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# How Medicare Pays Doctors. 1980.

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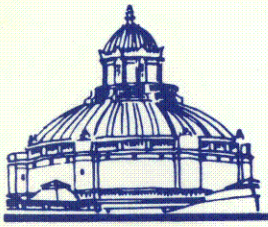

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ABSTRACT

Payments for physicians' services under Medicare are made under the Part B or Supplementary Medical Insurance portion of the program. Federal law provides that payments are to be made on the basis of reasonable charges for covered services. This report: 1) details the criteria that are employed in making reasonable charge determinations; 2) discusses the "assignment" of Medicare claims including factors contributing to the declining assignment rate; and 3) summarizes those special circumstances where reimbursement for physician services are not automatically made on a reasonable charge basis.

## I. BACKGROUND

The Medicare program, which is authorized under Title XVIII of the Social Security Act, consists of two separate but complimentary types of health insurance for the aged and certain disabled persons. Part A, the Hospital Insurance Program, provides protection against hospital and related institutional costs; and Part B, the Supplementary Medical Insurance Program, covers physicians' services and many other medical services. Covered physicians' services include those provided by doctors of medicine and osteopathy (M.D.'s and D.O.'s) wherever furnished, including surgery, consultation, and home, office, and institutional calls. Also included are services provided by: 1) dentists when performing certain dental surgeries or setting dental fractures 2) podiatrists (foot doctors) for certain services other than routine foot care; and 3) chiropracters meeting certain standards, but only for treatment involving manual manipulation of the spine to correct a condition (called a subluxation) demonstrated to exist by X-ray. The Part B program generally pays 80 percent of the reasonable charges for covered services in excess of the deductible amount of $60 per year. Payment for outpatient treatment of mental illness is, however, limited to $250 per year.

The purpose of this report is to describe how Medicare pays for physicians' services covered under the program.

## II. STATUTORY REQUIREMENTS

Title XVIII of the Social Security Act provides that payments be made to or on behalf of persons enrolled under Part B, the Supplementary Medical

Insurance Program, for expenses incurred by them for covered physicians' services.

Section 1833(a) of the Act stipulates that, except for certain deductible and coinsurance amounts that must be paid by beneficiaries, benefit payments shall be made (with certain exceptions) on the basis of the "reasonable charges" for the covered services. Section 1842 of the Act, which deals with the use of carriers to administer the Part B program, sets forth the criteria to be used in arriving at the "reasonable charges" for specified services. Regulations establishing the criteria for the determination of "reasonable charges" are contained in Subpart E, Part 405, Title 42 of the Code of Federal Regulations.

## III. CRITERIA FOR DETERMINING "REASONABLE CHARGES"

The "reasonable charge" for a specific service, in the absence of unusual medical complications or certain other circumstances, can be --

(1) no higher than the individual practitioner's customary charge for that service;
(2) no higher than the applicable prevailing charge made for similar services in the locality; and
(3) no higher than the actual charge of the individual physician rendering the service.

The law further provides that the "reasonable charge" for a service may not exceed the charge applicable for a comparable service under comparable circumstances to the policyholders or subscribers of the carriers which administer the supplementary program. In applying these criteria, carriers are required to exercise judgment, based on charges made by physicians generally and special factors that may exist in individual cases, so that determinations are reasonable and equitable. A charge that exceeds either the customary charge of the practitioner or the prevailing charge in a locality, or both, can only be found to be reasonable, if there are

unusual circumstances or medical complications requiring additional time, effort or expense to support such a charge, and if it is acceptable practice in the locality to make such an extra charge.

A. "Customary Charges"

The term "customary charges" refers to the uniform amounts which a physician charges in the majority of cases for specific medical procedures or services. In determining these uniform amounts, token charges for charity patients and sub-standard charges for low-income patients are excluded. Similarly, exceptionally high fees that are attributable to a patient's unusual ability to pay should also be excluded. If a physician varies his charges for a particular procedure or service such that no one amount is charged in the majority of cases, the carrier is required to exercise judgment to establish a customary charge for such service rendered by such physician. The customary charge for a specific service, therefore, may vary from one physician to another.

