

# THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

## Increase in Medicare Fees Will Not Abolish Your Financial Woes

Physicians were granted a last-minute reprieve by the Centers for Medicare and Medicaid Services (CMS) when a regulation issued by the agency on February 26, 2003, quashed the expected 4.4% reduction in payments for services rendered to Medicare patients. Instead, reimbursements went up by an average of 1.6% as of March 1, 2003. More precisely, the physician fee conversion factor (CF) increased 1.6%. This is a dollar amount used to calculate reimbursement for each of 7,000-plus health care services and procedures included in the Medicare Physician Fee Schedule (MPFS).

"I would have bet everything I owned that this would never happen," says John W. McDaniel, president and

CEO of Physician Management Group, Inc., based in New Orleans, La. "It just shows you how wrong we can all be. The enactment of this legislation represents a huge lobbying victory for physicians."

Late this past December, CMS administrator Tom Scully reluctantly announced a 4.4% reduction in the CF—the second negative update in two years. At the same time, the agency reported that total physician spending would rise by an estimated 2% in 2003. "Nothing would make us happier than to not be issuing this rule today," he admitted, adding that an increase of 1.6% would be an accurate update. The decrease resulted from a defective formula used in the construction of the MPFS. However, because Medicare law specifies the formula, only Congress could mend the problem. And it did provide a temporary fix within its Consolidated Appropriations Resolution, 2003 (CAR), the law that delineates how the federal government will parcel out funds during the year.

The CAR does not stipulate the 1.6% hike, according to a CMS spokesperson. Rather, it allows the CMS to recalculate the current sustainable growth rate (SGR) by making retroactive corrections to the SGRs for 1998 and 1999. Essentially, the SGR is a percentage that is com-

puted annually to predict how much more Medicare will likely spend on physicians' fees in the upcoming year. For example, if the SGR for 2003 is 6%, the US government expects to pay up to 6% more than it did in 2002. Used to keep total payments for physicians' services in check, the SGR is based on cumulative actual and anticipated disbursements from April 1, 1996, through December 31 of the most recent year. If the American government spends more in a calendar year on physicians' services than it predicted, the update to the physician fee schedule is lowered. If the entire outlay is less than had been projected, the update is raised.

"The corrections we have made to the formula will have a positive impact not only in 2003, but for future updates," Scully optimistically predicted in announcing the unexpected increase to the MPFS. "More importantly, this rule restores the confidence of physicians and patients that the federal government will be a fair partner in the Medicare program."

### Check the schedule

Claims for services performed in January and February of this year are being reimbursed at the 2002 rates. However, those processed after February 28, 2003 are initially being paid at the higher 2003 value. This

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## Bolster Your Practice Income in an Era of Diminishing Returns

Despite a modest improvement in Medicare reimbursement, physicians are coping with numerous threats to their financial well-being. Among these are the skyrocketing costs of health and malpractice insurance, delayed payments by third-party payers, mounting accounts receivable, and increased scrutiny by the Office of Inspector General (OIG) for the US Department of Health and Human Services. Of course, you can also anticipate a boost in routine costs—say, the annual salary increases your employees expect to receive. Given that the situation isn't expected to improve any time soon, you should soon learn how to prevent unnecessary losses.

A common conditioned response to tough economic times is to diminish operating expenses, even if this means passing up business improvement opportunities. While this may be the quickest and most effective short-term strategy for easing cash flow, you can inadvertently stunt the growth of your practice.

The most prosperous medical practices continually focus on five key areas for improvement: reimbursement systems, billing and collection processes, management of accounts receivable, operations improvement, and practice growth. Specifically, these practices look at issues such as better coding compliance, favorable contract negotiations with managed care companies, quicker turnaround of denied claims, increased patient volume, and improved quality of care. Several helpful measures to achieve such goals are discussed in this month's cover article. Flourishing medical practices also think about ways to improve their employees' skills. For example, a past article in the *Physician's Compliance Alert* discussed the potential benefits of having a coding authority on staff. See "Does Your Office Need a Certified Coder? The Experts Say Yes," on our Web site (see page 8).

