunately, these annual fixes have increased the subsequent year’s negative update.

<sup>1</sup> Congressional Research Service: “Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System,” November, 2009.

<sup>2</sup> Ibid.

***Application of the -21.2% update, will result in a CY 2010 conversion factor of \$28.4061 as compared to the 2009 conversion factor of \$36.0666.***

### III. The Elimination of Consultation Payments *(continued)*

#### *Other Medicare Payment Changes – PE RVU Methodology*

- CMS will use data from a new source known as the *Physician Practice Information Survey* (PPIS) to calculate PE RVUs.
- Beginning in 2010 and phased in over a 4-year period.
- PPIS is conducted by the AMA and the Lewin Group.
- PPIS utilizes submitted data to establish a PE per hour benchmark for each specialty.
- This benchmark is used to determine indirect PE RVUs as well as the PE dollars available for all specialty-specific physician services.

## III. The Elimination of Consultation Payments *(continued)*

### *Other Medicare Payment Changes – PLI RVU Methodology*

- With previous fee schedules, PLI RVUs were updated based on information collected from the top 20 physician specialties.
- Under the 2010 MPFS and moving forward, PLI RVUs will be developed according to specialty-specific malpractice premium data.
- In addition, CMS has proposed to begin utilizing a resource-based methodology for developing PLI RVUs for technical component (TC) services.



### III. The Elimination of Consultation Payments *(continued)*

#### Impact of MPFS Changes on Reimbursement and RVU Production for Select Specialties<sup>1</sup>

Specialty	Average Change in WRVUs (2009–2010)	Average Change in Total RVUs (2009–2010)	Average Change in Reimbursement Conversion Factor = \$28.4061 (2009–2010)	Average Change in Reimbursement Conversion Factor = \$36.4994 (2009–2010) <sup>2</sup>
Cardiology – Invasive (Noninterventional)	-2%	-4%	-24%	-3%
Dermatology	1%	3%	-19%	4%
Family Practice Without OB	4%	5%	-17%	6%
Gastroenterology	-2%	0%	-22%	1%
Internal Medicine	4%	5%	-18%	6%
Internal Medicine – Hospitalist	0%	3%	-19%	4%
Nephrology	-1%	1%	-21%	2%
<b>NEUROLOGY</b>	<b>-5%</b>	<b>-3%</b>	<b>-23%</b>	<b>-1%</b>
Obstetrics/Gynecology	2%	2%	-20%	3%
<b>OPHTHALMOLOGY</b>	<b>1%</b>	<b>6%</b>	<b>-17%</b>	<b>7%</b>
Pediatrics	3%	4%	-18%	5%
Pulmonary Medicine	-4%	-3%	-23%	-1%
Rheumatology	-1%	-1%	-22%	0%
Surgery – General	-1%	2%	-20%	3%
Surgery – Orthopedics	1%	1%	-20%	2%
Urgent Care	5%	6%	-17%	7%
Urology	-1%	-2%	-23%	-1%

Source: ECG Northwest and Midwest *Provider Compensation, Production, and Benefits Survey*, year 2009 based on 2008 data.

Assumes the 1.2% payment update proposed by H.R. 3961 is applied to the 2009 conversion factor of \$36.0666.

**NOTE:** Impact results assume that eliminated consultation outpatient codes are replaced with new patient visit codes (99201–99205) and eliminated inpatient codes are replaced with an inpatient service code (99222). The results also account for the first year of implementation of the new methodology for determining PE RVUs. Calculations are based on reported 2008 CPT-level data as compared against the 2009 and 2010 MPFS.

## **IV. Implications for Neuro-Ophthalmology**

## IV. Implications for Neuro-Ophthalmology

*In order to determine the impact of eliminating consult codes, we modeled the reimbursement of several neuro-ophthalmology practices.*

- An informal survey of seven neuro-ophthalmology practices was conducted, which allowed us to obtain CPT-level volume data.
- Reimbursement for each practice was modeled based on the 2009 and 2010 MPFS.
- For 2010, all applicable consult codes (99241–99245) were cross-walked to the corresponding patient visit code.

## IV. Implications for Neuro-Ophthalmology *(continued)*

*In aggregate, 15 CPT codes accounted for nearly 85% of total practice payments based on 2009 payment levels.<sup>1</sup>*

- The volume and reimbursement are concentrated among a small number of codes/services.
- Consult and office visit codes represent over 50% of practice revenue on average.

