CMS May Hike Physician Pay for Cognitive Services

The proposed changes, the result of a 5-year review by CMS, would take effect January 2007.

BY MARY ELLEN SCHNEIDER
New York Bureau

A new proposal from the Centers for Medicare and Medicaid Services could result in a better bottom line next year for physicians who spend a lot of time on evaluation and management services.

CMS officials are seeking to increase the work component for relative value units (RVUs) for a number of evaluation and management service codes. For example, Medicare is proposing to increase the work RVUs for the commonly used established office visit codes 99213 and 99214. The proposed changes, which are the result of a mandatory 5-year review by the CMS, would take effect in January 2007.

The proposed rule, issued on June 29, also calls for changes in the practice expense methodology that would involve the use of practice expense survey data from eight specialties—including cardiology, dermatology, and gastroenterology—to better calculate the costs incurred by physicians. These changes would begin in January but would be phased in over 4 years.

To pay for the proposed increases in reimbursement, the CMS is required to impose across-the-board cuts in work RVUs. This could mean payment cuts for physicians who provide fewer evaluation and management services.

Moreover, the expected increase for primary care physicians could be offset by the end of the year if physicians are unable to get a temporary fix to the sustainable growth rate formula, which is expected to cut physician payments under Medicare by nearly 5%.

"The CMS proposal reinforces the urgent need for Congress to act to stop the Medicare physician payment cuts and ensure that payments keep up to practice costs," Dr. Cecil Wilson, AMA board chair, said in a statement.

Dr. J. Leonard Lichtenfeld said the proposed changes to evaluation and management services would help address the underfunding of primary care. Dr. Lichtenfeld, a medical oncologist, is the American College of Physicians' representative on the Relative Value Update Committee (RUC) of the American Medical Association. The RUC is a 29-member multispecialty committee that makes recommendations to the CMS annually on payment issues.

But although these changes go a long way in helping struggling physicians, it's not a complete solution, Dr. Lichtenfeld said, because it doesn't solve the underlying problem of inadequate funds in Medicare. "Someone's got to be there to be the captain of the ship," he said.

Primary care physicians aren't the only ones who will benefit from the increases for evaluation and management codes, he noted. Surgeons will see some benefit because of increases for surgical postoperative care, as well as physicians in cognitive specialties such as neurology, he said.

For Dr. Douglas Leahy, an alternate delegate to the RUC for the ACP and a general internist, the proposed increases would mean the chance to spend more time with patients. Dr. Leahy, who works in a large multispecialty practice in Knoxville, Tenn., said that with better reimbursement for evaluation and management services, he could devote more time to important areas such as diabetes prevention or counseling family members of an Alzheimer's patient.

Gauging the Impact

At press time, ACP officials were still calculating the financial impact of the changes for internists. But a rough estimate based on the CMS proposal shows that internists could see a $4,000-$6,000 increase in revenue in 2007 depending on the services they provide, said Brett Baker, ACP's director of regulatory affairs.

Some specialty societies have complained about the way practice expense changes were calculated, using recent data from only some societies.

CMS estimates in its proposed rule that internists will see an increase of about 5% in allowed charges in 2007 based on the combined impact of both work and practice expense RVU changes.

The changes also were praised by other primary care specialties. If finalized as proposed, the evaluation and management increases would be good news for family physicians, according to Dr. Thomas Felger, the American Academy of Family Physicians' representative on the RUC. The two main evaluation and management codes used by family physicians—99213 and 99214—are set to increase an average of about 10% in 2007, Dr. Felger said.

Ultimately the impact for physicians could be greater than estimated by the CMS, since private payers generally adopt the RVUs established by CMS, Dr. Felger said.

Dr. Felger, associate director of family medicine residency at St. Joseph's Regional Medical Center in South Bend, Ind., said the AAFP and a number of the other cognitive specialties had been pushing for these changes over the last few years. The work involved in an evaluation and management visit is much different from 10 years ago, when the CMS last made changes to how it values those services, he said.

For example, more preventive care is provided to Medicare patients and it's almost routine for a Medicare patient to have three chronic illnesses. The AAFP and others wanted the work RVUs to reflect the new requirements being placed on physicians, he said.

The proposal "recognizes that an office visit is more intense and more complex than it was 10 years ago," Dr. Felger said.