In our current issue, we clarify the considerations involved in incident-to billing. Correct use can increase reimbursements. However, because incident-to billing is so easily confused or mishandled, the OIG has, within its 2003 Work Plan, declared its intent to closely examine these claims. We also answer some pressing questions for readers, and perhaps you've wondered about these matters as well. Or, if you have your own queries, pass them on to us at our Web site and we'll do our best to track down the answers.



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# Incident-to Billing Confusion: Are You Losing Revenue or Risking an Audit?

Physicians are increasingly employing nonphysician practitioners in today's cost-conscious health care environment, thereby allowing the doctors who hired them to be more efficient, to boost practice revenues, and to see more patients.

Billing for these practitioners' services has caused considerable confusion, however. The reason for the problem is traceable to a change from the Centers for Medicare and Medicaid Services (CMS), which states that nonphysician practitioners such as physician assistants (PAs), nurse practitioners (NPs), certified nurse specialists, and certified nurse midwives can bill their services under the physician's name and number if certain requirements are met. These "incident-to" claims are reimbursed for 100% of the doctor's fee rate.

Medicare defines "incident to" as services or supplies that are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Examples of supplies that might be used by physicians while providing care are gauze, ointments, or oxygen. The only items covered are those that represent a practice expense, so you cannot charge for a drug that is bought by the patient and brought into the office for administration.

The most common example of an incident-to service is an injection given by a registered nurse (RN). Incident-to services can also include any care that state laws allow nonphysician health care professionals to perform without direct physician supervision. Any such treatment is categorized as incident to a physician's professional services if a physician oversees it. In these cases, claims

are prepared with the physician's name and identification number, just as if the physician provided the service. Without direct physician supervision, the same services are billed with the nonphysician practitioner's name and identification number. Reimbursement for services billed in this manner is generally 85% of the amount specified in the Medicare Physician Fee Schedule. In several states, payment is 75% of what a physician would receive. Obviously, the difference in reimbursement can be significant if your practice is not using incident-to billing when appropriate.

Unfortunately, the system is rife with opportunities for errors and misuse. Because of extensive abuse, the Office of Inspector General (OIG) for the US Department of Health and Human Services set down its intention to investigate incident-to billing in its General Work Plans for fiscal years 2002 and 2003. The agency will continue to evaluate the conditions under which physicians bill incident-to services and supplies. There is even speculation that incident-to billing may soon be eliminated, since it is easily misused. If this happens, the only incident-to service permitted would probably be billing of the evaluation and management (E&M) code 99211 by an RN who briefly provides care to an established patient with an already diagnosed ailment during an office or other outpatient visit. Otherwise, if Medicare does eliminate incident-to billing,

nonphysician practitioners would be required to bill all services that they provide using their own names and identification numbers, thus earning the partial reimbursement rate.

## Billing by the book

"There are two requirements that incident-to claims must meet," says Thomas Loughrey, CEO of Economedix, based in Orange, Calif. "First, the person who provides the service must be legally able to do so under state law. And second, the physician must supervise the practitioner and be immediately available." The physician does not have to be in the room, but must be a few seconds away, he adds. "Blocks away is no good."

So, when an RN gives a patient an injection, for example, or a PA treats a patient for a minor urinary tract infection (UTI), is the service billed as incident to a physician's service or as a service provided by a nonphysician practitioner? The answer depends on whether the physician is in the office at the time. "The mistake would be to have the PA bill for a PA-provided service when the doctor is there. That would mean a loss of 15% of the reimbursement," observes Loughrey.

The service must also be initiated and followed up by the physician, explains Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. "A new patient visit or a new medical

*(Continued on page 4)*

problem for an existing patient cannot be billed as an incident-to service," she says. The physician must first see and evaluate the patient, who is seen later by the nonphysician practitioner.

In another example, a patient is given a new diagnosis of hypertension. The doctor examines the patient and devises a care plan, and the patient reports for regular blood pressure (BP) monitoring and evaluation, to be provided by the NP and reviewed by the doctor. The patient's BP is evaluated a week later by the NP when the doctor is out of the office. Although this is a follow-up service, it should not be filed as an incident-to service because the doctor was clearly absent. The next week, the NP evaluates the same patient's BP when the doctor is in the next room. In this instance, the NP's services can be billed as incident-to exactly as if the doctor had provided it. "This is truly an incident-to service because it is a follow-up visit and the doctor is nearby," Picou points out.