<sup>1</sup> Payment based on 2009 MPFS.

## IV. Implications for Neuro-Ophthalmology *(continued)*

***In aggregate, 15 CPT codes accounted for nearly 85% of total practice payments based on 2009 payment levels.<sup>1</sup>***

CPT Code	Description	Total Payment	Percent of Total Payment	Cumulative Percent
99245	Office consultation	\$ 865,676	33.9%	33.9%
92083	Visual field examination(s)	170,143	6.7%	40.5%
99214	Office/outpatient visit, est	168,595	6.6%	47.1%
92014	Eye exam & treatment	158,439	6.2%	53.3%
99244	Office consultation	141,727	5.5%	58.9%
92060	Special eye evaluation	93,829	3.7%	62.5%
99215	Office/outpatient visit, est	90,099	3.5%	66.1%
99213	Office/outpatient visit, est	85,716	3.4%	69.4%
92135	Ophth dx imaging post seg	58,950	2.3%	71.7%
92275	Electroretinography	56,397	2.2%	73.9%
64612	Destroy nerve, face muscle	56,128	2.2%	76.1%
92250	Eye exam with photos	55,097	2.2%	78.3%
92082	Visual field examination(s)	54,781	2.1%	80.4%
92012	Eye exam established pat	54,502	2.1%	82.5%
99205	Office/outpatient visit, new	29,517	1.2%	83.7%
	Remaining Codes	416,702	16.3%	100%
<b>TOTAL</b>		<b>\$ 2,556,299</b>	<b>100.0%</b>	<b>100.0%</b>

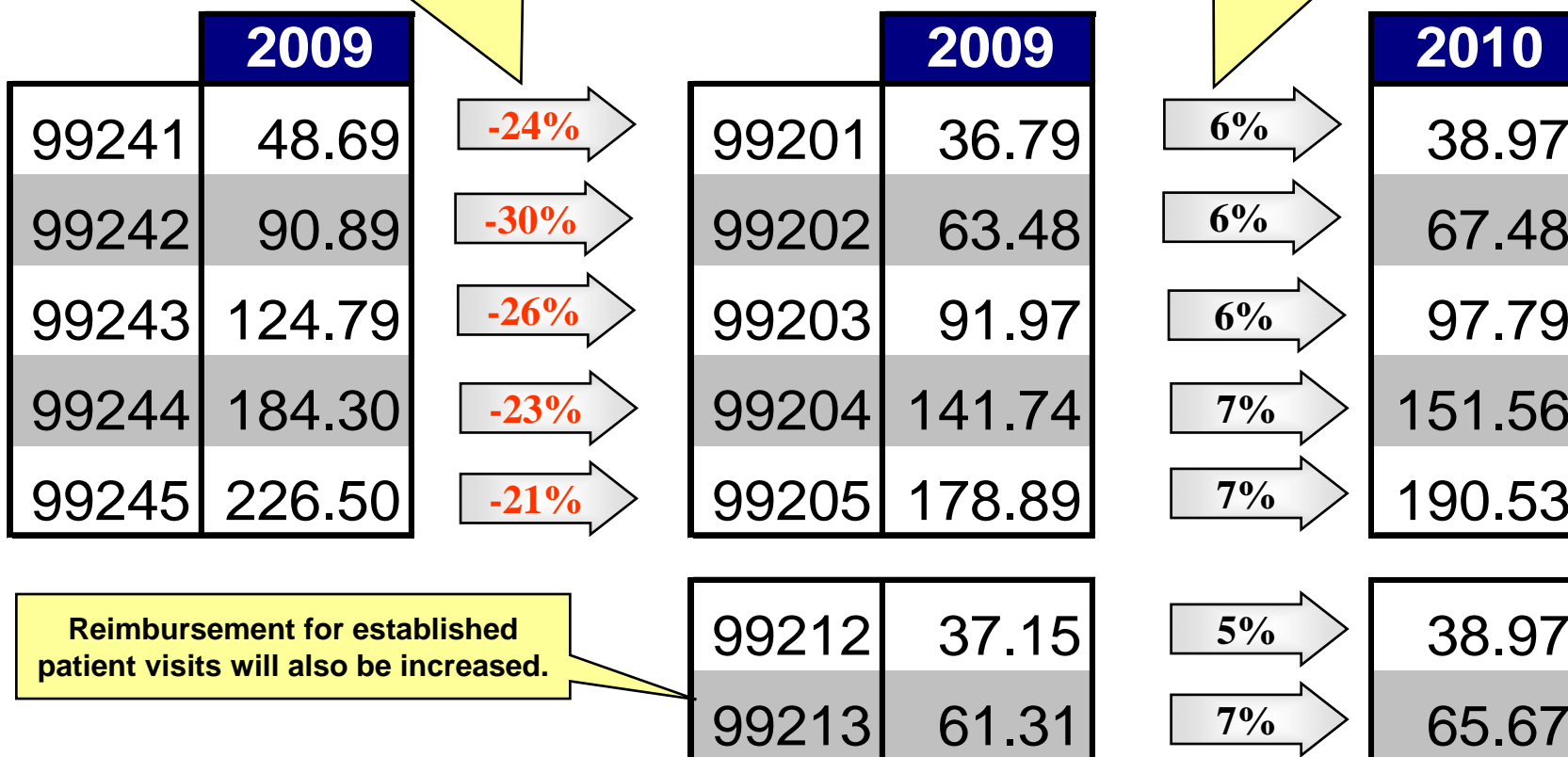
<sup>1</sup> Payment based on 2009 MPFS.