The customary charges of a physician are not necessarily static amounts. When a practitioner revises his patterns or charges, new customary charges for specific procedures and services develop. When a carrier determines, on the basis of adequate evidence, that a physician has changed his charges to the public in general, the customary charges for that physician resulting therefrom are recognized in subsequent reasonable charge determinations for his services. Customary charge screens are updated every July 1,[1/] and are based on the charge data developed by the carrier for the prior calendar year.

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1/ Customary and prevailing charge screens continue to be updated every July 1 for a 12 month period, despite the change in 1976 in the Federal fiscal year.

B. Prevailing Charges

The term "prevailing charges" refers to those charges which fall within the range of charges most frequently and widely used in a locality for particular procedures or services. The top of this range establishes an overall limitation on the charges which a carrier will accept as reasonable for payment purposes, unless there are unusual circumstances or medical complications. In the case of physicians' services, certain limitations, based on economic index data, have been placed on allowable increases in prevailing charge limits.

In determining prevailing charges, carriers base their screens on the overall pattern of "customary charges" existing in a particular locality. Carriers delineate the localities on the basis of their knowledge of local conditions; these localities generally correspond to a political or economic subdivision of a State. Prevailing charges may vary from one area to another. They may also differ within a locality for physicians who engage in a specialty practice compared with other practitioners. For example, a cardiologist may charge $25 for a specific examination while a general practitioner's charge is $15 for a similar examination. Both charges may be customary for each physician and fall within their respective prevailing charge ranges in the locality. Each of these charges, therefore, might be acceptable as reasonable charges.

The prevailing limit on the reasonable charge for a specific service is set at a level no higher than is necessary to embrace the 75th percentile of the customary charges. The charge level is updated every July 1 based on charge data obtained for the previous calendar year. For example, if customary charges for an appendectomy in a locality were at five levels with 10 percent of the services rendered by physicians whose customary charge was $225, 40 percent rendered by physicians who charge $250, 40 percent by physicians

who charge $275, 5 percent by physicians who charge $300, and 5 percent by physicians charging in excess of $300, the prevailing limit would be $275, since this is the level that would encompass at least 75 percent of the cases.

The "Social Security Amendments of 1972" established, for physicians' services, limitations on the yearly increases in prevailing charge levels which would be recognized as reasonable. Specifically, the levels could be increased for FY '74 and thereafter only to the extent justified by economic indices reflecting changes in the operating expenses of physicians and in earnings levels. Due to the fact that regulations to implement this provision were delayed, this provision first became effective for FY '76. Because of the delay, the implementation on July 1, 1975 resulted in a rollback of some physicians' fees. To correct this problem, Congress included a provision in P.L. 94-182 which assured that no prevailing charge in FY '76 would be less than it was in FY '75. Subsequently, Congress enacted P.L. 94-368 which assures that operation of the economic index limitation will never result in a rollback of prevailing charges below the FY '75 levels.

The economic index applicable to prevailing charges is promulgated annually for the 12 month period beginning July 1. The increase in the index over the base value of 1.000 is the maximum allowable increase in any prevailing charge for physicians' services in the current year over the corresponding prevailing charge for the same service in the same locality in FY '73. The rates are calculated based on the weighted averages of: 1) changes in general earnings levels, and 2) changes in expenses of the kind incurred by physicians in office practice. Rates promulgated to date are as follows:

| Period | Rates | Percent Increase Over Prior Period |
|---|---|---|
| 7/1/75 - 6/30/76 | 1.179 | |
| 7/1/76 - 6/30/77 | 1.276 | 8.23% |
| 7/1/77 - 6/30/78 | 1.357 | 6.35% |
| 7/1/78 - 6/30/79 | 1.426 | 5.08% |
| 7/1/79 - 6/30/80 | 1.533 | 7.50% |

Thus if the prevailing charge for a particular service was $100 in FY'73, the maximum recognized prevailing charge would be $117.90 for the period July 1, 1975 - June 30, 1976, $127.60 for July 1, 1976 - June 30, 1977, $135.70 for July 1, 1977 - June 30, 1978, $142.60 for July 1, 1978- June 30, 1979, and $153.30 for July 1, 1979 - June 30, 1980.

