AES 2013
Practice Management Course

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Outline

- The New Era of Health Care Financing
- 2014 Medicare Conversion Factor and SGR
- 2014 CPT Code Changes
- EHR discussion of what might be useful to members

Challenges in 2014

- CMS is required by law to cut the Conversion Factor on January 1, 2014 to maintain budget neutrality.
- Conversion Factor cut in 2014 is scheduled to be 23.7% to $27.0006 unless Congress changes the law as it has done annually since 2002.
- ICD-10 to begin on October 1, 2014
- Stage II Meaningful Use (Advanced Clinical Processes) will begin for all providers who have been in Stage I Meaningful Use (Data Capture and Exchange) for 1-2 years
- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_EPs_9_23_13.pdf
- Stage III Meaningful Use (Improved Outcomes) has been delayed by 1 year until 2017
- http://www.cms.gov/eHealth/ListServ_Stage3Implementation.html
- Four year roll out of new practice expense payments, 2010-2013, has ended

The Medicare Fee Schedule

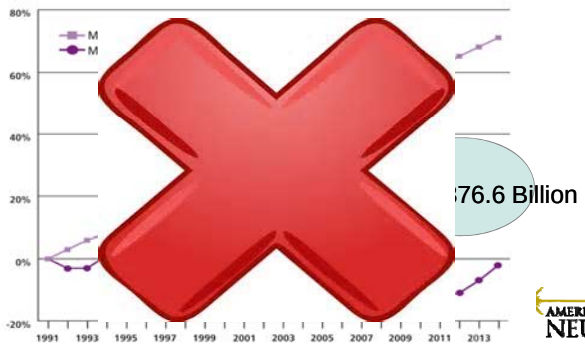
- In 2009, the Neurology Member Census showed 37% of Neurology patients are 65 and older and are thus on Medicare
- Medicare Fee Schedule is an open process
  - Private payers use a closed process but base payments on Medicare
- Codes are defined by the AMA CPT Editorial Panel
- Codes are given a relative work value (RVU) by the AMA RBRVS Update Committee (RUC) as a recommendation to CMS
- CMS reviews RUC values and assigns RVU (~90% unchanged from RUC)
- CMS publishes annual Conversion Factor (CF)
- Medicare payment formula is RVU x CF = Payment
- Annual Medicare payment determined by Sustainable Growth Rate

Sustainable Growth Rate (SGR)

- Law passed in 1997, requires Medicare payments to follow a formula linked to the cost of medical care, MEI
- Medicare Economic Index (MEI) is a conservative government estimate of the rate of inflation of medical care
- Annual overrides have prevented decreased payments to physicians since 2002, but the law has not been changed so the deficit keeps building
- The 2014 CF will be $27.2006 to comply with SGR, a cut of 23.7% unless Congress overrides the cut.
- Proposed 2014 one year override would have a Conversion Factor of about $35.64
- Total cost of repeal of the SGR has dropped to $153.2 billion over 10 years, down from the peak estimate in 2012 of $376.6 billion over 10 years
- Congress is working to override the cuts. Where will the money come from?
  - Likely targets are cuts to provider-based payments, hospitals, and medical education funding

SGR Annual Override

- On January 1, 2014, the Medicare Conversion Factor is scheduled to drop 24% unless Congress intervenes.
  - Congress has intervened annually since 2001 but all this has done has been to push the repayment down the road



