RBRVS Fee Update

BY PAUL L. GRIMALDI, PhD

The Health Care Financing Administration (HCFA) has clarified and revised Medicare policies governing the RBRVS (resource-based relative value scale) fee schedule. The changes may be financially important for certain hospitals that have salaried physicians or that perform billing functions for physicians.

Hospitals and physicians need to monitor the changes to know when their carriers actually implement them, whether to submit revised bills if the changes are retroactive, and deadlines for submitting revised bills. They should also determine whether any additional amount collected will outweigh the cost to rebill. Furthermore, because Medicare carriers have implemented certain RBRVS provisions differently, hospitals and physicians should carefully monitor payments they receive to be sure the amounts are consistent with stated payment policies.

This RBRVS fee update explains the most important changes related to critical care, emergency room services, and evaluation and management (E/M) services rendered in hospitals. Readers wishing to obtain additional information about these or other areas such as surgical global fees and radiology imaging can contact their Medicare carrier or HCFA's regional office for a copy of HCFA's memorandum clarifying physician billing and payment policies under the RBRVS fee schedule.

Critical Care

Medicare payment policies have been clarified regarding:

- Procedures bundled into critical care codes
- Length of care
- Concurrent care
- Daily care limits
- Major global surgery (i.e., serious surgery requiring general anesthesia such as hysterectomy)

Usually, but not always, critical care is provided in a critical area of a hospital, such as an intensive care unit, coronary care unit, or emergency department.

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Bundled Procedures Since before the advent of RBRVS, questions have persisted about whether physicians may be paid separately for certain procedures when they provide critical care. HCFA has decided the procedures listed in the **Box** on p. 19 should not be paid separately when the same physician provides them on the same day that critical care is provided. Separate payment is available, however, if another physician provides these procedures, but that physician's involvement must be medically warranted.

Length of Care The description of CPT (Current Procedural Terminology) code 99291 indicates that it is for the first hour of critical care. HCFA has directed that this code be used to report the services of a physician providing *constant attention* to a critically ill patient for 30 minutes to one hour on a given day.

If the total duration of critical care is less than 30 minutes, the appropriate E/M code should be used. In a hospital setting, the physician's service often is defined as subsequent hospital care. In any case, the physician may bill the service, as well as one or more of the procedures listed in the **Box**, because they are not bundled into noncritical care E/M codes.

CPT code 99292 should be used to report the services of a physician providing constant attention to the critically ill patient for 15 to 30 minutes beyond the first hour of critical care on a given day. The 61st through 74th minute is not billed separately, but rather, for billing purposes, is considered to be part of the first hour of critical care.

Concurrent Care When a primary care physician and an intensivist concurrently treat a critically ill patient, Medicare payment may be made to both physicians as long as:

- The primary care physician has requested in writing the intensivist's services.
- The intensivist bills for either a consultation or critical care but not both.

• The hospital record documents that the primary care physician contributed substantially to the patient's care.

Daily Care Limits Medicare does not limit the number of necessary and documented critical care services that may be billed per day or hospital stay. However, only one physician may bill for a given hour of critical care, even if multiple physicians provided critical care during the given hour.

Major Global Surgery Separate payment may be made for preoperative or postoperative critical care if (1) the critically ill patient requires the physician's constant attention, and (2) the critical care is unrelated to the specific anatomic injury or general surgical procedure performed, as in the case of a burned patient or other patient whose condition is significantly life threatening.

For a physician to receive Medicare payment for preoperative critical care, a critical care code (with the appropriate modifier) must be used that signifies the same physician provided significant, separately identifiable E/M services on the day of the procedure. Likewise, to receive payment for postoperative critical care, the physician must use a critical care code with a modifier that indicates the same physician provided unrelated E/M services during a postoperative period.

Emergency Room Services

Medicare payment policies have been clarified for certain situations involving two physicians seeing an emergency room (ER) patient concurrently. First, separate payment is available for a primary care physician who advises a patient to go to a hospital's ER for care, is subsequently requested by the ER physician to see the patient, and then advises the ER physician about whether the patient should be admitted to the hospital. Medicare's payment depends on whether the patient is hospitalized.

If the patient is hospitalized by the primary care physician, the primary care physician bills only the appropriate level of initial hospital care because all E/M services related to the admission are part of the initial hospital care. The ER physician should bill the appropriate ER code.

If the patient is sent home, the primary care physician bills the appropriate ER code, and not a consultation code, because the physician is responsible for the overall management of the patient. The ER physician bills the appropriate ER code.

Second, if the ER physician asks a specialist to see a patient in the ER, separate Medicare payment is available for the specialist. The specialist's service should be billed as a consultation, if the definition of a consultation is met. Otherwise, the service is billed as an ER visit. If the specialist subsequently takes over care of the patient, the additional patient encounters are billed as visits, not follow-up consultations.

