PHYSICIAN SERVICES PAYMENT SYSTEM

*payment***basics**

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Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. In some cases, nonphysician practitioners, such as nurse practitioners, may furnish physician services. In 2006, about 569,000 physicians billed Medicare. Of them, 497,000 had Medicare caseloads of 15 or more beneficiaries.

Physician services are billed to Part B. Payments for these services (about $60 billion in 2008) account for about 13 percent of total Medicare spending.

Medicare pays for physician services based on a list of services and their payment rates, called the physician fee schedule. In determining payment rates for each service on the fee schedule, the Centers for Medicare & Medicaid Services (CMS) considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final amount, less any applicable beneficiary coinsurance.

The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate (SGR) system. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last several years, the Congress has specified an update outside of the SGR formula.

Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. These products, however, range from narrow services (an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related pre-operative and post-operative visits. All services—surgical and non-surgical—are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for about 6,700 distinct services.

Setting the payment rates

Under the fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and professional liability insurance (PLI) expenses. The RVUs for physician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums physicians pay for professional liability insurance, also known as medical malpractice insurance.

This document does not reflect proposed legislation or regulatory actions.

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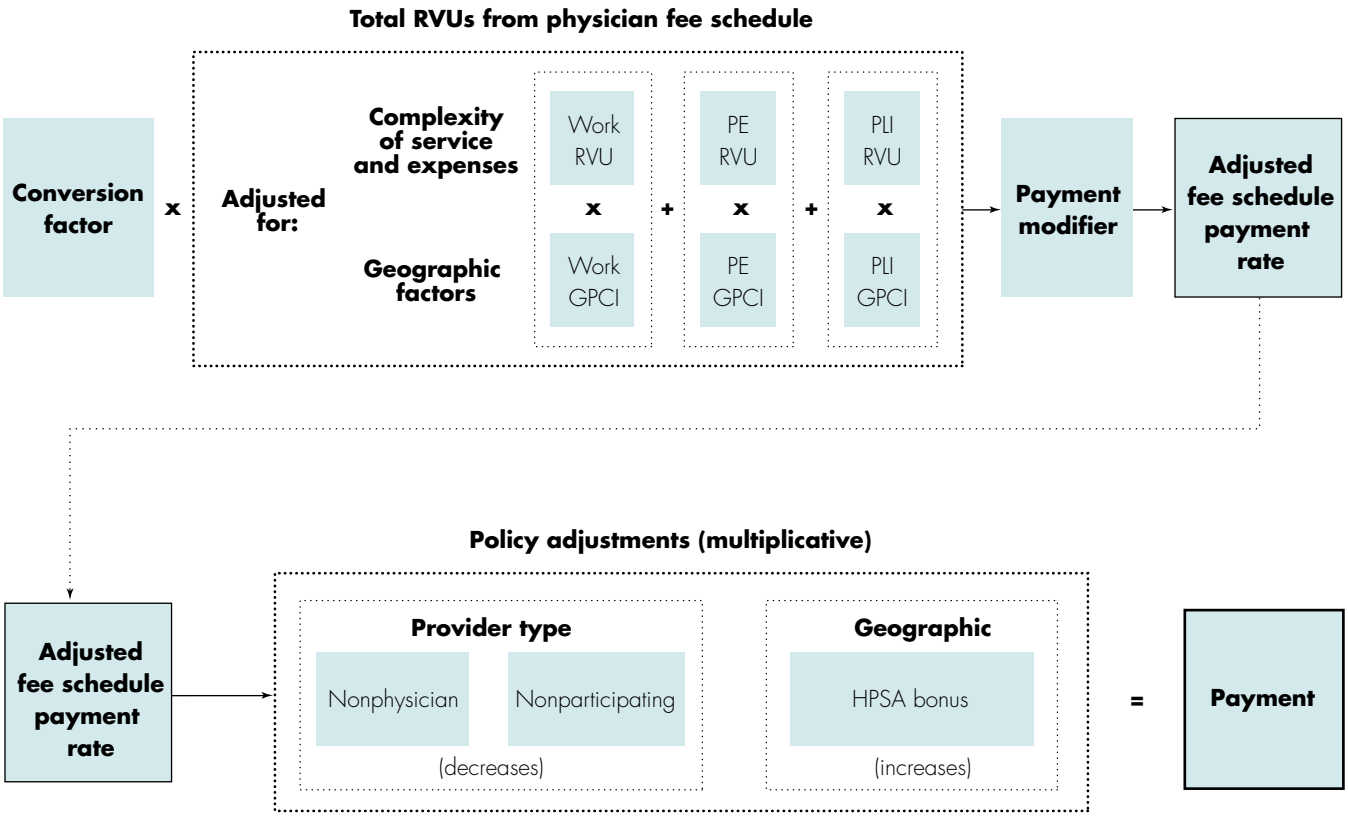
Figure 1 Physician services payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The physician fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are reduced when specified nonphysician practicioners bill Medicare separately, but not when services are provided "incident to" a physician.

In calculating payment rates, each of the three RVUs is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (Figure 1). For most physician services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple surgical procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Payments under the physician fee schedule also may be adjusted upward or downward to reflect other factors. The first potential downward adjustment occurs if services are furnished by certain nonphysician practitioners. For example,

services billed separately and provided by nurse practitioners are paid at 85 percent of physicians' fees. When nonphysician practitioners perform services "incident to" or under direct physician supervision, they may not bill Medicare separately and Medicare pays for the fee schedule amount for the service as if the physician had personally furnished it.

Another instance in which Medicare can adjust fee schedule payments downward occurs when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by nonparticipating physicians are 95 percent of the fee schedule payment rate.

Physicians and other health professionals may receive increases for services they provide in underserved areas. Under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

Updating payments

The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the SGR system, a formula intended to keep spending on physician services—a function of service volume—consistent with a target based on growth in the national economy. The SGR ties physician payment updates to a number of factors, including growth in input costs, growth in fee-for-service enrollment, and growth in the volume of physician services relative to growth in the national economy. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than the target, the update is less than the change in input prices. In the last several years, the Congress has specified an update outside of the SGR formula, thereby averting negative conversion factors called for by the SGR. ■