### Room for confusion

"One problem is that there are no guidelines for the use of code 99211, so there's room for confusion," she comments. For instance, a patient calls the physician's office and reports symptoms of a UTI. The doctor is not in the office that day, so the nurse asks the patient to come in and provide a

urine specimen. The nurse gives the patient the specimen cup and explains how to use it, and the doctor later calls in an antibiotic prescription based on the results of the urinalysis. "Some offices bill using 99211 for the nurse's service, but that's incorrect because this was a first-level established patient visit with a new problem," she says. Incident-to billing would also be incorrect because the doctor was not present when the patient was seen. The correct strategy would be to forfeit the E&M fee and simply bill for the urinalysis.

Private insurers don't generally recognize the separate roles of midlevel providers. "As a result, most don't address incident-to billing at all, and the services provided by a nonphysician practitioner are just submitted in the doctor's name," says Picou.

In the past, the nonphysician provider was required to be an employee of the physician. Now, the provider can be someone whose services are leased. The exceptions are personnel who are employees of another company, for example someone employed by a laboratory to carry out services in the doctor's office. These providers cannot submit incident-to claims.

Another sticking point for incident-to billing is the requirement that physicians stay "involved" in the patient's care during the follow-up. "Although this is a criterion for

incident-to billing, 'involved' is not defined specifically," notes Picou.

### The importance of documentation

Certain indications of misuse could spark an audit. Auditors could become suspicious if they received a number of calls saying that the doctor did not actually see the patient for the services provided. "They would also likely look at a provider whose profile demonstrated a higher number of services than could be provided by one provider in the period of time reviewed," says Picou.

"Only a chart audit would show who provided the services," she emphasizes. And as the physician's schedule would indicate whether the doctor was in at the time or not, Picou concludes that good documentation is obviously the optimal way to protect your practice.

"It's critical to document that the doctor is on-site," says Loughrey. There are no specific rules on how to do this, however. The best way is to maintain an accurate schedule that indicates that the doctor saw patients on the day that a nonphysician practitioner provided services. In some practices, the doctor also co-signs and dates the chart after the NP or PA has seen a patient.

The physician who can see just one more patient a day because of nonphysician practitioners can earn extra revenues of \$1,500 a year, notes Loughrey. Such practitioners give doctors a true opportunity to build their practices and to become more cost-efficient. Knowing when these practitioners can bill for services in the doctor's name can boost practice revenues even further.

*Reported and written by Deborah Epstein, in West Milford, NJ. More information on accurate coding is available on our Web site (see page 8).*

## When Can Another's Services Be Billed in the Physician's Name?

Services and supplies that are billed as incident to a physician's service must be:

- An integral but incidental part of the physician's practice;
- Commonly rendered without charge or included in the doctor's bill;
- Frequently provided in physicians' offices or clinics;
- Offered by the physician, another qualifying practitioner, or auxiliary personnel under the doctor's direct supervision.

# Modifier Madness: When Should I Bill for a Technical Component?

**Q:** *Would you please describe proper use of the modifier “-TC”?*

**A:** Three types of services involve both a professional component and a technical component, explains Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. The Centers for Medicare and Medicaid Services (CMS) specifies these as diagnostic tests that require a physician’s interpretation (eg, cardiac stress tests or electroencephalograms), diagnostic and therapeutic radiology services, and physician pathology services. The professional portion of the service encompasses the physician’s work plus the costs associated with doing that work—specifically overhead and professional liability insurance. In contrast, the technical element reimburses for the cost of performing the test, so it takes into account the cost of the equipment as well as factors such as necessary supplies and technicians’ salaries.

If you provide both components of a service, use the appropriate CPT code without any modifier. Physicians providing only the professional component should affix the “-26” modifier to the CPT code; provision of the technical component alone is indicated by attaching “-TC” to the CPT code.

One important point to remember is that physicians providing services to hospital outpatients or inpatients are only allowed to bill for the professional component, Picou says. Hospitals are entitled to the fee for nonphysician services performed on behalf of hospital patients even when the service is carried out in a doctor’s office. Private

insurers may require you to report technical services with the “-TC” modifier or they may have a different method they want you to use. “Reporting and reimbursement policies may vary among insurers, so it is important to familiarize yourself with individual requirements for describing the technical component of a procedure,” Picou advises. “For Medicare beneficiaries, review the fee schedule to determine which codes have a separately billable technical component.”