Specialty Societies Speak Out

Although primary care groups have expressed support for the CMS proposal, some specialties are complaining about the way the practice expense changes were calculated. The agency put out a notice asking various specialties to submit their own data for consideration by CMS. One member of the Practicing Physicians Advisory Council, which advises the CMS on issues affecting physicians, took the agency to task at the council's May meeting for allowing only some specialties to submit new data.

"I am more than a little frustrated that there [already] was a data set which admittedly was old, but it was collected from all specialties at the same time," said Dr. Tye Ouzounian, an orthopedic surgeon from Tarzana, Calif. "Now some specialties have selectively submitted new data, which is 10 years newer, which is probably going to be more extensive. Those societies are being allowed to use new data, whereas other societies were not allowed to use new data, and that's not fair."

The only way to make things fair, he continued, "is to allow all societies to participate equally on the same footing with the same survey at the same time. To cherry-pick data that are 10 years newer from 4 or 7 specialties is not fair to the groups that didn't do it."

Don Thompson, senior technical advisor to the CMS, said that although he had heard similar comments from specialty societies that didn't participate in the survey, "we also received comments from those specialty societies that did do surveys. The thrust of their argument is that other medical specialty societies had an opportunity to do surveys and chose not to, and their assumption was those societies felt the value they had was correct."

Mr. Thompson added that the agency had invited all the specialty societies to do surveys, "and we had criteria ahead of time about what we would [need] to accept surveys. The surveys that were done that met the requirements—random surveys, internally consistent—we had proposed to use them on that basis." Ideally, he said, "we would like to see more recent survey data for all specialties."

TALK BACK

How optimistic are you about plans to boost Medicare payments for evaluation and management services?

Weigh in at www.rheumatologynews.com
We look forward to hearing from you!

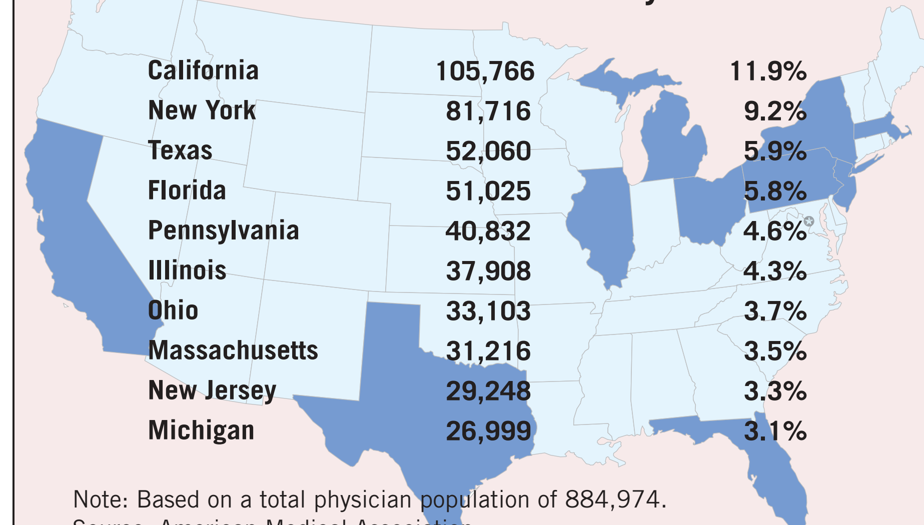
Dr. Ouzounian noted that the American Medical Association was discussing coordinating a survey of practice expenses for a large number of specialties. Mr. Thompson seemed receptive to that idea. "We would be supportive of the AMA going out and doing a survey, and if the data that resulted are better than what we have now, we'd want to incorporate that into our methodology," Mr. Thompson said.

Although the increased payments for evaluation and management services and surgical postoperative care are needed, they are accompanied by an average 5% across-the-board cut in payments, according to the AMA. That cut is the result of the budget neutrality adjustment that the CMS is required by law to make whenever changes in RVUs cause an increase or decrease in overall physician fee schedule outlays of more than $20 million. The proposed work RVU changes are estimated to increase expenditures by about $4 billion, according to the CMS.

The proposal was published in the June 29 issue of the Federal Register. The CMS is accepting comments until Aug. 21. ■

The proposed rule is available online at www.cms.hhs.gov/PhysicianFeeSched. Senior editor Joyce Frieden contributed to this report.

DATA WATCH



RICHARD FRANKI/ELSEVIER GLOBAL MEDICAL NEWS