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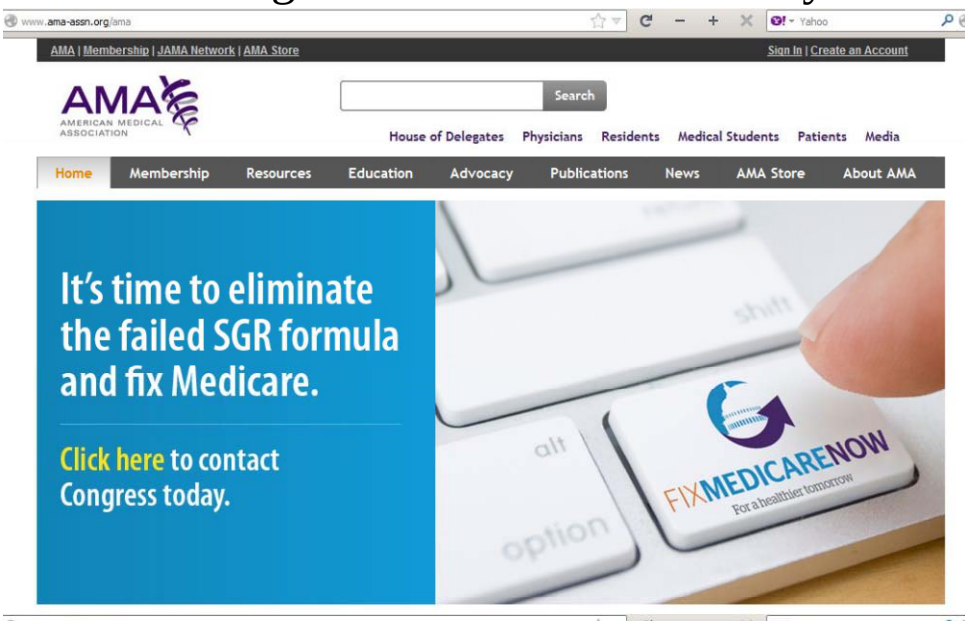
Making Your Voice Heard is Easy

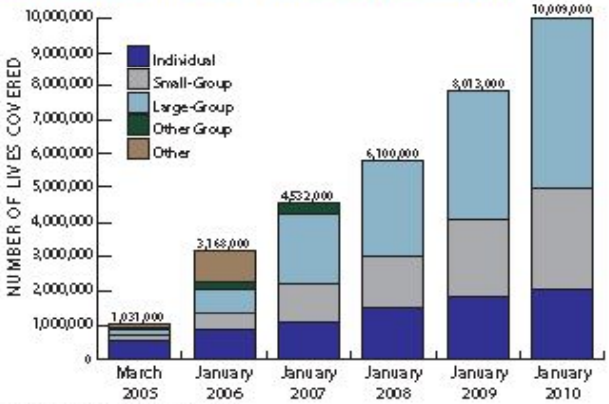


Why has the cost of the SGR fix gone down?

- SGR is linked to the Medicare Economic Index.
- Health care inflation has decreased primarily due to the recession
- A major factor has been the marked increase in insurance policy deductions and in copayments
- 50 Million Americans without insurance, many with poor insurance/Medicaid, and cannot afford care
- A progressive trend to deny inpatient payments by classifying patients as outpatients
- CMS 30 day readmission penalty
- Shifts to outpatient procedures
- Decreases in advanced imaging technical payments by changing the work formula from a 50% use to a 90% use during a 48 hour work week
- Rise of generic drugs

The Rise of HSAs

FIGURE 1.
Growth of HSA/HDHP Enrollment from March 2005 to January 2010



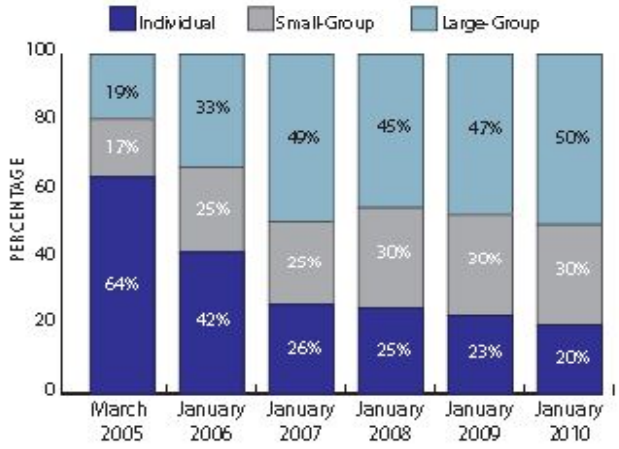
Source: 2010 AHIP HSA/HDHP Census

1 For 2010, the minimum annual deductible for self-only HSA/HDHP coverage is $1,200, and the maximum out-of-pocket limit is $5,950. For family HSA/HDHP coverage, the minimum deductible is $2,400, and the maximum out-of-pocket limit is $11,900. These amounts are indexed annually for inflation.