# IV. Implications for Neuro-Ophthalmology

*In order to model 2010 rates, consult codes (99241–99245) were cross-walked to their commensurate office visit codes (99201–99205).*

The transition of consult codes to visit codes results in a significant decrease in reimbursement.

This decrease is partially offset by an increase in payment rates for office visits.



Reimbursement for established patient visits will also be increased.

## IV. Implications for Neuro-Ophthalmology *(continued)*

*Reimbursement changes were modeled assuming a 50/50 split between Medicare and commercial payors.*

### Changes in Practice Reimbursement from 2009 to 2010

	2009 Percentage Consults	2009 Revenue	2010 Revenue	Percentage Change in Revenue
Practice A	72.7%	\$ 445,138	\$ 422,775	-5.0%
Practice B	25.1%	\$ 224,086	\$ 225,159	0.5%
Practice C	12.2%	\$ 206,051	\$ 210,422	2.1%
Practice D	28.3%	\$ 1,144,995	\$ 1,139,250	-0.5%
Practice E	36.2%	\$ 172,906	\$ 170,421	-1.4%
Practice F	63.2%	\$ 221,762	\$ 213,114	-3.9%
Practice G	68.5%	\$ 141,359	\$ 135,230	-4.3%

*Reimbursement changes will be largely dependent on how much practice revenue was derived from consult codes prior to the reimbursement changes.*

## IV. Implications for Neuro-Ophthalmology *(continued)*

*The table below presents the modeled impact if 50% of the payors (including Medicare) were to eliminate consult codes.*

