

Understanding the Reimbursement Rules

Chapter FastFACTS

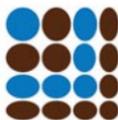
- 1. The ACA requires Medicare to cover the entire cost of most preventive services recommended by the U.S. Preventive Services Task Force.**
- 2. ACA rules address e-prescribing, meaningful use requirements, and home health certification.**
- 3. Most major changes implemented from 2013 on will take place first as pilot projects and experiments.**
- 4. Upcoming billing and coding changes are not technically part of health reform, but they are connected to it.**
- 5. Physicians need to become keenly aware of their costs, outlays, and remunerations.**

How can you balance working under one system—in which you get paid more for doing more—while preparing for a risk-based capitation system that will pay more when you save money and prove the quality of your care? As one physician recently told healthcare consultant Dr. Browne: “I feel like I have one foot in each canoe, and I’m not sure I’m going to like how I’m going to land.”

He’s right to be concerned. J. Fred Ralston, Jr., MD, a general internist in Tennessee and president of ACP, says physicians must first ensure that their practices survive before taking steps to transform them. Health reform, he says, “cannot count on our risking the existence of our own practices to prepare for an uncertain future.”

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Just as transforming a twentieth-century U.S. healthcare system into one that will function throughout the present century will take time, payment rules and incentives will roll out over time as well. To complicate matters further, the ACA, federal budget, economic stimulus law, and other legislation affecting healthcare all contain provisions that will change physician reimbursement one way now but differently in the future. As one would expect, the provisions now being implemented are more specific than those taking effect years from now.

What's Happening First

In general, how physicians will be paid will seem largely familiar and will remain fee-for-service-based over the next few years. But later health reform envisions a world with much more risk-sharing and global payment (but not totally free of fee-for-service). Moreover, although the laws specifically apply only to government payers, i.e., mostly Medicare and Medicaid, the laws also encourage private payers to follow their lead (or even to lead, but in the same direction), making similar changes in how they pay healthcare providers. The following are some of health reform's near-term rule changes:

Preventive medicine. As of January 2011, new annual "wellness" visits for Medicare beneficiaries will be reimbursed as a level 4 exam, and patients do not have to pay the typical 20% copayment or count the visit toward a deductible. According to ACP, the 2011 Medicare payment—not adjusted for geography—is approximately \$172 for G0438 (the code for the first annual wellness visit) and \$111 for G0439 (subsequent annual wellness visits). Consultants say these visits could be a boon to primary care providers because they will attract business and lead to more billings. They also will not require practices to use office resources in collecting co-pays. Another provision in the ACA requires Medicare to cover 100% of the cost of most preventive services recommended by the U.S. Preventive Services Task Force. The following preventive services are covered: pneumococcal, influenza and hepatitis B vaccines; mammography; pap tests, and screening pelvic exams; prostate cancer screening tests; colorectal cancer screening; bone mass measurement; medical nutrition therapy services; cardiovascular screen-

Health insurance in the U.S.

Employer-based coverage drops as government programs grow.

Coverage Type	Percent of U.S. Population (2009)
Employer-based private coverage	55.8
Individual private coverage	8.9
Medicare	14.3
Medicaid	15.7
Military	4.1
Uninsured	16.7

Source: "Income, Poverty and Health Insurance Coverage in the United States: 2009," issued September 2010, report from the U.S. Census Bureau, <http://www.census.gov/prod/2010 pubs/p60-238.pdf>.

ing blood tests; diabetes screening tests; and ultrasound screening for abdominal aortic aneurysm.

More money for primary care. Medicare's new primary care bonus will pay family physicians, general internists, and pediatricians who provide primary care services the bulk of the time a 10% bonus each year for the next five years. The bonus also applies to general surgeons working in health professional shortage areas (HPSAs). You don't have to code or bill any differently to receive the money, but check with your carriers to make sure they are correctly registered with the program and slated to receive the money. The first payment installments were scheduled to arrive shortly after March 31. (See "How to Prepare: The Primary Care Bonus.")

Private insurance expansion. Restrictions on private insurers' ability to set lifetime limits on essential benefits should help physicians decrease the reduced-fee or charity care they provide

New Law Extends Federal Deposit Insurance



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to long-time patients whose health insurance is cut off, consultants say. In addition, as more people get insurance, doctors will have access to more paying patients, a boon to physicians who are still being paid fees for services.

Electronic prescribing. The 2011 Medicare e-prescribing incentive program will pay a 1% bonus for successful e-prescribing this year, but in 2012 practices that have not participated in 2011 will be assessed a penalty.

Meaningful use payments. EHR incentives of \$44,000 per physician will begin for physicians who demonstrate they are using information technology systems in a meaningful way.

Home health certification. As of Jan. 1, 2011, the ACA requires a face-to-face encounter to certify beneficiary home healthcare. The visit can be with a physician, nurse practitioner, or physician assistant.

ICD-10 and the new 5010 transaction standard. This dramatic change in healthcare billing and coding is not technically part of health reform; but it is inherently connected to it, both in its timetable and in how it will affect everything from bundled payments to quality measures. On Oct. 1, 2013, the 13,600-code ICD-9 will change to a seven-digit ICD-10, with about 69,000 codes. Before that, practices need to upgrade their billing and coding systems to accommodate transactions on Version 5010, which is a software upgrade needed for ICD-10. CMS is warning, in fact, that practices that don't upgrade to Version 5010 by Jan. 1, 2012, may see "delays in claims reimbursement." Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. Discuss the changeover now with your billing and coding companies, electronic medical records vendors, and professional societies.