2 AHIP Center for Policy and Research, A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007 (November 2007). (http://www.ahipresearch.org/pdfs/HSA_PreventiveSurvey_Final.pdf)

Distribution of HSAs by Purchaser Type

FIGURE 2.
Percentage of Lives Covered by an HSA/HDHP, by Market Type

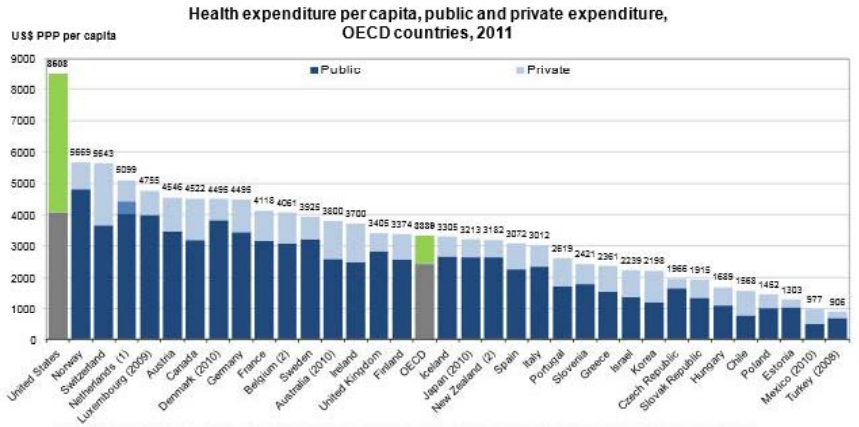


Sources: 2005–2010 AHIP HSA/HDHP Census Reports

Are HDHPs the driver of lower spending?

- HDHP are promoted as bringing market forces to health care
- But healthiest 50% of population consumes on 3% of health care $
- Sickest 5% of population consumes about 50% of health care $
- Sickest 20% of population consumes about 80% of health care $
- “HDHPs can undermine the basic purposes of health insurance: to reduce financial barriers to needed care and protect against financial hardship.”, Karen Davis et al, Commonweath Fund, 2005

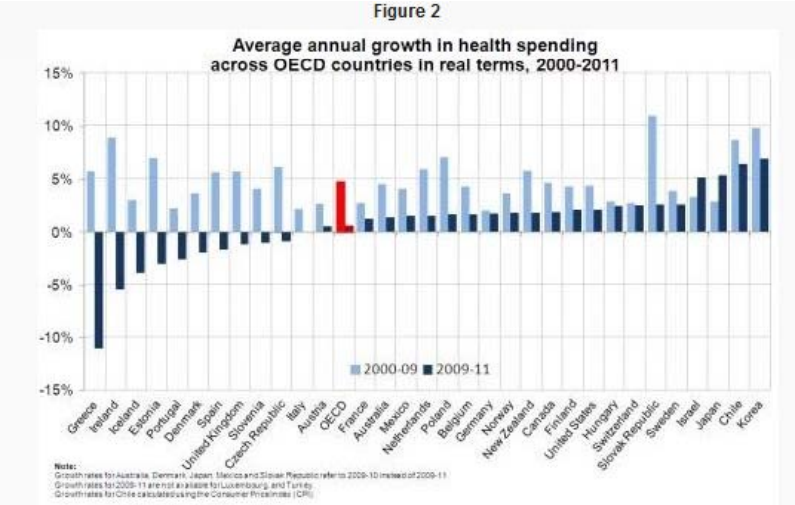
Government Health Care Spending Alone Exceeds Average OECD total Spending