Category	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Practice G	Total	Average
<b>2009 Payment</b>									
Consult	\$ 323,478	\$ 56,151	\$ 25,106	\$ 324,260	\$ 62,602	\$ 140,200	\$ 96,838	\$ 1,028,635	40.2%
Office Visit	99,143	21,835	79,147	37,132	66,464	65,273	44,320	413,313	16.2%
Medicine	323	28,647	21,823	710,807	11,335	15,853	-	788,789	30.9%
Surgery	-	116,939	64,719	30,114	22,096	-	-	233,868	9.1%
Inpatient	21,507	344	15,255	-	10,409	437	202	48,155	1.9%
Other	686	170	-	42,682	-	-	-	43,538	1.7%
<b>Grand Total</b>	<b>445,138</b>	<b>224,086</b>	<b>206,051</b>	<b>1,144,995</b>	<b>172,906</b>	<b>221,762</b>	<b>141,359</b>	<b>2,556,299</b>	<b>100.0%</b>
<b>2010 Payment</b>									
Consult	297,775	51,171	23,046	297,642	57,495	128,892	89,136	945,158	37.6%
Office Visit	102,400	22,545	81,760	38,357	68,648	67,477	45,892	427,079	17.0%
Medicine	331	29,270	22,327	728,584	11,318	16,301	-	808,131	32.1%
Surgery	-	121,657	67,777	32,005	22,471	-	-	243,909	9.7%
Inpatient	21,580	346	15,512	-	10,488	445	202	48,574	1.9%
Other	689	171	-	42,662	-	-	-	43,521	1.7%
<b>Grand Total</b>	<b>422,775</b>	<b>225,159</b>	<b>210,422</b>	<b>1,139,250</b>	<b>170,421</b>	<b>213,114</b>	<b>135,230</b>	<b>2,516,371</b>	<b>100.0%</b>
<b>Payment Variance, 2009 - 2010</b>									
Consult	(25,703)	(4,980)	(2,060)	(26,618)	(5,107)	(11,307)	(7,702)	(83,477)	-8.1%
Office Visit	3,257	710	2,612	1,225	2,185	2,204	1,572	13,765	3.3%
Medicine	8	622	504	17,777	(17)	448	-	19,342	2.5%
Surgery	-	4,718	3,058	1,891	375	-	-	10,041	4.3%
Inpatient	73	2	257	-	79	7	0	418	0.9%
Other	2	0	-	(20)	-	-	-	(17)	0.0%
<b>Grand Total</b>	<b>\$ (22,363)</b>	<b>\$ 1,073</b>	<b>\$ 4,371</b>	<b>\$ (5,746)</b>	<b>\$ (2,485)</b>	<b>\$ (8,648)</b>	<b>\$ (6,129)</b>	<b>\$ (39,928)</b>	<b>-1.6%</b>



## IV. Implications for Neuro-Ophthalmology *(continued)*

*The modeled impact of the 2010 changes (50% of payors) vary among practices depending on service mix.*

- Those practices most heavily weighted toward consult codes will experience the most significant financial impact.
- Although modeled revenue declines for five of the seven practices, the impact is more moderate for those with a more diverse mix of services.
- Decreases in consult code revenues are partially offset by increases in visit codes.

## **V. Potential Responses: *Payor-Related Tactics***

## V. Potential Responses

### *Payor-Related Tactics*

*A range of actions could be considered with regard to payors.*

- Ensure legitimate billing of consultation codes to non-Medicare payors.
- Pursue improved payments for neuro-ophthalmic services in new patient care contracts.
- Consider opting out of the Medicare program.

## V. Potential Responses

### *Payor-Related Tactics* (continued)

***Ensure legitimate billing of consultation codes to non-Medicare payors.***

- Medicare often includes payment policies that are distinct from RBRVS.
- Commercial payors will tend to track RBRVS changes quite closely.
- Commercial payors will vary in following Medicare payment policies.

Pennsylvania Example		
Insurer	Commercial Plans	Medicare Advantage Plans
Aetna	Consult codes allowed.	Consult codes allowed, <b>except for Medicare Open Plan.</b>
Capital Blue Cross	Consult codes allowed.	Consult codes allowed.
CIGNA	Consult codes allowed.	Consult codes allowed.
UnitedHealthcare	Consult codes allowed.	<b>Consult codes eliminated.</b>
Unison	<b>Consult codes eliminated.</b>	<b>Consult codes eliminated.</b>

## V. Potential Responses

### *Payor-Related Tactics* (continued)

#### *Ensure legitimate billing of consultation codes to non-Medicare payors*

- Hard to find a payor that does not base fee schedule on RBRVS, but their application can vary in material ways.
- Different conversion factors.
  - » May use one conversion factor.
  - » May apply different conversion factors to different code types to reflect payor priorities and/or market dynamics.
- Update schedule.
  - » Vary in frequency of updates to reflect new RBRVS versions.
  - » BCBS tends to update annually on April 1st.
- May or may not follow Medicare payment policies.
  - » Still not clear on consult codes.
  - » Most did not follow imaging cap on PE component.

## V. Potential Responses

### *Payor-Related Tactics* (continued)

*Pursue improved payments for neuro-ophthalmic services in new patient care contracts.*

- There is significant variation in the commercial payment rates that practices are able to negotiate.
- Variations for E&M codes can range from just 100% of Medicare to over 200%.
- This is true both across and within regions.
- Be proactive in negotiating the rates for services that are important to your practice.