C. Examples of "Reasonable Charge" Determinations

Situation: The prevailing charge for a specific procedure is $100 in a certain locality.

--Dr. A's bill is for $75, although he customarily charges $80.
--Dr. B's bill is his customary charge of $85.
--Dr. C's bill is for $90, although he customarily charges $80, and there are no special circumstances in the case.
--Dr. D's bill is his customary charge of $125.

The reasonable charge for Dr. A is $75, since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than the customary charge and below the prevailing charge.
The reasonable charge for Dr. B is $85, because it is his customary charge and it does not exceed the prevailing charge for the locality.
The reasonable charge for Dr. C is $80, because that is his customary charge. Even though his actual charge falls below the prevailing charge, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.
The reasonable charge for Dr. D is $100, the prevailing charge in the locality.

IV. ASSIGNMENT OF MEDICARE CLAIMS

A. Definition of "Assignments"

Payments for physicians' services under Medicare are made either directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. The itemized bill method involves the filing of claims without an execution of the assigned agreement.[2/] An assignment is an agreement between the physician and the Medicare beneficiary under which the beneficiary "assigns" (i.e., transfers) to the physician his rights to payments for covered services included in the claim. In return, the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. Thus he cannot charge the beneficiary (nor can he collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts. If the physician is dissatisfied with the amount of the reasonable charge, he may seek a review from the carrier.

A physician may accept or refuse requests for assignments on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he is precluded from "fragmenting" bills for the purpose of circumventing the reasonable charge limitations; he must either accept assignment or bill the patient for all of the services performed on one occasion.

Under the provisions of P.L. 95-142, the "Medicare-Medicaid Anti-Fraud and Abuse Amendments", a physician who knowingly, willfully and repeatedly

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2/ Physicians often submit itemized bills to carriers on behalf of the beneficiaries as a courtesy.

violates his assignment agreement would be guilty of a misdemeanor. The penalty for conviction would be a maximum $2,000 fine, up to six months imprisonment, or both.

B. Assignment Rate Experience

The number of claims on which physicians accept assignment has declined since 1968, the year HEW began reporting this data. The total of assigned claims as a percentage of total claims received by Medicare carriers is known as the total assignment rate. The net assignment rate is computed in the same manner except that it omits hospital-based physicians and group-practice prepayment plans which are considered assigned by definition. The following table shows the net assignment rates by year and quarter from 1968 through 1979.[3/]

TABLE 1

NET ASSIGNMENT RATES, BY YEAR AND QUARTER, 1968-1979
(in percent)

| QUARTER | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan.-Mar. | 53.4 | 58.1 | 58.3 | 57.9 | 54.2 | 50.3 | 49.9 | 50.7 | 49.0 | 49.1 | 49.4 | 50.3 |
| Apr.-June | 60.7 | 64.4 | 63.0 | 60.7 | 56.6 | 54.2 | 53.4 | 53.2 | 51.3 | 51.1 | 51.2 | 51.5 |
| July-Sept. | 62.3 | 63.7 | 63.3 | 60.3 | 56.4 | 54.5 | 53.1 | 53.0 | 51.9 | 51.8 | 51.6 | 52.3 |
| Oct.-Dec. | 59.7 | 60.4 | 59.1 | 55.3 | 53.4 | 51.6 | 51.4 | 50.3 | 50.0 | 50.2 | 50.4 | 51.0 |
| (Annual) | N.A. | 61.5 | 60.8 | 58.5 | 55.1 | 52.7 | 51.9 | 51.8 | 50.5 | 50.5 | 50.6 | 51.3 |

N.A. - Not Available

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3/ Health Insurance Statistics, U.S. Department of Health, Education and Welfare, Social Security Administration. DHEW Publication Numbers (SSA) Office of Research and Statistics; 72-11702 (Jan. 10, 1972), 73-11702 (June 20, 1973), and 75-11702 (Dec. 5, 1974); and calls to the staff of the Health Care Financing Administration, Department of Health and Human Services.