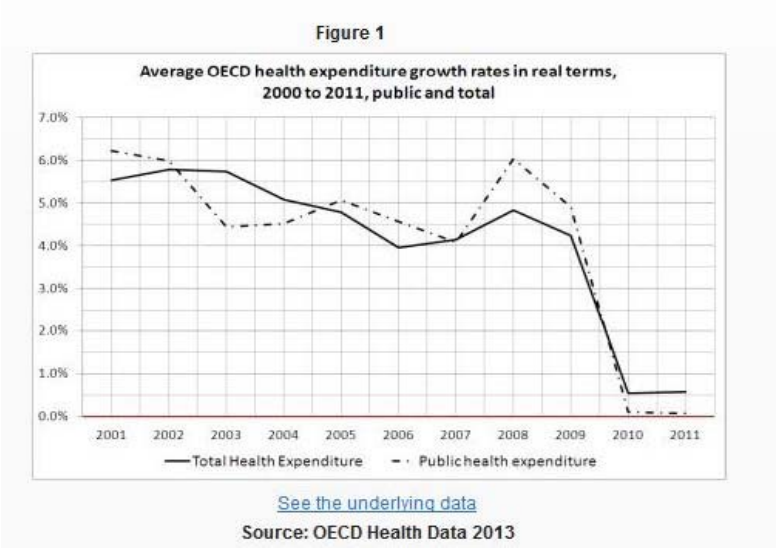
1. In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditures related to capital expenditure.
2. Total expenditure excluding capital expenditure. Source: *OECD Health Data 2013*, June 2013.

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

Why has the cost of the SGR fix gone down? Is it Obamacare?



Why has the cost of the SGR fix gone down? The real reason, "it's the ecomomy, stupid"



Why has the cost of the SGR fix gone down? II

A.See:

B.http://thehealthcareblog.com/blog/2013/12/06/is-obamacare-responsible-for-the-recent-slowdown-in-health-care-costs/

A.http://thehealthcareblog.com/blog/2012/05/08/barking-up-the-wrong-tree-affordability-not-cost-growth-is-the-policy-challenge/

All Physicians are not Paid the Same, I

- New since 2011: some physicians are paid more by specialty
- Primary Care Incentive Payments (PCIP) now in place, 2011-2015
- Primary care physicians are paid a 10% bonus for non-hospital E&M visits.
- The payments are paid quarterly to primary care physicians.
- Does not apply to neurologists despite the attempts of the AAN to include neurologists.
- APRN/PA payments are 85% of the rate that physicians are paid, but for a primary care APRN/PA, with the 10% bonus, their payment for the same level of service is 93% of what a specialist would receive for the same service, say for CPT code 99213.

2007-8 Physician Practice Information Survey redistributed practice expenses

- Average physician spends 2200 hours per year on patient care over 50 weeks
- Total direct and indirect office expenses are
  - $116.96/hr for average doctor
  - $127.21 for average neurologist
  - Overall, there is a 3% increase in practice expense for neurologists
- Four year roll out of new practice expense payments 2010-2013 is now over
- Equipment is assumed to be used 50% of the time in a 48 hour work week except for CT/MRI which is assumed to be used 90% of time
- Increases in practice expense limited by budget neutrality resulting in decrease in the conversion factor and decreased payments for professional services

All Physicians are not Paid the Same, II

- Your type of practice and the site of service determines how you will be paid
- In private offices, payments are global
- In medical centers, payments to physicians are for professional fees only
  - Technical payments by HOPPS as APCs to medical center
  - Same applies to patients seen in emergency rooms and observation patients who are not admitted and are subject to outpatient copays
- For inpatients, payments to physicians are for professional fees only
  - Technical payments are bundled IPPS as DRGs paid to hospital

CPT Medicare Payment Relative to Site of Services

- Inpatient care:
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid by DRG to hospital using IPPS (DRG values based upon hospital cost reporting) Top-down methodology
- Outpatient care: Provider-based billing
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid to medical center using HOPPS (APC charges based upon hospital cost reporting averaged for all procedures in the APC) Top-down methodology
- Outpatient care: private office
  - Professional fee bundled with technical payment, so-called global billing using CMS MFS largely following RUC recommended values. Bottom-up methodology