## V. Potential Responses

### *Payor-Related Tactics* (continued)

*Pursue improved payments for neuro-ophthalmic services in new patient care contracts.*

#### Nuances of Commercial Plan Contracts/Negotiations

- Look to define contract terms as a percentage increase over the prior year, not simply an increase in the fee schedule.
  - » Adjusted for changes in RVUs, payment policies, covered benefits, and so forth.
  - » Defined based on the mix of services provided by the group for patients covered by the given payor.
  - » Include all services (labs, drugs, etc.) in baseline against which annual increases are measured.

## V. Potential Responses

### *Payor-Related Tactics (continued)*

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- Understand the impact of RVU changes based on the mix of services (CPT/HCPCS code mix) of the group.
- Understand whether these changes positively or negatively affect the group in comparison with the prior year.
- If the group is planning for changes in the settings of care in which patients are seen (e.g., office- to provider-based), understand/measure the impact of commercial payor methodologies.
- Look to include provisions that will adjust for any material changes in payment methodologies. For example:
  - » Consult codes.
  - » SOS adjustment.
  - » Change in drug payments from AWP to ASP.



## V. Potential Responses

### *Payor-Related Tactics* (continued)

***Consider opting out of the Medicare program.***

There are three Medicare contractual obligation models for physicians:

<b>Physician Medicare Status</b>	<b>Billing Status</b>
PAR Physician Agreement	Accept Medicare's allowed charge as payment in full.
Non-PAR Physician	Physician can make assignment decisions on a case-by-case basis, and bill more than the Medicare allowance for unassigned claims.
Private Contracting Physician	Physician bills patient directly and forgoes any payments from Medicare.

## V. Potential Responses

### *Payor-Related Tactics* (continued)

#### ***Consider opting out of the Medicare program: PAR Physician Agreement.***

- PAR physicians agree to take assignment on all Medicare claims.
- Assignment means the physician must accept Medicare's approved amount.
  - » 80% paid by Medicare.
  - » 20% patient co-payment.
- PAR physicians are not required to accept every Medicare patient who seeks treatment.
- Benefits of being a PAR physician include the following:
  - » Medicare-approved amounts are 5% higher than approved amounts for non-PAR physicians.
  - » Directories of PAR physicians are provided to senior citizen groups and at individual requests.
  - » Carriers provide toll-free claims processing lines for PAR physicians.

## V. Potential Responses

### *Payor-Related Tactics (continued)*

#### ***Consider opting out of the Medicare program: Non-PAR Physician Status.***

- Medicare-approved amounts for non-PAR physicians are set at 95 percent of approved amounts for PAR physicians.
- Non-PAR physicians can charge more than the Medicare-approved amount.
  - » Limited to 115% of the non-PAR-approved amount.
  - » Effectively only 9.25% above the PAR-approved amount.
- Non-PAR physicians can make assignment decisions on a case-by-case basis.
  - » Accepting assignment on low-income patients would limit the allowable amount to 95% of that of PAR physicians.
  - » Declining assignment on higher-income patients would enable billing at the full 115% of the non-PAR-approved amount.
- Significant consideration must be given to self-pay collection costs, bad debt, and anticipated Medicare “assignment mix.”

## V. Potential Responses

### *Payor-Related Tactics* (continued)

**Consider opting out of the Medicare program: Non-PAR Physician Status.**

Example: A Service for Which MPFS Amount is \$100			
Payment Arrangement	Total Payment Rate	Amount From Medicare	Payment Amount From Patient
PAR Physician	\$100 = 100% MPFS.	\$80 (80%) carrier direct to physician.	\$20 (20%) paid by patient or supplemental insurance.
Non-PAR/Assigned Claim	\$95 = 95% MPFS.	\$76 (80%) carrier direct to physician.	\$19 (20%) paid by patient or supplemental insurance.
Non-PAR/Unassigned Claim	\$109.25 = Limiting charge of 115% of 95% MPFS.	\$0.	<ul style="list-style-type: none"> <li>■ \$76 (80%) paid by carrier to patient plus.</li> <li>■ \$19 (20%) paid by patient or supplemental insurance plus.</li> <li>■ \$14.25 balance bill to patient.</li> </ul>

## V. Potential Responses

### *Payor-Related Tactics* (continued)

#### ***Consider opting out of the Medicare program: Private Contracting.***

- The Balance Budget Act of 1997 gave physicians and their Medicare patients the freedom to privately contract for healthcare services outside of the Medicare program.
- Once a physician has opted out of the Medicare program, he/she cannot submit a claim to Medicare for any of their patients for a 2-year period.
- To privately contract with a Medicare beneficiary:
  - » The physician and patient must sign a private contract.
  - » The physician must complete an opt-out affidavit.
- The private contract acknowledges that neither the physician nor the Medicare beneficiary will submit a claim or seek payment from the Medicare program for the services rendered.
- In essence, the private contract is a self-pay model.