The seasonal variability in assignment rates appears to be due to the changes in volume of unassigned claims received during the year by carriers. Receipt of unassigned claims rises sharply at the end of each year as beneficiaries submit their year's accumulation of medical bills. The increased volume carries over into each January. These unassigned claims make up a larger share of the claims received by carriers in the first and last calendar quarters accounting for a comparable drop in the percentage of assigned claims.

The statistics included in Table 1 are program-wide data. Net assignment rates also vary geographically. For example, in 1969 the net assignment rate ranged from a high of 73.7 percent in the Boston region to a low of 48.7 percent in the New York region. By 1979, the net assignment rate had declined in every region except two:

TABLE 2

NET ASSIGNMENT RATES, BY REGION, 1969 AND 1979
(in percent)

| Region | 1969 a/ | 1979 b/ | Change |
|---|---|---|---|
| Boston | 73.7 | 67.6 | -8.3% |
| New York | 48.7 | 50.5 | 3.7% |
| Philadelphia | 57.3 | 61.6 | 7.5% |
| Atlanta | 58.8 | 52.1 | -11.4% |
| Chicago | 54.5 | 47.4 | -13.0% |
| Dallas | 71.1 | 49.7 | -30.1% |
| Kansas City | 63.8 | 40.7 | -36.2% |
| Denver | 73.0 | 40.0 | -45.2% |
| San Francisco | 70.5 | 53.4 | -24.3% |
| Seattle | 64.8 | 32.1 | -50.5% |

a/ DHEW Publication No. (SSA) Office of Research and Statistics: 72-11702, (January 10, 1972).

b/ Telephone conversation with officials of Health Care Financing Administration.

The variations in assignment rates are even more dramatic when comparisons are made between individual carriers. For example, in October 1979, Rhode Island Blue Shield was the carrier with the highest net assignment rate (80.9%) among the single State-wide carriers, while the lowest carrier net assignment rate was experienced in the state of Wyoming by the Equitable Insurance Company (18.9%).[4/]

C. Factors Contributing to Declining Assignment Rates

Net and total assignment rates have been declining steadily since 1968. Acceptance of assignments by physicians depends upon a number of factors including general attitudes toward the program, the size of the bills for specific services, relationships with patients, the ability of patients to pay, and assurances of prompt payment. A number of administrative and operating changes made in the program relating to "reasonable charge" determinations have also had a major impact on the net assignment rate. Of particular importance are two administrative policies which were adopted by the program and subsequently incorporated in the "Social Security Amendments of 1972" (P.L. 92-603). These involved:

--Updating the customary charge screens every July 1 based on the physicians' charges which were in effect the preceding calendar year. This can represent as much as an 18 month delay in recognizing increases in physicians' customary charges.

--Updating the prevailing charge screens every July 1 set at the 75th percentile of customary charges made by physicians in the area during the preceding calendar year. Earlier, the prevailing

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4/ October 1979 Part B Carrier Workload Report, Bureau of Program Operations, Health Care Financing Administration, Department of Health, Education, and Welfare, January 17, 1980.

charge limit had been set at the 83rd percentile. "Reasonable charge" determinations are further affected by the provision in P.L. 92-603 limiting increases in prevailing charges to those justified by economic changes.