**Q:** *How should the visit be coded when a physician provides preoperative clearance for an established patient whose surgery will be performed by another physician?*

**A:** In this situation, the physician performing the presurgical examination is acting as a consultant and providing an opinion at the request of the surgeon, according to Picou. Even though the physician has a long-standing relationship with the patient, the visit is coded as a consultation, a service that pays more than an office visit for an established patient. Ensure that the exchange of information is documented in the patient’s chart. For example, you might note: “Mrs. Smith is being evaluated today at the request of Dr. Porter, who plans to perform a total knee replacement and requires an opinion regarding medical stability for surgery.” A copy of the surgical clearance report should be sent to the requesting physician, and then the service should be billed using the appropriate level of consultation code. For more information on this subject, see the article, “Miscoding of Consultations: A Common and

Often Costly Mistake,” which was published in our November 2002 issue and is accessible on our Web site.

**Q:** *I’ve been using the HCPCS code Q0091 to bill Medicare for Pap smears but the claims have been rejected. What V codes should I be using?*

**A:** The CMS stipulates that when filing a claim for a Pap test, you must also report either the ICD-9-CM code V76.2 for patients deemed to be at low risk for cervical or vaginal cancer or the code V15.89 for patients believed to be at high risk. Factors that increase the probability of disease are:

- Sexual activity at ages younger than 16 years.
- Five or more sexual partners in a lifetime.
- History of sexually transmitted disease, including HIV infection.
- Fewer than three negative Pap smears within the previous seven years—or no tests whatsoever during this period.
- In utero exposure to diethylstilbestrol.

Place the appropriate code in column 24E of the CMS-1500 form. All women enrolled in Medicare are entitled to regular Pap smears. The test is covered once every 24 months for those in the low-risk group and once every 12 months for women at high risk of malignancy as well as for those of childbearing age who have had an abnormal Pap smear within the previous 36 months.

*Editor’s note: Readers of The Physician’s Compliance Alert are invited to visit our Web site (see page 8) and submit their questions. Members of our Advisory Board will offer their expert opinions in response.*

July, carriers will request refunds for the difference. Such a cumbersome procedure will soon be discarded—as of July, Medicare's systems will be able to carry multiple fee schedules.

While the boost in the CF is 1.6%, specific fees are going to be affected more or less than that, McDaniel says. That's because several elements are involved in the calculation of each payment, and more than one may change from year to year.

Essential to the equation are so-called relative value units (RVUs).

**The average doctor today is discounting his or her business between 40% and 60%. I've seen it for the last two weeks in all of our annual reviews with our clients.**

**—John W. McDaniel**

The CMS assigns a numeric measure of worth to each of three components pertinent to physician reimbursement, McDaniel explains. One is the RVU for physician work, which remains fairly consistent over time. For example, brain surgery carries more weight than a standard office visit since it involves more intensive labor. The second RVU gauges practice expense; the third, malpractice expense. To adjust for location, each element is multiplied by a geographic practice cost index (the work RVU is also multiplied by a "work adjuster"). The three products are added together and then multiplied by the national CF, which is \$36.79 for 2003. "If the total is one and the CF is \$36.79, then the service pays \$36.79," he continues. "If the combined weight is 0.5, it pays about \$18.40."

"The final RVU for physician work will be pretty much the same, wherever you come from," adds Rhonda Lynn Picou, RN, MSN,

CPC, vice president of physician compliance for the aforementioned Physician Management Group, Inc. "Your office and malpractice expenses are going to vary more, depending on your geographic region and whether tort reform has occurred. If you're living in Steamboat Springs, Colorado, you're going to have higher leases than if you live in Bunkie, Louisiana."

You can estimate the effect of the fee update on your finances. McDaniel and Picou recommend using your billing software to deter-

mine the 20 to 25 CPT codes used most frequently in your practice. You can then go to the MPFSs for 2003 and figure out how much you are likely to receive for the services you commonly provide.