Besides being a potentially mammoth headache for IT departments, the switch will affect physicians and their practices by

- requiring them to be even more specific in their documentation than they are now so that coders will be able to assign the proper code for billing and quality reporting purposes;
- reducing the effectiveness of superbills since most ICD-9 codes will be replaced by multiple, more specific ICD-10 codes;
- requiring all physicians to use an EHR or coding software; and

■ forcing them to rework forms for encounters and lab or radiology orders in order to convert from ICD-9 to ICD-10 codes.

Medicare fee schedule cuts. Doctors won a temporary reprieve late last fall from looming Medicare fee schedule cuts put in place by the Balanced Budget Act of 1997. Without Congressional intervention, however, those cuts of nearly 30% could start in January 2012. Meanwhile, President Obama's 2012 budget proposal, released in mid-February, would freeze current Medicare pay rates for physicians until 2014; and the Republican Congress plans to lay out its proposal for reforming Medicare, Medicaid, and Social Security.

Increased Medicaid rates. Starting in 2013, the amount Medicaid will pay for primary care (evaluation and management) services and immunizations will increase to be no less than Medicare's rates, and these will be fully paid.

Rules for Tomorrow's Reimbursement System

Here are major changes that are expected to be implemented. Some will kick in as early as 2013, and most will take place first in the form of widely varying pilot projects and experiments before being fully implemented, changed, or scrapped.

Risk sharing, bundled payments, and capitation. Several innovative provider payment provisions in health reform aim to pay physicians and hospitals a fixed amount for each patient no matter how much care the patient receives rather than paying based on fee-for-service. In general, the law does not immediately implement fundamental payment reform; instead, it fosters a number of experiments. Beginning in 2013, there will be a national, voluntary pilot project on bundled payments to providers for 10 conditions.

ACOs. The ACA encourages doctors and hospitals to work together in accountable care organizations (ACOs). If these integrated healthcare delivery organizations can save Medicare or Medicaid money, compared with other ACOs trying to do the same, they will be allowed to share in the savings and will be able to distribute that money among providers (however they determine), including a fee-for-service system. Just how this will work, however, is unclear and will be subject to many pilots, demonstration projects, and experiments over the next few years.

How to Prepare: the Primary Care Bonus

One of the most immediate and direct ways the ACA rewards primary care physicians is with a 10% bonus—what some say is better than nothing and perhaps a start toward something more—to be paid over five years starting this past January.

The advantage of the Medicare Primary Care Incentive Program (PCIP) is that most physicians won't have to file additional paperwork, increase documentation, or jump through other bureaucratic hoops to receive the money. They will receive the money automatically depending on the specialty designation they used to enroll in Medicare. (Eligible designations are "08," family practice; "11," internal medicine; "37," pediatrics; and "38," geriatrics.) In addition, at least 60% of their Medicare billings must be for certain primary care services. (The law defines eligible primary care services as office/outpatient visits, CPT 99201-99215; nursing facility services, CPT 99304-99318; domiciliary, rest home, or custodial care services, CPT 99324-99340; and home services, CPT 99341-99350.)

Check your Medicare contractor's Website to see if you were deemed eligible for the bonus based on 2009 Medicare charges. Physicians new to Medicare this year may have to wait until 2012 to begin receiving bonuses. If a physician whose name isn't listed believes he or she should be eligible based on previous billings, professional societies recommend that that physician call his or her Medicare contract administrator. Each contractor's Web address can be found through the CMS website at <http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

CMS estimates that about 60% of general internists and 80% of family physicians will qualify for the bonuses. The bonus is equal to 10% of the Medicare-paid portion (i.e., 80% of the charge) of a primary care health professional's allowed charges under Medicare Part B for primary care services billed starting Jan. 1, 2011, and continuing through Jan. 1, 2016. ACP estimates that the average general internist who receives approximately \$200,000 in annual Medicare revenue may receive about \$12,000 to \$16,000 during the bonus year, depending on the mix of services and the amount of Medicare-allowed charges.

A check will come after each year quarter; and CMS has stated that bonus payments will be made promptly, the first arriving sometime after March 31. Because the bonus will be issued as separate checks, consultants recommend that billing and office personnel, who may not be aware of the program, be alerted to look out for the checks.

The law also permits HHS to employ other payment methods, like partial capitation, in lieu of a shared-savings model.

Paying for quality but not poor quality. The ACA will reduce physicians' Medicare payments beginning in 2015 if they do not participate in the PQRS. By 2013, CMS's "Physician Compare" Website will contain PQRS information on physician performance.

How to Prepare

Coping with the rollbacks, stresses, complexities, and uncertainties of physician payment under health reform is driving some physician groups to sell their practices to hospitals and health systems, calculating that these businesses will have the deep pockets needed to weather this reimbursement uncertainty. Others are counting on their substantial investment in EHRs to prepare them for future reimbursement rules while allowing them to maximize billings and collections now, staying afloat independently. Still others are hoping that grants and demonstration projects will buy them time and resources.

Nonetheless, it is clear that the days of doctors' practicing medicine without regard to costs and charges will be over. Instead, they will have to become keenly aware of their costs, outlays, and remunerations, consultants say, not only so they can make do with less, but also so they can charge third-party payers and patients competitive amounts today and manage risk contracts tomorrow.

The new reimbursement rules mean that doctors have to stop thinking of medical care as dispensed in discrete packages for which they can charge. "The answer always has been that if we can't get reimbursed for it, then we can't do it. That mindset has to change," says William "Marty" Martin, PsyD, MPH, professor at DePaul University's College of Commerce in Chicago and a faculty member for the ACPE.

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