These changes have been accompanied by a substantial increase in the "reasonable charge" reduction rate -- i.e., the percentage of assigned claims in which the physician accepts assignment, but where he receives a reduced payment, because his bill is greater than the "reasonable charge" determination made by the carrier. During the third quarter of 1969, the "reasonable charge" reduction rate stood at about 22 percent.[5/] This meant that about one in five approved assigned claims resulted in a payment to a physician of an amount less than his billed charges. By the second quarter of 1979, the "reasonable charge" reduction rate among assigned claims (excluding those from hospital-based physicians) had reached 79.5 percent.[6/] In other words, over three-fourths of all assigned claims resulted in reduced payments from billed charges (amounting to $325 million or $20.27 per approved claim).[7/] Physicians who do not accept assignments are not affected by possible reductions in billed charges; the beneficiary must make up the difference. The "reasonable charge" reduction rate for such unassigned claims (excluding those from hospital-based physicians) during the second quarter of 1979 was also sizeable -- 83.5 percent. The amount reduced per approved claim was $20.83 for a total of $313 million.

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5/ DHEW Publication No. (SSA) Office of Research and Statistics: 75-11702, (December 5, 1974).

6/ Quarterly Report on SMI Carrier Reasonable Charge and Denial Activity, April-June 1979; Bureau of Program Operations, Health Care Financing Administration, DHEW, September 28, 1979.

7/ Ibid.

## V. SPECIAL CIRCUMSTANCES

The majority of services rendered by physicians are reimbursable on a bill-by-bill basis on the basis of "reasonable charges". There are, however, a few situations, principally involving teaching physicians and hospital-based physicians, where this rule does not automatically apply.

### A. Services in a Teaching Hospital

Many Medicare patients receive hospital services in institutions with approved graduate medical education programs. These teaching hospitals range in character from the large inner-city institutions for indigents, in which most of the medical care is provided by residents and interns (i.e., house officers), to suburban hospitals with a small teaching program where paying patients are cared for primarily by their personal physician. The supervision and training of house officers is carried out by teaching physicians. These physicians have a variety of arrangements with the hospital medical education program, ranging from salaried physicians employed full-time by the hospital or affiliated medical school to volunteer physicians with a private practice in the community who donate time to a medical education program. Teaching physicians devote varying amounts of time to their educational, patient care, research, and administrative functions.

#### 1. Reimbursement for Services of Teaching Physicians

The original Medicare legislation provided that teaching hospitals would be reimbursed for costs associated with their teaching programs in the same manner as other hospital costs. It was expected that direct patient care services rendered by a teaching physician could be reimbursed on a fee-for-service basis under Part B. However, the question of how the program

should pay for their supervisory activities was not specified. Implementing regulations permitted reimbursement under the Part B program (similar to that for independent practitioners) in cases where the physician provided personal and identifiable direction to house officers caring for the patient, including supervision in person in the case of major surgery or other complex or dangerous situation. However, uniform application of these policies on a case-by-case basis proved difficult in the widely varying teaching hospital settings. Fee-for-service billings occurred in some cases without the required personal involvement, in some cases where the physician merely took the legal responsibility for care, or in certain cases in amounts out of proportion to the service or charges billed to other patients.

The Congress therefore included in the "Social Security Amendments of 1972" a provision dealing specifically with teaching physicians. Section 227 provided that fee-based reimbursement was to be limited to situations involving bona fide private patients. The legislation provided for a presumption to be made that all of the inpatients or outpatients of a teaching hospital would be deemed to be private patients if in 1966 and each year thereafter all of the patients of the hospital had been regularly billed for physicians' services, reasonable efforts had been made to collect, and payments had been regularly collected in full or substantial part from at least 50 percent of all inpatients. The legislation also liberalized cost reimbursement for teaching physicians' services for which no Medicare fee would previously have been allowed. Payments were permitted to a charitable or educational fund in recognition of services donated by volunteer teaching physicians.