2007-8 Physician Practice Information Survey redistributed practice expenses

		Indirect Expenses			Direct Expenses		
Specialty	**Total Practice expense/hour**	**Office expense**	**Clerical Payroll**	**Other Expense**	**Medical supplies**	**Medical Equipment**	**Clinical Payroll, can't bill independently**
Average all MD/DOs	$116.96	$46.38	$28.03	$11.95	$7.47	$4.77	$18.36
Neurology	$127.21	$64.68	$35.95	$9.76	$3.10	$2.74	$10.98
Highest (Repro Endocrinology)	$350.65						
Lowest (Psychiatry)	$32.10						

How to Improve Your Net Revenue, I

- Control costs
- Control costs
- Control costs
  - Rent, supplies, staff each need to be scrutinized

How to Improve Your Net Revenue, II

- Check to make sure that your staff is not stealing from you
  - If it involves money, someone will try and take it from you
  - Set up checks & balances for for all processes involving money
    - Always have two people handling money
- Nearly 83% of 688 practice managers were affiliated at some point with medical offices where employee theft occurred (MGMA Survey 11/5/2010)
- Nearly 45% of practice managers reported cash stolen before or after it was recorded on the books.
- Profile of the embezzler: first one in, last to one to leave, never takes a vacation, stops by on weekends, very friendly and helpful; be suspicious of those who have a gambling habit

2014 MFS for Neurology Services*

*Assuming conversion factor of $35.6446

- 95812, EEG 41-60 minutes
  - Total RVU: 12.11; -9%
  - PE: 10.96 RVU; -10%, $373.91, -5.91%
  - Professional: 1.62 RVU, -1%; $58.10, +4.13%
  - Physician Work (wRVU): 1.08, No change
- 95813, EEG > 1 hour
  - Total RVU: 14.17, -7%
  - PE: 12.33 RVU, -8%; $412.41, -4.40%
  - Professional: 2.60 RVU, -1%; $92.68, +3.57%
  - Physician Work (wRVU): 1.73, No change

2014 MFS for Neurology Services*

*Assuming Conversion Factor of $35.6446

- 95816, Awake EEG
  - Total RVU: 9,90, -19%
  - PE: 8,74 RVU, -21%; $294.78, -17.95%
  - Professional: 1.63 RVU, -1%; $58.10, +2.86%
  - Physician Work (wRVU): 1.08, No change
- 95819, Awake and Asleep EEG
  - Total RVU: 11.30, -20%
  - PE: 10.15 RVU, -21%; $354.04, -18.15%
  - Professional: 1.62 RVU, -2%; $57.74, +2.86%
  - Physician Work (wRVU): 1.08, No change

2014 MFS for Neurology Services*

*Assuming Conversion Factor of $35.6446

- 95822, Sleep EEG
  - Total RVU: 12.55, +22%
  - PE: 8.92 RVU, -22%; $301.20, -18.78%
  - Professional: 1.62 RVU, -2%; $54.75, +2.86%
  - Physician Work (wRVU): 1.08, No change
- 95824, EEG for Brain Death
  - Practice Expense: none (IPPS only)
  - Professional: 1.14 RVU, -1%; $40.63; +3.86%
  - Physician Work (wRVU): 0.74, No change

2014 MFS for Neurology Services*

*Assuming Conversion Factor of $35.6446

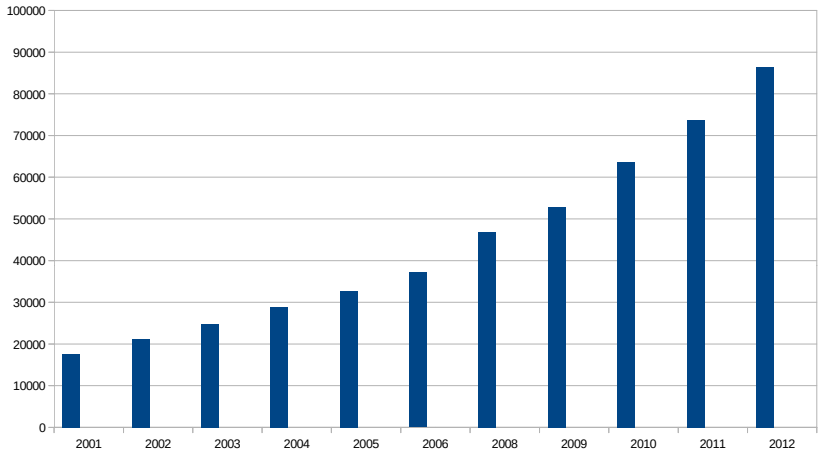
- 95827, Overnight EEG
  - Total RVU: 23.88, +21%
  - PE: 20.55 RVU, -9%; $717,53, -5.13%
  - Professional: 1.63 RVU, -1%; $58.10, +3.50%
  - Physician Work (wRVU): 1.08, No change
- 95829, Surgery Electrocorticogram
  - Total RVU: 57.96, +18%
  - PE: 45.46 RVU, -12%; $1520.60, -8.25%
  - Professional: 9.20 RVU, -2%; $327.93, +2.98%
  - Physician Work (wRVU): 6.20, No change