Third, separate Medicare payment also is made if, at the ER physician's request, a specialist sees a patient in the specialist's office rather than the ER. The specialist would bill for an office visit, not a consultation, because the ER physician is referring the patient, instead of seeking an opinion or advice.

Fourth, separate Medicare payment may be made to a physician who provides (in his or her office) follow-up care for a minor surgery provided by the ER physician. The office visit is billed at the appropriate office fee. The global fee paid to the ER physician is not reduced.

E/M Services in Hospitals

HCFA has clarified certain policies dealing with physician visits related to a hospital admission or discharge. First, if a physician performs a comprehensive physical examination several days before admission and less comprehensive services the day of admission, the physician should bill a comprehensive office visit and the lowest level of initial hospital care.

Second, when two physicians are involved in the same admission, only one of them may bill for initial hospital care. The other physician should

Continued on next page

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BUNDLED CRITICAL CARE CODES

When the following CPT codes are reported in conjunction with critical care codes 99291 and 99292, Medicare payment will be made only for the critical care code.

36000	71020	94656
36410	91055	94657
36415	92953	94760
36600	93561	94761
71010	93562	94762

Continued from page 19

report a consultation or subsequent hospital care, as circumstances warrant.

Third, separate Medicare payment can be made to the physician for both hospital discharge management and a nursing facility admission when discharge and admission occur on the same day. Special rules apply, however, if the physician is a surgeon.

If the patient's admission to the nursing facility is for a condition unrelated to the surgery, the surgeon may bill separately for the admission. If the admission is for a related condition, no separate payment is made because the admission would be covered by the global surgery fee.

Fourth, separate Medicare payment may be available when a given physician transfers a patient between facilities. If the transfer is between (1) different hospitals, (2) different hospitals under common ownership and without merged records, or (3) an acute care unit and a prospective payment system–exempt unit within the same hospital that do not have merged records, the physician may bill for both hospital discharge management and initial hospital care for the admission to the other hospital or exempt unit.

In other transfer circumstances, the hospital discharge management code and the admission code may not be billed separately. The physician should bill only the appropriate level of subsequent hospital care.

Future Clarifications

The RBRVS fee schedule is evolving. Physicians, hospital medical directors, clinical department heads, and other interested parties are scrutinizing the relative values and the associated CPT codes. And additional revisions can be expected in the near future.

Hospitals and physicians should study the soon-to-be-published RBRVS rule for 1993; it may contain changes that are financially consequential. □

Continued from page 12

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tient care, the volume and total Medicare spending for such care have skyrocketed. This massive shift has implications for the organization and future of hospital care.

As hospital outpatient care has grown, so has the competition to provide such care. ProPAC estimates that the number of freestanding ambulatory surgical centers increased from 239 in 1983 to 1,383 in 1990. Ambulatory treatment in physicians' offices and new types of diagnostic centers are also burgeoning. In his June testimony, ProPAC's Altman questioned the impact of these trends on hospitals: "If these trends accelerate, will the hospital of the future be able to use its outpatient department as a profit center to counter the losses on the inpatient side? If it cannot, how will hospitals cope with declining income?"

Future Reform

To counter the negative trends of falling profit margins, wide cost shifts, and hospital occupancy rates that had fallen to a low of 63.5 percent for 1991, Altman offered several policy recommendations to Congress.

First, he recommended that "we continue to tighten the reimbursement system for all payers of hospital care. This will force hospitals themselves to deal with their excess capacity."

Second, "to keep overall financial pressure on hospitals and the total healthcare system," Altman recommended the establishment of a national healthcare expenditure board and a system of regional healthcare expenditure boards, similar to the Federal Reserve System. All insurers, public and private, would pay hospitals the same price for the same service. The national board would set a total expenditure target related to the growth in the national income. However, the board would have the flexibility to make trade-offs regarding healthcare spending and other national priorities.

Such a plan is but one strategy for reducing the inefficiencies and inherent instability of the current system of paying hospitals. Whatever direction reform takes, some change seems necessary. As Lewin-ICF's Allen Dobson and James Roney observe, "The evidence suggests that cost-shifting's days may be numbered and that systemic healthcare reform will be required if we are to avoid a serious breakdown in the financial structure of the nation's healthcare delivery system."[8] □

NOTES

1. Prospective Payment Assessment Commission (ProPAC), *Medicare and the American Health Care System: Report to the Congress*, Washington, DC, June 1992, Table 1-2.
2. ProPAC.
3. Allen Dobson and James Roney, "Cost-Shifting: A Self Limiting Process," Lewin-ICF, Fairfax, VA, April 1992.
4. ProPAC, Table 1-7.
5. ProPAC, Figure 2-2.
6. Allen Dobson et al., "An Evaluation of Winners and Losers under Medicare's Prospective Payment System," Extramural Report E-92-02, prepared by Lewin-ICF for ProPAC, Washington, DC, May 1992.
7. Deborah Williams et al., "Winners and Losers under PPS," Intramural Report I-92-01, ProPAC, Washington, DC, June 1992.
8. Dobson and Roney.