The concept of a private patient proved difficult to define in view of the multiplicity of teaching programs, and questions were raised regarding the impact of the provision on various teaching hospitals. Thus in 1973 legislation was

enacted which directed HEW to arrange for a study, to be conducted by the National Academy of Sciences (NAS), of appropriate and equitable methods of reimbursement for physicians' services in teaching hospitals. The final NAS report, prepared by the Institute of Medicine was issued in March 1976. This report underscored the problems associated with the development of a single payment method for all teaching hospitals.

Subsequent amendments to Section 227 postponed its effective date and restricted the more favorable cost reimbursement provisions to hospitals that elected cost payments in lieu of any reasonable charge reimbursement otherwise due them. The effective date of the section is October 1, 1978. However, as of this writing, final regulations implementing the provision have not been issued. As a result, except where teaching hospitals have elected reasonable cost reimbursement, payments continue to be made according to the procedures in effect prior to enactment of 1972 amendments.

The issue of the reimbursement for the services of teaching physicians is under review by the 96th Congress. In December 1979, the Senate Finance Committee reported H.R. 934 which extended until October 1, 1979 the implementation of Section 227 and provided for an alternative reimbursement method for certain teaching teams. On March 4, 1980, the House Interstate and Foreign Commerce Committee ordered reported H.R. 4000. One section of this bill repeals the provision of the 1972 amendment except for that portion relating to teaching hospitals electing reasonable cost reimbursement.

2. Reimbursement for Services of Residents and Interns

By law the services of interns and residents in approved teaching programs are excluded from the definition of "physicians' services" and reimbursement on a fee basis is precluded. Services of house officers are instead included as a component of allowable hospital costs.

B. Hospital-Based Physicians

Many hospitals retain physicians on a full-time basis particularly in the fields of radiology, anesthesiology and pathology. These provider-based physicians generally engage in a variety of activities including teaching, research, administration, and other provider-related activities as well as direct medical services to individual patients. The general practice among many hospitals and other providers employing these physicians is to compensate them either on a fixed salary or a percentage of income basis (either gross or net) for all their services. There are also arrangements under which the physician assumes all or part of the costs of operating a provider department through a lease or concession arrangement.

For purposes of Medicare reimbursement a distinction must be made between those medical and surgical services rendered directly to an individual patient (the professional component) and those services for the provider (the provider component). In general, reimbursement for the professional component is made on a reasonable charge basis under the Part B program. Reimbursement for the provider component is made on a reasonable cost basis under Part A for inpatient hospital services and under Part B for outpatient hospital services and for certain inpatient ancillary services when Part A benefits have been exhausted. The allocation of compensation between the professional and provider components is based on the time the physician spends in his various activities.

C. Reimbursement for Renal Dialysis

The "Social Security Amendments of 1972" (P.L. 92-603), extended Medicare coverage to persons under age 65 for the costs of services and

supplies furnished in connection with end-stage chronic renal disease. P.L. 95-292 (enacted June 13, 1978) amended the program by providing incentives for the use of lower cost, medically appropriate self dialysis (particularly home dialysis); eliminating program disincentives to the use of transplantation; and providing for the use of incentive reimbursement methods for services furnished by renal dialysis facilities to patients dialyzing in the facility or at home.

P.L. 95-292 also provided statutory authority for existing program policies permitting the Secretary to make alternative reimbursement methods available with respect to services provided in connection with routine maintenance dialysis episodes. Two methods are available. Under the first, the physician bills the Medicare program reasonable charges for all emergency services he furnishes during a maintenance dialysis episode. The physician looks to the facility for payment for his routine dialysis services and the facility is reimbursed for these payments by the program. The second method, known as "comprehensive reimbursement," provides a fixed monthly payment for all medical services furnished to a maintenance dialysis patient during a month, other than inpatient hospital services and services not related to the patient's renal problem that require extra visits. (Reasonable charges for these latter services may be billed separately.) Program regulations specify that the comprehensive payment method can only be used by a physician if he, and the other physicians in any renal dialysis facility in which he may practice, agree to use it in billing for all their renal patients.