2014 MFS for Neurology Services*

*Assuming Conversion Factor of $35.6446

- 95950, Ambulatory Cassette EEG, unattended (Old Oxford Medilog)
  - Total RVU: 10.28, +17%
  - PE: 7.75 RVU, -11%; $252,36, -6.93%
  - Professional: 2.28 RVU, -1%; $81.27; +3.41%
  - Physician Work (wRVU): 1.51, No change
- 95951, 24 Hour Video EEG
  - Practice Expense: *Carrier-defined technical expense
  - Professional: 9.24 RVU, +2%; $329.36, +2.98%
  - Physician Work (wRVU): 5.99, No change
  - Hospital coders: use 89.19 for inpatient coding

2001-2012 Claims for 95951, RUC database



2014 MFS for Neurology Services*

*Assuming Conversion Factor of $35.6446

- 95953, 24 hour automated computerized digital EEG, unattended
- Use this code for all uses of computerized digital EEG +/- video
  - Total RVU: 13.03, +3%
  - Practice Expense: 8.87 RVU, -9%; $266.98, -5.69%
  - Professional: 4.63 RVU, -3%; $165,03, +2.99%
  - Physician Work (wRVU): 3.08, no change
- 95956, 24 Hour attended EEG without video (assuming 1 tech: 2 patients)
  - Total RVU: 51.17, +48%
  - Practice Expense: 42.69 RVU, -10%; $1467.84; -5.53%
  - Professional: 5.42 RVU, -1%; $193.19; +3.24%
  - Physician Work (wRVU): 3.61, no change

2014 MFS for Neurology Services*

*Assuming a Conversion Factor of $35.6446

- 95954, EEG with administration of drugs
  - Total RVU: 14.03, +18%
  - Practice Expense: 9.70 RVU, -15%; $314.74, -11.64%
  - Professional: 3.47 RVU, -3%; $123,69, +2.12%
  - Physician Work (wRVU): 2.45, no change
- 95955, EEG during surgery
  - Total RVU: 7.02, +23%
  - Practice Expense: 5.35 RVU, -10%; $174.30, -6.34%
  - Professional: 1.52 RVU, -2%; $54.18, +2.74%
  - Physician Work (wRVU): 1.01, no change

2014 MFS for Neurology Services*

*Assuming Conversion Factor = $35.6446

- 95957, EEG Digital Analysis
- Do not use with 95951 as analysis is inherent in 95951
  - Total RVU: 13.69, +21%
  - Practice Expense: 10.27 RVU, -11%; $333.99, -7.91%
  - Professional: 2.99 RVU, -1%; $106.58, +3.38%
  - Physician Work (wRVU): 1.98, no change
- 95958, EEG monitoring, functional mapping (Wada Test)
  - Total RVU: 17.24, +18%
  - Practice Expense: 11.36 RVU, -11%; $338.62, -8.01%
  - Professional: 6.35 RVU, -1%; $226.34, +3.62%
  - Physician Work (wRVU): 4.24, no change