## **V. Potential Responses: *Practice Management Tactics***

## V. Potential Responses

### *Practice Management Tactics*

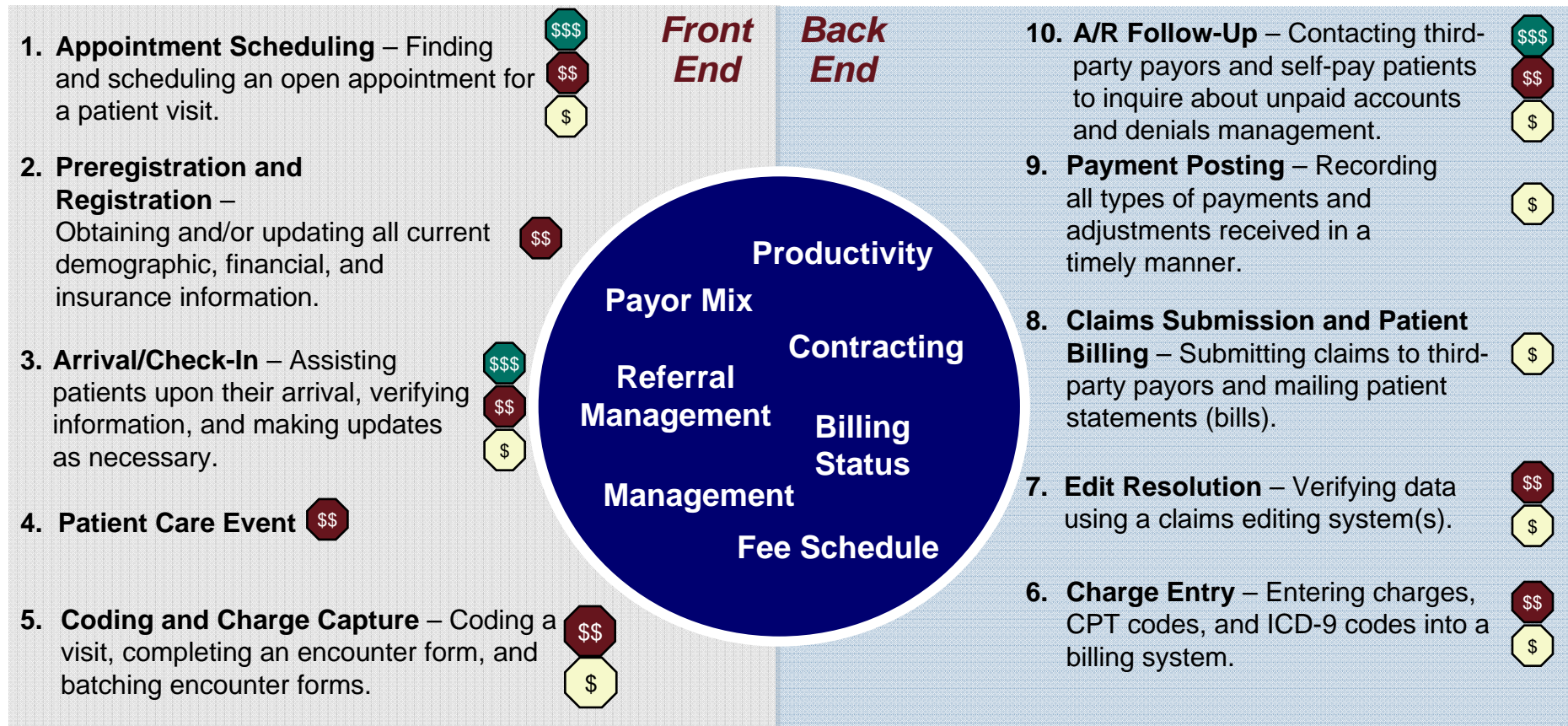
*A range of actions could be considered that relates to practice management.*

- Ensure efficiency of all revenue cycle processes.
- Attempt to insulate compensation under group/department compensation plans.
- With a willing hospital partner, consider provider-based status to reduce burden of practice expenses.

