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Internal Medicine Coding Alert

Medicare Reimbursement Changes for 2000

Internal medicine groups will not be hit with reductions to the values assigned to the codes internists report most often. An analysis of the Medicare relative value units (RVUs) for internal medicine codes reveals that, if anything, many offices may be seeing a slight benefit under the new fee schedule, reports **Jim Stephenson, CPC,** the consulting editor for Internal Medicine Coding Alert and the billing manager for Premium Medical Management Inc., a multispecialty physician group practice in Elyria, Ohio.

I was kind of surprised, with the year change and the new millennium, that there were not more changes affecting internal medicine, he says. The evaluation and management (E/M) services are staying fairly consistent [with the previous year]. Any changes largely will be found in the practice-expense portion of the total relative value units assigned to a particular code, Stephenson adds.

Note: The new fee schedule and changes were published in the Nov. 2, 1999, issue of the Federal Register, under the heading, Health Care Financing Administration: Medicare Program; Final Rule on Revisions to Payment Policies Under the Physician Fee Schedule for the Calendar Year 2000.

Practices Can Calculate Expected Reimbursement

Among the changes to this years final rule is an easier-to-read relative value unit (RVU) table that includes the exact formula physician groups can use to calculate the payments they will receive from carriers.

One of the many comments we received last year was that we did not include the formula in the final rule, said **Carolyn Mullen,** senior technical advisor with the Health Care Financing Administration in Baltimore, Md. We included the formula this time. You should be able to calculate the exact amount that you will receive from the carrier. There may be a difference of a few pennies. But, in most cases, the carrier payment and the calculation by the physician should match.

The calculation formula is:

Work RVU x Work GPCI = __
+PE RVU x PE GPCI = __
+PLI RVU x PLI GPCI = __
Total RVU = __
Payment = Total RVU x CF

RVUs are listed in Addendum B of the final rule. GPCIs (geographic practice cost indexes) are listed in Addendum D. CF is the conversion factor (year 2000 CF is $36.6137).

Editors note: Copies of the final rule can be obtained by writing to the Federal Register at: New Orders, Superintendent of Documents, P. O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested and enclose a check or money order to the Superintendent of Documents. The cost is $8 per copy. Credit card orders can be placed by calling the government printing office (GPO) at 1-888-293-6498. Or, you can download the document from HCFAs web site at http://www.hcfa.gov by going to the home page, selecting Medicare, Professional/Technical Information, Medicare Payment Systems and then, Physician Fee Schedule.

RVU Table Now Includes Modifier and Practice Expense Information

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HCFA has added more information to the final rule on revisions to the physician fee schedule for coders and physicians to be able to calculate reimbursement and discern coverage information about a particular code at a glance, explains Mullen.

The new RVU table starts on page 59443 of the document. It has 15 columns:
CPT/HCPCS
MOD
Status
Description
Physician Work RVUs
Fully Implemented Non-Facility PE RVUs
Year 2000 Transitional Non-Facility PE RVUs
Fully Implemented Facility PE RVUs
Year 2000 Transitional Facility PE RVUs
Malpractice RVUs
Fully Implemented Non-Facility Total
Year 2000 Transitional Non-Facility Total
Fully Implemented Facility Total
Year 2000 Transitional Facility Total
Global

The CPT/HCPCS column contains the CPT and alphanumeric HCPCS codes. The MOD column is for modifier and will contain either a TC or PC to indicate the technical component or professional component, says Mullen. If there are no letters in this column, the values are for the entire code and include the technical and professional components, she noted.

The Status column will contain a letter that indicates whether the code is in the fee schedule and whether it is separately payable, Mullen says. The letters correspond to the following definitions:

AActive code.
BBundled code. Payment is always bundled into other services.
CCarrier-priced code. Carriers establish RVUs and payment amounts for these codes.
DDeleted code.
EExcluded code by regulation. No payment is made under fee schedule for these services.
GCode not valid for Medicare purposes.
NNon-covered service.
PBundled or excluded codes.
RRestricted coverage.
TInjections.
XExclusion by law. These codes represent an item or service not within the definition of physicians services.

The columns for Description and Physician Work RVUs are self-explanatory, but Mullen explains that physician practices should be sure to distinguish between the transitional practice expense (PE) RVUs for both facility and non-facility services. If you are determining payment for this year, use the values in the transitional columns, not the fully implemented values, Mullen explains.

Medicare is phasing in the transition from charge-based practice expenses and malpractice insurance expenses to resource-based practice and malpractice insurance expenses. The fully implemented values will not be in effect until 2002. Lobbyists and others will be interested in these values, but, for calculating payments for the next year, use the 2000 transitional values.

In addition, Mullen notes, when determining whether to use the facility or non-facility RVUs, a facility service is defined as one that occurs in a hospital, ambulatory surgical center (ASC) that provides Medicare-approved services or a skilled nursing facility (SNF). All other services should be considered non-facility. When services are provided in both a facility

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and an outpatient settingfor example, a hospital-owned physicians officeit depends on whether the patient is considered the facilitys patient or the physicians.

If the facility is submitting a bill, then it should be considered a facility service, says Mullen. The key is that Medicare does not want to pay twice for the practice expense and malpractice insurance portions of the fee.

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