2014 MFS for Neurology Services*

*Assuming a conversion factor of $35.6446

- 95961, Electrode stimulation, brain, first hour
  - Total RVU: 8.44 RVU, +6%
  - Practice Expense: 4.91 RVU, -8%; $127.60, -4.08%
  - Professional: 4.44 RVU, -2%; $158.26, +2.68%
  - Physician Work (wRVU): 2.97, no change
- 95962, Electrode stimulation, brain, each additional hour
  - Total RVU: 7.31 RVU, +5%
  - Practice Expense: 3.72 RVU, -6%; $81.27, -1.70%
  - Professional: 4.79 RVU, -2%; $170.74, +2.83%
  - Physician Work (wRVU): 3.21, no change

2014 MFS for Neurology Services*

*Assuming a Conversion Factor of $35.6446

- Technical Expenses not defined, only APCs assigned for MEG codes
- 95965, MEG, spontaneous
  - Professional: 12.11 RVU, -4%; $431.66, +1.09%
  - Physician Work (wRVU): 7.99, no change
- 95966, MEG, evoked, single
  - Professional: 6.15 RVU, %+6.6%; $219.21, +11.67%
  - Physician Work 3.99 (wRVU): no change
- 95967, MEG, evoked, each additional
  - Professional: 5.40 RVU, +6.6%; $192.48, +11.59%
  - Physician Work (wRVU): 3.49, no change

2014 MFS for Neurology Services

- 95970, Analyze neurostimulator, no programming
  - Total RVU: 1.93, -9%
  - Practice Expense: 1.44 RVU, +3%;
  - Physician Work (wRVU): 0.45, no change
- 95974, Cranial neurostimulation, complex analysis and programming, first hour (3 or more parameters)
  - Total RVU: 5.84, -3%
  - Practice Expense: 2.59 RVU, -7%
  - Physician Work (wRVU): 3.00, no change
  - Use -52 modifier if less than 30 minutes
- 95975 Cranial neurostimulation, complex, each additional 30 minutes
  - Total RVU: 3.12 RVU, -3%
  - Practice Expense: 1.31 RVU, -7%
  - Physician Work (wRVU): 1.70, no change

CPT Medicare Payment Relative to Site of Services

- Inpatient care:
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid by DRG to hospital using IPPS
- Outpatient care: Facility-based billing
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid to medical center using HOPPS
- Outpatient care: private office
  - Professional fee bundled with technical payment, so-called global billing using CMS MFS largely following RUC recommended values

Mapping of Seizure codes to DRGs

- Terminology is important:
  - Epilepsy, 345.00-345.91, maps to DRGs 100, Seizure without MCC, and 101, Seizure with MCC.
  - Seizure(s), 780.39, maps to DRG 100 and 101.
  - Recurrent seizures, seizure disorder, 345.8x maps to DRG 100 and 101
  - Pseudoseizure, Conversion disorder, psychogenic conversion disorder, 300.11 (even with a secondary code of 780.39), maps to DRG 880, Acute Adjustment Reaction

2014 Hospital Outpatient Prospective Payment System (HOPPS)

- 1281 pages of explanation and responses to comments:

http://www.ofr.gov/OFRUpload/OFRData/2013-28737_PI.pdf

Actual APC files are listed below in the same section under Related Links under the heading of CY2013 OPPS Addenda

  - Addenda A is the numerical listing of all 700+ procedure APCs plus thousands of injectable drugs per unit price
  - Addenda B is the listing by CPT code of each Code and the APC into which it falls

- Payment for the technical portion of CPT codes done on Medicare outpatients, a top-down system based upon hospital-reported charges
  - Averaged charges for a group of similar procedures
    - Some codes benefit by the averaging
  - As CMS moves procedures in and out of APCs, the average value shifts
  - This year, CMS eliminated HOPPS payments for add-on codes, e.g. EMG after NCV

2014 Proposed Rule Capped PEs over HOPPs payment

- In the Proposed Rule, CMS found 209 codes where the APC values were lower than the global technical fee
- CMS proposed that the Practice Expense for these codes be lowered to the APC rate
- Three EEG codes, 95819, 95816, and 95822 were among the codes identified.
- Under this proposal, 95819 would have dropped from $354.04 to $181.60 for the technical fee
- AAN and other affected societies wrote letters to CMS.
- In the Final Rule, CMS did not finalize its proposal to adjust RVUs of PE to be capped by the HOPPs. It did state that it was taking time to consider the comments and plans to address this in the future.