# V. Potential Responses

## Practice Management Tactics (continued)

Ensure efficiency of all revenue cycle processes.



Direct opportunity for cash collections.

Opportunity for increased collections from process enhancement.

Opportunity for cost savings from increased efficiency.



## V. Potential Responses

### *Practice Management Tactics* (continued)

*Attempt to insulate compensation under group/department compensation plans.*

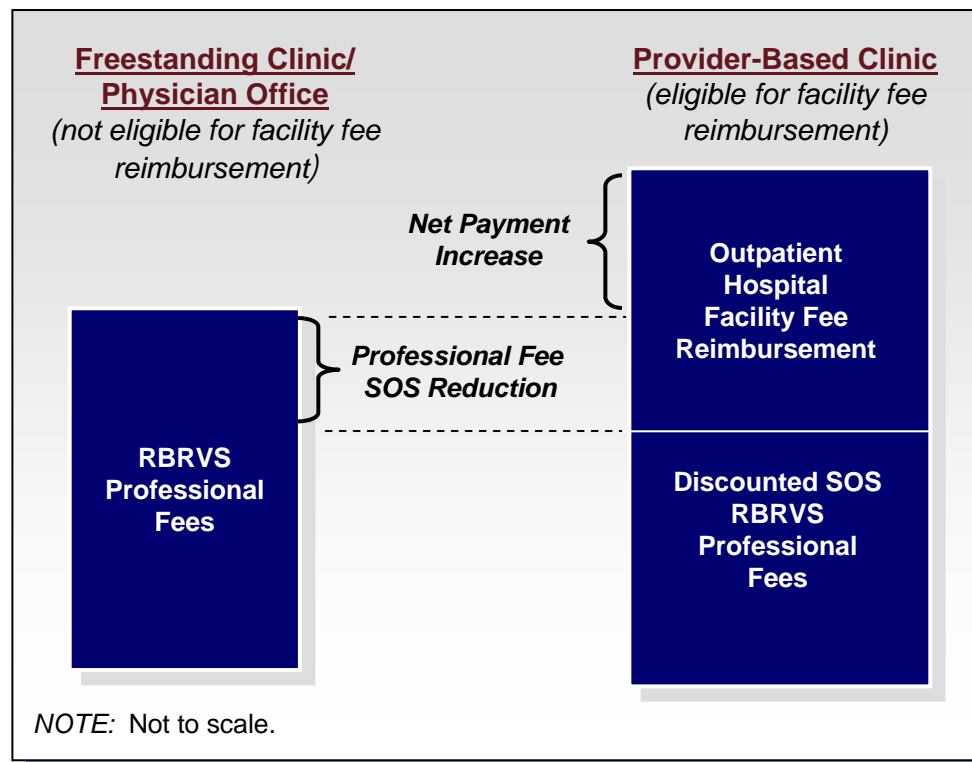
- Ophthalmology, as an aggregated specialty, may benefit from an overall increase in payments from the changes in the Medicare program.
- In contrast, declines are expected in neurology.
- If the compensation plan exists within an ophthalmology department or group practice:
  - » Advocate for the preservation of compensation levels.
  - » Seek redistribution of Medicare revenues within the department or group.
  - » Consider non-revenue-based compensation arrangements.

# V. Potential Responses

## *Practice Management Tactics* (continued)

***With a willing hospital partner, consider provider-based status to reduce burden of practice expenses.***

### Financial Advantage of Provider-Based Status



## V. Potential Responses

### *Practice Management Tactics* (continued)

*With a willing hospital partner, consider provider-based status to reduce burden of practice expenses.*

#### Freestanding Clinics

- Physicians receive the full Medicare professional/global (RBRVS) fee.
- The hospital receives no Medicare reimbursement for facility expenses.
- Management and operations are the responsibility of the physicians.

#### Provider-Based Clinics

- Physicians receive a reduced Medicare professional fee for selected services.
- The hospital bills a facility fee.
- The hospital absorbs nonphysician practice costs.
- Clinics are held to more stringent operating requirements than physician offices.