Fee information is available on the CMS Web site at: [cms.hhs.gov/physicians/pfs/](http://cms.hhs.gov/physicians/pfs/). This page will lead you to the carrier specific files where MPFS zip files are listed by state and year. Within each is a text file with fee information and a document explaining how to read it. The text file looks daunting, but reading carefully from left to right you'll note the year, the carrier number, the locality, the relevant code, the non-facility fee schedule amount, and the facility fee schedule amount. You can then compare what you received in 2002 with what you can expect in 2003. Some examples appear in the table on page 7. Keep in mind that states may be divided into more than one locality. For example, Louisiana has one set of

fees for practitioners in New Orleans and another for those in the rest of the state. Similarly, New Jersey is divided into two localities.

### **Buck up your bottom line**

While Medicare is not cutting fees for 2003, you're not going to earn significantly more than you did in 2002. In addition, the CMS is already forecasting a negative update for 2004. It would be wise to look to other prospects for increasing revenue.

"I hate to keep saying it, but it's never going to change: the first opportunity is to improve coding performance," McDaniel emphasizes. "The majority of doctors still tend to under-code." Also, accurate coding reduces denials, which can slow cash flow. Next he advises that you assess your revenue cycle management. How efficient are you at collecting co-payments, annual deductibles, fees for noncovered services, and outstanding balances? "All practices need to do a better job of up-front collections," he remarks.

Follow up aggressively on rejected claims. "If you're in the habit of setting aside denials to get to them when you can, you now have four months instead of six months in which to do so," McDaniel says. "As long as it sits there, you're not getting paid for it. In the days when you got 80% of what you charged, you could better afford sloppy management. The average doctor today is discounting his or her business between 40% and 60%. I've seen it for the last two weeks in all of our annual reviews with our clients. I couldn't stay in business that way. Very few people could."

If that's the case in your practice, then every dollar counts. "The revenue cycle management process has to become compacted," McDaniel continues. "To convert work to cash, you have to do a very good job of collect-

*(Continued on page 7)*

ing what's due you in a much shorter period of time." Practices should also examine their payer mix. "It used to be the more patients, the better," he recalls. "That's not true anymore. If your volume increases mainly among Medicare and Medicaid patients, you can literally work yourself into bankruptcy." Try to market your services to patients with private insurance. Make yourself more visible in the community by speaking to groups or participating in health fairs.

Or, consider target marketing—for example, buy a mailing list that contains local households with incomes over \$30,000 and adults younger than 60 years of age. Put information about your practice in each of those mailboxes. "Of course, expanding your practice appropriately is a longer term strategy," McDaniel notes. To attract younger patients, you should also think about increasing your availability. "If you have a two- or three-week wait, you're going to run off the insured patients," he says. Picou agrees. "You can get more commercially insured patients when you consider hours other than 8 am to 5 pm, Monday through Friday," she observes. "Younger patients may not want to leave work for a problem that isn't urgent. Retired patients usually don't care when they come." Seeing patients late one evening or on Saturday mornings is a useful alternative to a traditional schedule.

Make sure you're taking advantage of Medicare's willingness to pay for preventive services, Picou suggests. In fact, the fee for administering vaccines has increased significantly. Send out reminders for yearly influenza shots or when applicable, pneumococcal pneumonia vaccines.

"A lot of internists have stopped doing pelvic exams, prostate exams, and prostate-specific antigen testing," Picou points out. However, Medicare

## A Tale of Two Conversion Factors<sup>1</sup>

CPT Code <sup>2</sup>	Fee, 2002 New Orleans	Original Fee, 2003 New Orleans -4.4%	Revised Fee, 2003 New Orleans +1.6%	Fee, 2002 Northern NJ	Original Fee, 2003 Northern NJ -4.4%	Revised Fee, 2002 Northern NJ +1.6%
99203	90.44	85.77	91.21	102.18	96.82	102.96
99214	77.17	73.42	78.08	88.29	83.95	89.28
99223	149.61	141.66	150.64	164.27	155.32	165.17
99232	53.03	50.35	53.54	58.37	55.37	58.88
99244	161.85	153.68	163.42	181.89	172.57	183.52
93000	24.64	23.87	25.39	29.04	28.16	29.95
90471	3.89	6.98	7.42	4.63	8.55	9.09
90472	3.89	5.02	5.34	4.63	6.08	6.46
71020	32.73	31.93	33.95	38.61	37.32	40.11
76700	108.85	106.96	113.74	127.92	125.95	133.94
52204	303.65	266.31	283.19	361.89	315.70	335.72
43235	310.63	279.51	297.24	371.11	332.76	353.86
45300	61.89	58.81	62.54	73.98	70.28	74.74
G0108	56.57	27.25	28.98	71.14	34.14	36.30
G0109	33.30	16.13	17.16	41.77	20.11	21.38