2014 HOPPS APC 0213

- APC 0213 Level I Extended EEG, Sleep, and CV studies
  - 95812 EEG 41-60 min
  - 95812 EEG > 1 hour
  - 95816 EEG awake and drowsy
  - 95819 EEG awake and asleep
  - 96822 EEG sleep and/or coma
  - 95827 EEG all night recording
  - 95958 EEG monitoring/function test
- 2014 APC rate = $181.60, +5.2%
- 2013 APC rate = $172.61

2014 HOPPS APC 0209

- APC 0209 Level II Extended EEG, Sleep & CV
  - 95950 ambulatory cassette EEG
  - 95953 ambulatory digital EEG
  - 95956 24 hour EEG without video
  - 95827 All night EEG
- 2014 APC Rate = $440.12, -45.4%
- 2013 APC Rate = $806.13
- NB. 95951, MSLT, polysom. have been moved to APC 0435

2013 HOPPS APC 218

- APC 218 Level II Nerve and Muscle Tests
  - 95970 Neurostimulation, analysis with no programming
  - 95954 EEG monitoring with drug administration
- 2012 payment = $127.75, +60%
- 2013 payment = $79.83

2014 HOPPS APC 216

- APC 216 Level III Nerve and Muscle Tests
  - 95961 Cortical Stimulation, 1st hour
  - 95824, EEG cerebral death only
- 2012 payment is $185.46
- 2014 APC rate = $216.79

N.B., 95962 Cortical Stimulation, each additional hour, now has no technical payment

2014 HOPPS APC 0435

A.APC 0435, Level III Extended EEG, Sleep & CV

- 95951, 24 hour video EEG
- 95958, Wada test
- 95805, MSLT
- Polysomography codes

•In 2013 these codes were in APC 209 = $806.13

•2014 APC rate = $862.51

•Newly created APC code for 2014

2014 HOPPS APC 0692

- APC 0692 Level II Electronic Analysis of Devices
  - 95971 Analyze neurostim, simple
  - 95972 Analyze neurostim, complex
  - 95973 Analyze neurostim, complex
  - 95974 Cranial neurostim, complex
  - 95974 Cranial neurostim, complex
  - 95978 Analyze neurostim brain, 1st hour
  - 95982 Low gain neurostim subseq w/ reprogram
- 2014 payment = $115.86, +3.9%
- 2013 payment = $111.47

2014 MEG HOPPs

A. Technical payments for MEG studies in hospital-based outpatient care facilities

Does not apply to free standing MEG sites

- Carrier priced

Does not apply to MEG studies done on inpatients

- Technical fees bundled to DRG

- In 2013, MEG was listed in
- APC 0066 Level II Stereotactic Radiosurgery, MRgFUS, and MEG
- APC 0065 Level I Stereotactic radiosurgery, MRgFUS, and MEG
- In 2014, MEG switched to APC 0065 IORT, MRgFUS, and MEG

2014 HOPPS MEG payment

- In 2013, APC 0066, Level II Stereotactic Radiosurgery, MrgFUS, and MEG = $2,520.30 for 95965, Spontaneous MEG
  - For 2014, APC 0066 decreases to $1921.30 and renamed Level I Stereotactic Radiosurgery
  - But MEG 95965 moves to APC 0065 in 2014, now IORT, MRgFUS, and MEG
  - MEG 95966 remains in APC 065
  - APC 0065 payment = $1,248.28, -50.4% for Spontaneous MEG
  - 2013 APC 0065 payment = $978.25, +27.7% for 95966
  - 95967 has gone from APC 065 to no payment in 2014
    - 100% decrease

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You should shop locally, particularly if you practice in a small town
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Professionalism

This has been a business talk, but do not forget why you became a physician in the first place

You are expected to give back to the community by donating your talent, your time, and your money to support worthy causes

These include: your hospital, nonprofit disease organizations such as the Epilepsy Foundation, the American Academy of Neurology, etc.