## **V. Potential Responses: *Practice Profile Tactics***

## V. Potential Responses

### *Practice Profile Tactics*

*A range of actions could be considered with regard to practice patterns and profile.*

- Patient mix.
- Time.
- Testing and procedures.

## V. Potential Responses

### *Practice Profile Tactics* (continued)

#### *Patient Mix*

- If possible, shifting the payor mix in the neuro-ophthalmic patient panel can affect revenue generation.
  - » De-emphasize Medicare business.
  - » Avoid other payors who may adopt elimination of consult codes.
  - » Favor payors who continue to reimburse for consultation services.
- New patient visits are reimbursed at a higher rate than follow-up visits.
- Accordingly, if possible, pursue development of a strong referral practice.

## V. Potential Responses

### *Practice Profile Tactics* (continued)

#### *Time*

- A survey of NANOS membership regarding ideas for alternative revenue generation included suggestions for billing incrementally for various types of expended time.
- Examples might include:
  - » Prolonged care.
    - Direct patient contact (99354–99355).
    - Without direct patient contact (99358–99359).
  - » Telephone calls (99441–99443): Medicare noncovered service.
  - » On-line medical evaluation (99444): Medicare noncovered service.
- All physicians should receive training in appropriate coding, to ensure that billing is compliant and that billed services do not conflict with contractual requirements.

# V. Potential Responses

## *Practice Profile Tactics* (continued)

*Time*

### Prolonged Care

- Direct patient contact:
  - » 99354 – Prolonged physician service, office/outpatient; first hour (RVU = 2.60).
  - » 99355 – Each additional 30 minutes (RVU = 2.58).
- Without direct patient contact:
  - » Review of extensive records and tests, communication with other professionals and/or the patient/family).
  - » 99358 – Prolonged E&M, before and/or after direct patient care; first hour (RVU = 2.98).
  - » 99359 – Each additional 30 minutes (RVU = 1.43).
- Appropriate documentation is required to bill for prolonged care.



# V. Potential Responses

## *Practice Profile Tactics* (continued)

*Time*

Prolonged Care  
(in minutes)

Code	Typical Time for Code	Threshold Time to Bill 99354	Threshold Time to Bill 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135

# V. Potential Responses

## *Practice Profile Tactics* (continued)

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*Time*

### Telephone Calls

- Noncovered Medicare service, so physicians must directly charge patients.
- Physicians must follow all Medicare policies for charging patients for noncovered services (e.g., formal notification to patients regarding the rendering of noncovered services).
- Requirements:
  - » Established patient, parent, or guardian.
  - » Not originating from a related E&M service provided within previous 7 days or within the next 24 hours (or soonest available appointment).
  - » Patient must initiate telephone call.

## V. Potential Responses

### *Practice Profile Tactics* (continued)

*Time*

#### Telephone Calls

<b>Code</b>	<b>Duration</b>	<b>RVU</b>
99441	10 Minutes of Medical Discussion	0.38
99442	11 – 20 Minutes of Medical Discussion	0.74
99443	21 – 30 Minutes of Medical Discussion	1.08

# V. Potential Responses

## *Practice Profile Tactics* (continued)

### *Testing and Procedures*

- Analysis of the select set of neuro-ophthalmology practices indicated that those practices with a more diverse mix of services were more insulated from the change in consultation payments.
- A survey of NANOS membership regarding ideas for alternative revenue generation included suggestions for adding, where appropriately indicated, such services as:
  - » Visual field exams and OCTs.
  - » Extended color vision testing.
  - » Extended sensorimotor examination.
- Ophthalmologically trained neuro-ophthalmologists could consider developing proficiency in procedures such as strabismus surgery and orbital surgery.
- Neurologically trained neuro-ophthalmologists could consider developing proficiency in EMG.

## VI. Conclusions

## VI. Conclusions

### *Unique Responses for Unique Practices*

- The elimination of consultation payments will have a negative impact on many neuro-ophthalmology practices.
- The magnitude of the impact will likely vary significantly among practices.
- Other pending Medicare changes may also affect future revenue generation possibilities.
- There are a variety of potential responses that neuro-ophthalmologists could pursue to mitigate negative changes.
- NANOS membership would likely benefit from maintaining a “clearinghouse” of best practices and successful tactics to inform and guide future actions.

# Comments & Questions