1. All fees are in dollars.

2. Code 99203, new patient visit, level 3; 99214, established patient visit, level 4; 99223, hospital admission, high-complexity; 99232, subsequent hospital care, moderate complexity; 99244, office consultation, moderate complexity; 93000, routine ECG with at least 12 leads (with interpretation and report); 90471, immunization administration, one vaccine; 90472, each additional vaccine; 71020, chest x-ray, 2 views; 76700, complete abdominal ultrasound; 52204, cystourethroscopy, with biopsy; 43235, diagnostic upper gastrointestinal endoscopy, with or without specimen collection by brushing or washing; 45300, diagnostic rigid proctosigmoidoscopy, with or without specimen collection by brushing or washing; G0108, diabetes outpatient self-management training services, individual, per 30 minutes; G0109, diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

pays for these services, and patients may prefer to come to you for this care. "Don't refer all these things out," she says. "Keep that revenue within your practice. Women go to the obstetrician-gynecologist and wait for hours because their doctor had to deliver a baby. It may be that the patient would gladly say, sure, if you can do it all when I come in and see you, I don't have to go over there and wait."

"Think about how you can accom-

modate your primary market, which is the insured patient," McDaniel concludes. "It's the same way retail business is done. In Manhattan, they have 24-hour Gap stores. It's a 24-hour city. I think practices have to be more accessible to the paying patient because that patient population is shrinking. That's how you start being better than the competition."

*Written and reported by Cynthia Starr, editor. For more information on the MPFS, go to our Web site (see page 8).*

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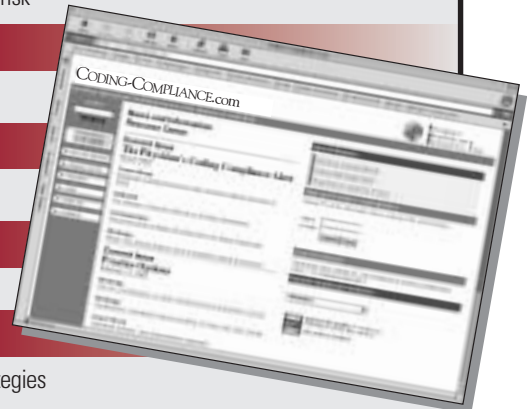
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Late this past December, CMS administrator Tom Scully reluctantly announced a 4.4% reduction in the CF—the second negative update in two years. At the same time, the agency reported that total physician spending would rise by an estimated 2% in 2003. "Nothing would make us happier than to not be issuing this rule today," he admitted, adding that an increase of 1.6% would be an accurate update. The decrease resulted from a defective formula used in the construction of the MPFS. However, because Medicare law specifies the formula, only Congress could mend the problem. And it did provide a temporary fix within its Consolidated Appropriations Resolution, 2003 (CAR), the law that delineates how the federal government will parcel out funds during the year.

The CAR does not stipulate the 1.6% hike, according to a CMS spokesperson. Rather, it allows the CMS to recalculate the current sustainable growth rate (SGR) by making retroactive corrections to the SGRs for 1998 and 1999. Essentially, the SGR is a percentage that is com-

puted annually to predict how much more Medicare will likely spend on physicians' fees in the upcoming year. For example, if the SGR for 2003 is 6%, the US government expects to pay up to 6% more than it did in 2002. Used to keep total payments for physicians' services in check, the SGR is based on cumulative actual and anticipated disbursements from April 1, 1996, through December 31 of the most recent year. If the American government spends more in a calendar year on physicians' services than it predicted, the update to the physician fee schedule is lowered. If the entire outlay is less than had been projected, the update is raised.

"The corrections we have made to the formula will have a positive impact not only in 2003, but for future updates," Scully optimistically predicted in announcing the unexpected increase to the MPFS. "More importantly, this rule restores the confidence of physicians and patients that the federal government will be a fair partner in the Medicare program."

### Check the schedule

Claims for services performed in January and February of this year are being reimbursed at the 2002 rates. However, those processed after February 28, 2003 are initially being paid at the higher 2003 value. This

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